IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

December 30, 2014

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 complaint survey at Liberty Dialysis Idaho Falls, which was concluded on December 16, 2014.

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.

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 **January 12, 2015**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please write or call this office at (208) 334-6626, option 4.

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 _____	C 12/16/2014

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 The following deficiencies were cited during the complaint survey of your facility conducted from 12/15/14 - 12/16/14. The surveyor conducting the survey was: Patricia O'Hara RN, HFS, Team Leader Acronyms used in this report include: ADA - Americans With Disabilities Act ADLs - Activities of daily living CMS - Centers for Medicare and Medicaid Services MSW - Master Social Work POC - Plan of Care	V 000		
V 452	494.70(a)(1) PR-RESPECT & DIGNITY The patient has the right to- (1) Respect, dignity, and recognition of his or her individuality and personal needs, and sensitivity to his or her psychological needs and ability to cope with ESRD This STANDARD is not met as evidenced by: Based on observation interview and record review, it was determined the facility failed to ensure 4 of 4 patients (Patients #1 - #4) who were assessed as having ambulation disabilities, were treated with respect, dignity, and sensitivity to their individualized ambulation needs. This failure resulted in increased risks to patients, a loss of independence, and created the need for family members to leave work to assist patients with accessing dialysis treatments. Findings include: 1. The facility's Patient Responsibilities policy,	V 452	**V 452 – 494.70(a)(1) PR-RESPECT & DIGNITY** On 1/12/15 the Clinic Manager will have a meeting to review the findings from the 12/16/14 Survey with the Idaho Falls staff. In this meeting the Clinic Manager will review the Policy and procedure on Patient Rights and Responsibilities (**FMS-CS-IC-I-103-005A**)(**FMS-CS-IC-I-103-005C**) with the staff emphasizing the respect, dignity, and sensitivity of the patients. The Grievance policy will also be reviewed with the staff. Staff will also be shown where patients can look at the grievance procedure in the Lobby. Beginning the week of 1/12/15 for a period of two weeks the Ward Clerk will be charged with showing patients as the come in, where to find the Patient Rights and Responsibilities information, Grievance Process, and Important numbers located in the Lobby.	2/5/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

DIRECTOR OF OPERATIONS 1/9/15

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.

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 _____	C 12/16/2014

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 452	Continued From page 1 dated 4/4/12, stated "Staff are strongly discouraged from leaving the facility to assist an arriving or departing patient. Arrange to have someone with you when you come to dialysis if you need help getting into or out of your vehicle or in and out of the facility." In an interview on 12/15/14 at 12:30 p.m., the nurse manager stated since the facility opened in 2006, patients had been allowed to enter the treatment floor through a door from the lobby and through a separate door from the handicapped parking area. On 12/9/14 the door from the handicapped parking area was deemed an "emergency only" door and was locked. Patients were not informed of this change prior to access being denied. A letter was later given to patients instructing them to enter and exit through the front lobby door. Facility records included a letter, dated 12/9/14, addressed to all patients. The letter stated "In an effort to keep our patients safe and out of harm's way, the side treatment door will now be an emergency exit only. Please use the front lobby door to enter and exit and facility [sic]. We know this will be an inconvenience for many, but please understand it is for the safety of everyone at the clinic..." The facility's grievance log included a complaint voiced by Patient #5 on 12/9/14 and a complaint voiced by Patient #1 on 12/10/14. Both complaints documented the patients were "upset that side treatment door is locked." The grievance log documented Patient #1 and #5 had been spoken to "regarding Policy and CMS regulations to provide locked safe [sic] treatment room..." The log documented Patient #5 and his	V 452	On 1/12/15 the Clinic Manager and MSW will perform Empathy training on 1/12/15, provided by the FMC education department, to help staff to understand the toll that is on each one of the patients that need dialysis. Starting the week of 1/12/15 through the end of January, the RNs will evaluate 100% of patients' ambulatory status identifying the ambulation needs of all patients. From the RNs evaluation a transportation assessment will be completed by the MSW identifying any underlying transportation barriers inhibiting a patient's independence. The MSW will have the transportation assessments completed by the end of January. MSW will then work with the patients that require assistance in obtaining resources for transportation. On 12/12/14 an email was sent to a FMC project manager looking to see if the HC parking could be moved closer to the front door. On 12/17/14 a follow up email provided to the Director of Operations per the Project Manager, provided details that Handicap Parking was in compliance with ADA requirements and it could not be placed any closer due to the covered porch and ambulance accessibility to the front door. On 12/17/14 a letter was sent out to all patients requesting that they disclose any	

