IDAHO DEPARTMENT OF
HEALTH & WELFARE

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December 12, 2013

Phyllicia Harris, Administrator
Liberty Dialysis Idaho Falls
2381 East Sunnyside Road
Idaho Falls, ID 83404

RE: Liberty Dialysis Idaho Falls, Provider #132514

Dear Ms. Harris:

This is to advise you of the findings of the Medicare survey of Liberty Dialysis Idaho Falls, which was conducted on December 6, 2013.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicare deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

An acceptable plan of correction (PoC) contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the ESRD into compliance, and that the ESRD remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

After you have completed your Plan of Correction, return the original to this office by **December 26, 2013,** and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

Trish O'Hara

TRISH O'HARA
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

TO/pmt
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132514	A. BUILDING _____ B. WING _____	12/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS IDAHO FALLS	2381 EAST SUNNYSIDE ROAD IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 000	INITIAL COMMENTS [CORE] The following deficiencies were cited during the recertification survey of your ESRD facility from 12/3/13 - 12/6/13. The surveyor conducting the survey was: Trish O'Hara, RN Acronyms used in this report include: MMWR - Morbidity and Mortality Weekly Report PD - Peritoneal Dialysis POC - Plan of Care RN - Registered Nurse	V 000	RECEIVED DEC 24 2013 FACILITY STANDARDS	
V 124	494.30(a)(1)(i) IC: HBV: TEST ALL,REV RESULTS/STATUS B4 ADMIT Routine Testing for Hepatitis B The HBV serological status (i.e. HBsAg, total anti-HBc and anti-HBs) of all patients should be known before admission to the hemodialysis unit. Routinely test all patients [as required by the referenced schedule for routine testing for Hepatitis B Virus]. Promptly review results, and ensure that patients are managed appropriately based on their testing results. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to provide infection control precautions for 2 of 10 patients (Patients #3 and #5) whose records were reviewed. This failure placed patients at risk of complications caused by undetected Hepatitis B infections. Findings include:	V 124	See attached. completed by 1/1/14	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shyiesha Davis RN — TITLE: Clinic Manager — (X6) DATE: 12-23-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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V 124	Continued From page 1 1. According to the CDC "Recommendations for Preventing transmission of Infections Among Chronic Hemodialysis Patients" (MMWR, Vol. 50/No. RR-5,)anti-HBs is a serological test to determine a persons immunity to the Hepatitis B virus. A laboratory value less than 10 indicates no immunity to the virus. A value more than 10 indicates the person has immunity to the Hepatitis B virus. The same CDC document defines HBsAg as a serological test to determine the presence of active Hepatitis B virus. A negative result indicates no active disease. A positive result indicates active Hepatitis B virus is present. In an interview on 12/5/13 at 4:15 P.M., the nurse manager said it was facility policy that all patients who did not have Hepatitis B immunity, or whose immunity status was unknown, be tested on a monthly basis to detect active Hepatitis B. However, patient records did not reflect the testing, as follows: a. Patient #3 was a 54 year old female who had been dialyzing at the facility since 5/14/13. Review of her laboratory values showed Patient #3 did not have Hepatitis B immunity as indicated by 2 anti-HBs results, dated 5/6/13 and 5/23/13, with values less than 10. Further, there were no documented HBsAg test results for the months of September, October or November 2013, to determine whether Patient #3 had acquired active Hepatitis B. b. Patient #5 was a 55 year old male who had dialyzed at the facility since April 2012. He was a	V 124		

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V 124	Continued From page 2 PD patient until he converted to hemodialysis on 9/11/13. Review of his record showed he had received 2 series of the Hepatitis B vaccine but remained a non-responder to the vaccine with no acquired immunity. This was documented by anti-HBs values less than 10 on 10/2/12, 4/10/12 and 1/11/13. Further, there were no documented HBsAg results for the months of September, October or November 2013, to determine whether Patient #5 had acquired active Hepatitis B. The facility failed to ensure Hepatitis B status was monitored.	V 124		
V 128	494.30(a)(1)(i) IC-HBV-ISOLATION (EXISTING FACILITY) Isolation of HBV+ Patients To isolate HBsAg positive patients, designate a separate room for their treatment. For existing units in which a separate room is not possible, HBsAg positive patients should be separated from HBsAg susceptible patients in an area removed from the mainstream of activity. This STANDARD is not met as evidenced by: Based on observation and staff interview it was determined the facility failed to provide 76 of 76 patients (Patients #1 - #76) who dialyzed at the facility, with protection from potential exposure to the Hepatitis B virus. This failure allowed potential patient exposure to serious illness and complications. Findings include: During a tour of the facility on 12/3/13 at 8:00	V 128	See attached POC Completed 12/4/13	

