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October 16, 2006

Joanna Engle, Administrator
St Alphonsus Nephrology Center
846 Parkcenter Way
Nampa, ID 83651

Dear Ms. Engle:

On **October 5, 2006**, a Complaint Investigation was conducted at St Alphonsus Nephrology Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00001676

Allegation #1: The complaint alleged the facility was not clean which caused an increase in infections.

Findings: An unannounced visit was made to the facility on 9/21/06. Infection control records were reviewed, Facility Patient Grievance Logs for June, July, and August were reviewed, observations were made, and staff interviews were completed.

A tour of the patient area was completed and observations of patients receiving treatments for two hours was done. The area was clean and neat. Two patients were observed being put on the machines and two patients were observed being taken off the machines. All procedures were done correctly. Staff washed their hands as needed and wore gloves and masks as required. Infection control logs were reviewed. The facility does monthly monitoring and it was identified that there was an increase in the overall infection rate in June. An interview was conducted with the facility Administrator on 9/21/06, at 10:30 AM. She stated they review the infection control rates monthly with investigation of possible causes for a rate increase, as well as implementation of solutions.

For example, when the rate increased in June, the facility investigation determined the chairs used by patients were worn, old, and hard to keep clean, a staff person providing care to patients was not washing her hands appropriately. These had been possible contributing factors. The administrator stated they had the chairs deep cleaned by a special company at the time and had ordered all new chairs. In addition, staff have all been re-inserviced on proper cleaning of patient chairs and equipment and hand washing. Review of the infection control logs for the months of July, August, and September documented the infection control rates went down in July, August, and September.

An interview was conducted with the facility Social Worker. She was responsible for facility complaints. The log had no documentation of complaints concerning the facility being unclean.

Conclusion: No evidence of the facility being unclean was identified. There was an increase in the facility infection rate in June, however with investigation and implemented solutions the rate decreased and it was undeterminable if the infection rate increase in June was related to the infection identified in the complaint.. In addition, the infection identified in the complaint alleged it was related to the patient's dialysis treatment and during record review it was identified as a leg wound in June and a pneumonia in July.

Allegation #2: The complaint alleged facility staff do not wash their hands.

Findings: Observation of agency staff and patient treatment areas were completed for over two hours. At no time was staff observed not washing their hands at required times. For example, between patient cares and before/after patient treatment.

Conclusion: There was no evidence facility staff did not wash their hands appropriately.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

SYLVIA CRESWELL
Supervisor
Non-Long Term Care

SC/mlw