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 _____	C 12/16/2014

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 452	Continued From page 2 "...wife seem to understand rationale and accept new policy." However, the grievance log documented Patient #1 was "...still not happy about process." The log further documented the Area Director of Operations was to have the parking lot surveyed and "check for compliance to ADA guidelines." Patient #1's complaint had not been resolved and ADA compliance had not been established at the time of the survey. A physical assessment of the facility conducted on 12/15/14 at 3:00 p.m., showed the distance from the handicapped parking area to the treatment floor through the handicapped door was approximately 8 yards. The distance from the handicapped parking area to the front lobby door, continuing on through the lobby to the treatment area was approximately 63 yards. Patient records were reviewed. The records documented patients experienced ambulation difficulties as follows: a. Patient #4 was a 59 year old male who had been dialyzing at the facility since 1/24/12. His comprehensive nursing assessment, dated 4/9/14, showed Patient #4 walked with an assistive device, had decreased sensation in his extremities and had "toe amputations that inhibit his walking." b. Patient #3 was a 51 year old female who had been dialyzing at the facility since 3/22/13. Her comprehensive nursing assessment, dated 7/17/14, showed Patient #3 was confined to a wheelchair and had a partial amputation of her lower left extremity. The assessment also documented she had poor eyesight, neurological problems and a history of falls.	V 452	needs they may have in regard to ambulation assistance. The DPC staff (RN/PCT/CM) in conjunction with the MSW will be doing follow up visits with all patients to listen and collect response information from the letter sent out. The Clinical Manager is responsible to review, analyze and trend all data and monitoring results as related to this Plan of Correction prior to presenting to the QAI Committee monthly for review and oversight. The Director of Operations is responsible to analyze actions presented through the QAI as related to the Plan of Correction and present to the Governing Body for oversight. The QAI Committee is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified with the Statement of Deficiency, is effective and is providing resolution of the issues. The Governing Body will review the analysis as provided by the QAI including the trending of the issues. If any deficiencies are noted they will work with the QAI Committee to determine the root cause and amend the Plan to ensure resolution of the deficiency. Minutes of the Governing Body and QAI meetings, as well as monitoring forms and	

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 _____	C 12/16/2014

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 452	Continued From page 3 c. Patient #1 was a 46 year old male who had been dialyzing at the facility since 10/25/11. His comprehensive nursing assessment, dated 7/17/14, showed Patient #1 ambulated with a walker, was unsteady on his feet, had chronic upper and lower back pain, and had neuropathy (decreased feeling and increased pain) in both feet. d. Patient #2 was a 66 year old female who had been dialyzing at the facility since 12/24/12. Her comprehensive nursing assessment, dated 3/12/14, showed Patient #2 ambulated with a cane,was unsteady on her feet, and experienced numbness in her arms. The assessment also documented a history of back surgery resulting in chronic back pain and partial paralysis of her left leg. In an interview on 12/15/14 at 4:00 p.m., Patient #2 said she was unable to ambulate from the handicapped parking area to the front lobby door and back to the treatment area unassisted. She said since the handicapped door had been locked she no longer drove herself to dialysis treatments. Her spouse now left his place of work to assist her in accessing the dialysis unit and worked late into the evening to make up the missed work hours. In an interview on 12/15/14 at 4:00 p.m., the Area Director of Operations stated there had been no event where unauthorized persons had accessed the treatment area. He stated the door had been locked because CMS regulations required a locked treatment floor. When asked, during an interview on 12/15/14 at	V 452	educational documentation will provide evidence of these actions, the Governing Body's direction and oversight and the QAI Committee's ongoing monitoring of facility activities. These are available for review at the facility.	

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 _____	C 12/16/2014

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 452	Continued From page 4 2:00 p.m., if additional accommodations had been made for patients who were potentially impacted by locking the door near the handicapped parking area, the nurse manager said no. The facility failed to ensure patients with ambulation difficulties were treated with respect, dignity, and sensitivity to their individualized ambulation needs.	V 452		
V 541	494.90 POC-GOALS=COMMUNITY-BASED STANDARDS The interdisciplinary team as defined at §494.80 must develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the patient's needs, as identified by the comprehensive assessment and changes in the patient's condition, and must include measurable and expected outcomes and estimated timetables to achieve these outcomes. The outcomes specified in the patient plan of care must be consistent with current evidence-based professionally-accepted clinical practice standards. This STANDARD is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure the POC addressed all of the assessed needs of 4 of 4 patients (Patients #1 - #4) who had ambulatory disabilities. Failure to address these needs resulted in a lack of information being available to facility staff regarding patient interventions. The findings include:	V 541	**V 541 – 494.90 POC-GOALS=COMMUNITY-BASED STANDARDS** As addressed in V 452 the clinic will reassess all patients' ambulation status, provided resources to patients who are in need of assistance, and utilize the feedback from the letter sent out on 12/17/14 to improve accessibility/transportation to the unit. In addition to these measures to meet V541 the IDT in the month of January will be addressing all patients' ambulatory status in the regularly scheduled monthly POC follow-up documentation. The IDT will incorporate this into their monthly rounding on the patients and address barriers that surround ambulation. All patients identified with ambulation issues determined from the assessment will be provided with a KDQOL by the MSW. The KDQOLs will be provided to the patients in the week of 1/12/14 after the assessment and given two weeks for a completion date for the KDQOLs of 1/30/15.	