PAPIN

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V 128	Continued From page 3 A.M., it was noted the treatment floor consisted of 20 dialysis stations. There was no isolation room present. In an interview on 12/3/13 at 4:00 P.M., the nurse manager said any patient found to have active Hepatitis B would be transferred to a nearby dialysis unit, owned by another entity, with whom the facility had a written agreement. However, she was unable to find the written agreement and said it must have been a verbal agreement. The facility failed to maintain an infection control plan for safely treating Hepatitis B positive patients. Note: The facility obtained a written agreement, signed on 12/4/13, for the transfer and care of the facility's patients who required isolation to another dialysis unit.	V 128		
V 516	494.80(b)(1) PA-FREQUENCY-INITIAL-30 DAYS/13 TX An initial comprehensive assessment must be conducted on all new patients (that is, all admissions to a dialysis facility), within the latter of 30 calendar days or 13 hemodialysis sessions beginning with the first dialysis session. This STANDARD is not met as evidenced by: Based on review of medical records and staff interview, it was determined the facility failed to ensure a comprehensive initial assessment was completed within 30 days or 13 treatments of the initiation of dialysis for 1 of 1 patients (Patient #5) who changed modalities during the third quarter of 2013. Failure to complete an initial	V 516	See Attached completion by 2/28/14	

PATIN

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V 516	Continued From page 4 assessment had the potential to result in unmet patient needs. Findings include: Patient #5 was a 55 year old male who had dialyzed at the facility since April 2012. He was a PD patient until he converted to hemodialysis on 9/11/13, dialyzing twice a week. Based on his dialysis schedule, initial comprehensive assessments were to be completed by 10/22/13, the latter of 30 days or 13 treatments. However, an assessment was not completed by the dietician until 10/25/13 and an assessment was not completed by the RN until 11/18/13. In an interview on 12/5/13 at 3:00 P.M., the regional educator said it was corporate policy to have assessments completed by the latter of 30 days or 13 treatments. Patient #5 did not receive a comprehensive assessment in a timely manner.	V 516		
V 519	494.80(d)(1) PA-FREQUENCY REASSESSMENT-STABLE 1X/YR In accordance with the standards specified in paragraphs (a)(1) through (a)(13) of this section, a comprehensive reassessment of each patient and a revision of the plan of care must be conducted- (1) At least annually for stable patients; This STANDARD is not met as evidenced by: Based on review of medical records and staff interview, it was determined the facility failed to	V 519	See Attached Completed by 2/28/14	

PHRN

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V 519	Continued From page 5 ensure a comprehensive reassessment and revision of the POC was completed annually for 1 of 3 PD patients (Patient #5) whose records were reviewed. Failure to complete reassessments and revise the POC had the potential to result in patient needs remaining unidentified and unaddressed. Findings include: Patient #5 was a 55 year old male who had dialyzed at the facility since April 2102. His 90 day assessment and plan of care was dated June 2012. Annual reassessments and plan of care revision were to be completed in June 2013. However, review of Patient #5's record showed no documentation of nursing reassessment and no revision to his plan of care in June 2013. Further, no reassessments or changes to Patient #5's plan of care were documented until October 2013 when he changed modalities to hemodialysis. In an interview on 12/5/13 at 4:00 P.M., the PD training nurse confirmed Patient #5 did not have comprehensive reassessment and POC revisions in June 2013. The facility failed to reassess and revise the plan of care on an annual basis.	V 519		

PHPN

Liberty Dialysis Idaho Falls
Plan of Correction
Date of Survey: 12/06/2013

V124: 494.30(a)(1)(i) IC: HBV: TEST ALL, REV RESULTS/STATUS B4 ADMIT

On 12/6/13, the Medical Director, Director of Operations, Clinical Manager, Regional Quality Manager, and Regional Director of Education met to discuss the findings and institute correction of the deficiency related to the facility's failure to provide infection control precautions for 2 of 10 patients whose records were reviewed placing patients at risk of complications caused by undetected Hepatitis B infections.

The deficiency will be corrected by:

1. By 12/10/13, the Registered Nursing staff will review FMS policy: Patient Testing and Vaccination for Hepatitis B (FMS-CS-IC-II-155-142A)
2. By 12/18/13, a 100% chart audit inclusive of patients #3, and #5 will be completed for hepatitis vaccination records and hepatitis lab results to ensure all patient records are up to date
3. By 12/20/13, any patient records found out of compliance will be reviewed with the patient's physician, actions will be taken and documentation will be placed in the patient's plan of care.
4. Beginning 1/1/14, the Clinical Manager or designee will utilize the Hepatitis B Summary Report to track patient name, consent/declination, hepatitis lab results and series dates (if applicable) and non-responders.
5. The Clinical Manager met with all professional staff to review the hepatitis tracking report to ensure all professional staff members were aware of the process for tracking. Ongoing monitoring will occur utilizing the hepatitis report.

Ongoing monitoring for compliance will be performed utilizing the monthly Quality Assessment and Improvement requirement for Hepatitis tracking by the Clinical Manager or designee.

The Clinical Manager is responsible to review, analyze and trend the results of all hepatitis audits and tracking information and report to the QAI Committee on a monthly basis for review and oversight.