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 _____	C 12/16/2014

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 541	Continued From page 5 a. Patient #1 was a 46 year old male who had been dialyzing at the facility since 10/25/11. His comprehensive nursing assessment, dated 7/17/14, showed Patient #1 ambulated with a walker, was unsteady on his feet, had chronic upper and lower back pain, and had neuropathy (decreased feeling and increased pain) in both feet. A review of Patient #1's POC, dated 7/22/14, showed no plan had been developed or implemented to address his ambulatory needs. b. Patient #2 was a 66 year old female who had been dialyzing at the facility since 12/24/12. Her comprehensive nursing assessment, dated 3/12/14, showed Patient #2 ambulated with a cane,was unsteady on her feet, and experienced numbness in her arms. The assessment also documented a history of back surgery resulting in chronic back pain and partial paralysis of her left leg. A review of Patient #2's POC, dated 3/25/14, showed no plan had been developed or implemented to address her ambulatory needs. c. Patient #3 was a 51 year old female who had been dialyzing at the facility since 3/22/13. Her comprehensive nursing assessment, dated 7/17/14, showed Patient #3 was confined to a wheelchair, and had a partial amputation of her lower left extremity. The assessment also documented she had poor eyesight, neurological problems and a history of falls. A review of Patient #3's POC, dated 7/22/14, showed no plan had been developed or implemented to address her ambulatory needs.	V 541	Issues identified in the monthly POC follow-up will be handled by the IDT and resources implemented to meet the specific needs of the individual patient. The Clinical Manager is responsible to review, analyze and trend all data and monitoring results as related to this Plan of Correction prior to presenting to the QAI Committee monthly for review and oversight. The Director of Operations is responsible to analyze actions presented through the QAI as related to the Plan of Correction and present to the Governing Body for oversight. The QAI Committee is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified with the Statement of Deficiency, is effective and is providing resolution of the issues. The Governing Body will review the analysis as provided by the QAI including the trending of the issues. If any deficiencies are noted they will work with the QAI Committee to determine the root cause and amend the Plan to ensure resolution of the deficiency. Minutes of the Governing Body and QAI meetings, as well as monitoring forms and educational documentation will provide	

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 _____	C 12/16/2014

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 541	Continued From page 6 d. Patient #4 was a 59 year old male who had been dialyzing at the facility since 1/24/12. His comprehensive nursing assessment, dated 4/9/14, showed Patient #4 walked with an assistive device, had decreased sensation in his extremities and had "toe amputations that inhibit his walking." A review of Patient #4's POC, dated 4/21/14, showed no plan had been developed or implemented to address his ambulatory needs. In an interview on 12/15/14 at 5:00 p.m., the MSW said she was told to include only vocational rehabilitation under the rehabilitation status portion of patients' POCs. Additionally, the POC had a section concerning ADLs. The MSW said this section addressed patients having the appropriate durable medical equipment and help at home. In the same interview the nurse manager confirmed Patient #1 - #4 did not have POCs addressing assessed ambulation needs. The facility failed to address ambulation needs for Patient #1 - #4.	V 541	evidence of these actions, the Governing Body's direction and oversight and the QAI Committee's ongoing monitoring of facility activities. These are available for review at the facility.	

Idaho Falls (7424) POC Addendum:

V452

On the week of January 19th the social worker met with the IDT to discuss the results of the RN evaluations completed and responses to letter sent out to patients about their ambulation status. All patients were identified as having the appropriate Durable Medical Equipment to help facilitate ambulation. At this time the physician did not identify any patients needing physical therapy. Based on the patients evaluations no new wounds were identified that have not been addressed that may hinder a patients ambulation status.

On the week of January 19th the social worker met with patients identified as having issues ambulating from the handicap parking space to the lobby area. These patients have made arrangements with family members to assist them to the lobby area.

On January 26th the clinical manager created a tool that identifies patients that need staff assistance. The tool will be updated monthly after the RN progress notes have been completed.

Based on the RN and MSW ambulatory assessment, findings will be reviewed and monitored at the POC follow up meetings with IDT.

Beginning the week of February 2nd the Social Worker and Clinical manager will re-educate all patients utilizing a handout created by the Clinical Manager on the company's practice to provide staff assistance from the clinic entry to the clinic floor (treatment floor). In addition 1:1 patient education will be provided by the Direct Patient Cares staff. All education will be completed by February 6th, 2015. Going forward re-education will be provided during the nurse's monthly ambulation assessment. Patients who have been identified in the ambulation assessment as needing assistance will be discussed by the interdisciplinary team during the monthly POC follow up meetings.

V541

On the week of January 19th the social worker met with the IDT to discuss the results of the RN evaluations completed and responses to letter sent out to patients about their ambulation status. All patients were identified as having the appropriate Durable Medical Equipment to help facilitate ambulation. At this time the physician did not identify any patients needing physical therapy. Based on the patients evaluations no new wounds were identified that have not been addressed that may hinder a patients ambulation status.

On January 5th the clinical manager added a section to the nurse's monthly note that addresses the patient's ambulation status.

On January 12th the clinical manager educated the Social Worker and instructed her to address any patient transportation issues in her monthly progress note.

Ongoing monitoring of Ambulatory status will be completed monthly by the Interdisciplinary team during the monthly POC follow up meetings.

Based on the RN and MSW ambulatory assessment, findings will be reviewed and monitored at the POC follow up meetings with IDT.

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

December 30, 2014

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:

On **December 16, 2014**, a complaint survey was conducted at Liberty Dialysis Idaho Falls. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006792

Allegation: Patients' individual physical needs are not addressed.

Findings: An unannounced visit was made to the facility on 12/15 - 12/16/14. Staff and patient interviews were conducted, policies were reviewed, patient medical records were reviewed and the facility grievance log was reviewed. A physical assessment of the facility's access was performed.

In an interview on 12/15/14 at 12:30 p.m., the nurse manager explained the following: Since the facility opened in 2006, patients had been allowed to enter the treatment floor through a door from the lobby and through a separate door from the handicapped parking area. On 12/9/14 the door from the handicapped parking area was deemed an "emergency only" door and was locked. Patients were not informed of this change prior to access being denied. A letter was later given to patients instructing them to enter and exit through the front lobby door.

A physical assessment of the facility conducted on 12/15/14 at 3:00 p.m., showed the distance from the handicapped parking area to the treatment floor through the adjacent door was approximately 8 yards. The distance from the parking area to the front lobby door, continuing on through the lobby to the treatment area was approximately 63 yards.

In an interview on 12/15/14 at 2:00 p.m., the nurse manager said no additional accommodations had been made for patients who were potentially impacted by this change. She presented the facility's Patient Responsibilities policy stating "Staff are strongly discouraged from leaving the facility to assist an arriving or departing patient. Arrange to have someone with you when you come to dialysis if you need help getting into or out of your vehicle or in and out of the facility."

Four direct care staff members were interviewed. When asked how many patients used the handicapped door out of necessity rather than convenience, one staff said approximately 50% of patients used the door because of ambulatory impairment. A second staff said 25 - 30% of patients used it because of ambulatory impairment.

Nine patient records were reviewed. Four of the nine records identified ambulation needs in the comprehensive nursing assessment. None of the four identified patients had a plan of care addressing their ambulation needs.

Two complaints were found on the facility grievance log related to the issue. One had been resolved with patient satisfaction, one had not been resolved with patient satisfaction.

Two patients were interviewed. Both patients had been identified with an ambulation disability. Both stated they were unable to walk the additional distance required as a result of the door change. Both said their independence had been limited by the change, and both had spouses who were taking off work to assist the patient with access to the facility for treatment.

In an interview on 12/15/14 at 4:00 p.m., the Area Director of Operations (DO) stated access through the door had been discontinued for the following reasons:

The Area Director of Operations also stated patients were safer waiting in the lobby area where the ward clerk could observe them. However, the ward clerk began work at 8:00 a.m., while patients arrived at the facility as early as 5:30 a.m.

The Area Director of Operations stated opening the door allowed wind to blow through the treatment floor creating an infection control issue. However, no policy was available designating the treatment area as "clean" or restricting possible outside contaminants. Infection control data for the facility did not indicate any increase in infections potentially caused by outside contamination.

He stated the door had always been an emergency door according to architectural drawings and it had been locked for security reasons. He stated there had been no event where unauthorized persons had accessed the treatment area, but the door had been locked because CMS regulations required a locked treatment floor.

When asked why the facility had not installed a doorbell or other mechanism to alert staff to patients arriving at the side door when it was locked, the Area Director of Operations stated it was an increased fall risk to patients to stand outside in the elements waiting for a staff to let them into the facility. However, there was no documentation that patients had fallen in the parking lot. Additionally, no information could be found to demonstrate the patients' fall risk had been re-evaluated given the increased distance they were required to walk.

The facility failed to demonstrate observance of patients' rights and consideration of patients' physical condition. Therefore the allegation was substantiated and deficiencies were cited at V452 and V541.

Conclusion: Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626, option 4.

Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Trish O'Hara

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

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

TO/pmt