Monitoring of hepatitis tracking will be discussed monthly with the Director of Operations and Medical Director at the Quality Assessment and Improvement meeting beginning December 2013.

Meeting minutes will document the activity and will be available for review at the facility. The Clinical Manager is responsible and the QAI committee monitors for compliance.

V128: 494.30(a)(1)(i) IC-HBV-ISOLATION (EXISTING FACILITY)

On 12/6/13, the Medical Director, Director of Operations, Vice President of Quality, Regional Vice President and Regional Quality Manager discussed the findings and instituted correction of the deficiency related to the facility's failure to provide patients who dialyzed at the facility with protection from potential exposure to the Hepatitis B virus. This failure allowed potential patient exposure to serious illness and complications.

The deficiency was corrected by:

1. On 12/4/2013, the facility obtained a written agreement, signed on 12/4/2013, for the transfer and care of the facility's patients who required isolation to another dialysis unit.

Ongoing monitoring will occur during annual review of contracts and agreements by the Governing Body.

V516: 494.80(b)(1) PA-FREQUENCY-INITIAL-30 DAYS/13 TX

On 12/6/13, the Medical Director, Director of Operations, Clinical Manager, Regional Quality Manager, and Regional Director of Education met to discuss the findings and institute correction of the deficiency related to the facility's failure to ensure a comprehensive initial assessment was completed within 30 days or 13 treatments of the initiation of dialysis for patients who change modality.

The deficiency will be corrected by:

1. On 12/17/13, the Interdisciplinary Team reviewed policy and procedure:
    a. Comprehensive Assessment and Plan of Care (FMS-CS-IC-I-110-125A)
2. By 12/20/13, the Clinical Manager or designee revised the Comprehensive Interdisciplinary Assessment/Plan of Care tracking system for all active patients, paying special attention to those patients who change modalities, to ensure that they are completed within the required time frame.
3. Beginning 1/1/14, the Clinical Manager will review each due CIA/POC for timely completion by the IDT.

4. By 1/31/14, 100% of the Comprehensive Patient Assessment documents will be audited by the Clinical Manager or designee to determine deficiencies in documentation of an initial assessment.
5. By 2/28/14, all patients with incomplete documentation will have a Comprehensive Assessment and Plan of Care completed by the Interdisciplinary Team.

The Clinical Manager is responsible to alert the IDT members of those patients due for assessment/ plan of care development and present a report at each monthly QAI meeting. Additionally, the Clinical Manager reports on identified non-compliance with reference to the timely completion of the patient comprehensive assessment requirements.

The QAI Committee will address any variance to the required process by identifying the root cause and developing and implementing a corrective action plan to resolution of the issue.

Ongoing monitoring will occur through the scheduled monthly QAI Medical Records audit per the calendar.

Monitoring of corrections will be discussed monthly with the Director of Operations and Medical Director at the Quality Assessment and Improvement meeting beginning December 2013.

Meeting minutes will document the activity and will be available for review at the facility.

V519: 494.80(d)(1) PA-FREQUENCY REASSESSMENT-STABLE 1X/YR

On 12/6/13, the Medical Director, Director of Operations, Clinical Manager, Regional Quality Manager, and Director of Education met to discuss the findings and institute correction of the deficiency related to the facility's failure to ensure that a comprehensive reassessment and revision of the POC was completed annually.

The deficiency will be corrected by:

1. On 12/17/13, the Interdisciplinary Team reviewed policy and procedure:
    a. Comprehensive Assessment and Plan of Care (FMS-CS-IC-I-110-125A)
2. On 12/17/13, the Clinical Manager reeducated the Interdisciplinary Team to the Plan of Care requirements for participation and the process for completion in the facility.

3. By 12/20/13, the Clinical Manager or designee revised the Comprehensive Interdisciplinary Assessment/Plan of Care tracking system for all active patients to ensure that they are completed within the required time frame.
4. Beginning 1/1/14, the Clinical Manager will review each due CIA/POC for timely completion by the IDT.
5. By 1/31/14, 100% of the Comprehensive Patient Assessment documents and Plans of Care will be audited by the Clinical Manager or designee to determine deficiencies in documentation of assessment.
6. By 2/28/14, all patients with incomplete documentation will have a Comprehensive Assessment and Plan of Care completed by the Interdisciplinary Team.

The Clinical Manager is responsible to alert the IDT members of those patients due for assessment/ plan of care development and present a report at each monthly QAI meeting. Additionally, the Clinical Manager reports on identified non-compliance with reference to the timely completion of the patient comprehensive assessment requirements.

The QAI Committee will address any variance to the required process by identifying the root cause and developing and implementing a corrective action plan to resolution of the issue.

Ongoing monitoring will occur through the scheduled monthly QAI Medical Records audit per the calendar.

Monitoring of corrections will be discussed monthly with the Director of Operations and Medical Director at the Quality Assessment and Improvement meeting beginning December 2013.

Meeting minutes will document the activity and will be available for review at the facility.