



IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

August 21, 2006

Janet Walker-Anderson, Administrator
Portneuf Nephrology Center
2001 Bench Road
Pocatello, ID 83201

FILE COPY

Dear Ms. Walker-Anderson:

On August 3, 2006, a complaint investigation survey was conducted at Portneuf Nephrology Center. The survey was conducted by Gary Guiles, Registered Nurse. This report outlines the findings of our investigation.

Complaint # ID00001692

Allegations #1: The patient was given the wrong dialyzer. He dialyzed for 20-30 minutes before the mistake was discovered.

Findings: An unannounced visit was made to the dialysis center on 7/31/06. A full Medicare recertification survey was conducted from 7/31/06 through 8/3/06.

In one record, a late entry by the LPN, stated a patient had received dialysis via another patient's reused dialyzer on 7/27/06. The treatment was stopped. The blood in the dialyzer and tubing was not returned. The correct dialyzer was then placed on another machine and dialysis continued.

The physician on call for 7/27/06 was interviewed on 8/1/06. He stated he had seen the affected patient on the day of the incident. He said he had ordered laboratory work and would continue to follow the patient at intervals to determine whether or not an injury had occurred as a result of the incident. The patient the incorrect dialyzer belonged to did not have a history of any blood borne infection or high risk behaviors.

The Reuse Technician involved in the incident was interviewed. The technician stated it had been a busy day when the dialyzers were reprocessed. A number of cleansed dialyzers had been allowed to pile up on the counter and two of the dialyzer labels had accidentally been transposed. The incident was discovered during dialysis when staff checked the labels on the second dialyzer and found they did not match. The technician said all of the dialyzers had been checked following the incident. At that time, the labeling was correct for the other dialyzers. Following the incident, the Reuse Technician stated the reprocessing procedure was changed and only one dialyzer was now being placed on the counter at a time. This dialyzer was to be labeled and put away before placing another dialyzer on the counter. This procedure was observed during the three days the surveyor was in the building. However, when interviewed, the administrator stated the procedure had not been formally changed. She also stated staff could place up to two dialyzers on the counter at a time while labeling them. All care staff had been directed to re-read the existing policies on reuse and setting up dialysis. A meeting with patient care staff had been held on the morning of 7/31/06 prior to the surveyor's arrival. The purpose of the meeting was to discuss the incident and instruct staff to re-read the policy.

A comprehensive account of the incident could not be established. For example, apparently only one of the dialyzers was mislabeled. If the account staff related to the surveyor was accurate, two of the dialyzers should have been mislabeled. Four staff who were involved in the incident were interviewed but they could not explain what happened to the missing label. In addition, there was no record of the contaminated dialyzer being disposed of. Staff were told to dispose of it but stated they had stored the dialyzer in a refrigerator with other dialyzers awaiting reprocessing. There was no record it had been reprocessed. Staff were unable to locate the dialyzer on the morning of 8/2/06. The most likely scenario was that the dialyzer had been disposed of but staff could not substantiate this.

An investigation of the above incident had not occurred and none was planned. The Administrator was interviewed on 8/2/06 at 3:20 PM. She confirmed a formal investigation had not occurred. She stated she did not know what the corporation expected in relation to the investigation of incidents.

During the survey, another adverse occurrence was noted. A run sheet, dated 6/23/06, stated a needle became dislodged while a patient was receiving dialysis, resulting in a 500 milliliter blood loss. Again, the facility had not investigated the incident. This was also confirmed by the Administrator.

The policy, "ADVERSE OCCURRENCE REPORTING POLICY (NON-TEAMMATE RELATED)", revised July 2004, stated "1. Any unexpected event that is inconsistent with the...routine provision of acute dialysis..." should be reported on a specific form. The policy stated "4. After completion of the (form), the Administrator/designee or manager will review the form for completeness and legibility." Except for incidents involving "unexpected deaths, unexpected hospitalizations, and/or sentinel events", the policy did not require an investigation.

Conclusion: The allegation was substantiated. It was determined the Condition of Coverage: Governing Body and Management, at 42 CFR 405.2136, was not met, partly because no procedure was in place to ensure significant adverse events were investigated. The facility was placed on a 90 day termination track with the opportunity to correct the deficiencies.

Allegation #2: When staff cleanse patients' arms prior to cannulation, they don't cleanse the skin from the inside out. Instead, they rub the area all over in no particular pattern.

Findings: The policy "AV GRAFT OR FISTULA CANNULATION WITH SAFETY FISTULA NEEDLES", revised, March 2004, stated, "9. With clean gloved hands, cleanse the site by applying an antimicrobial agent or germicidal agent using a circular rubbing motion, center out."

Conclusion: On the morning of 8/2/06, three different staff members were observed cleansing patients' access sites prior to cannulation. All staff who were observed followed the policy and cleansed the sites from the center out. The complaint could not be substantiated.

Allegation #3: Dialysis treatments are not started on time. Patients arrive at their scheduled times and have to wait 30-45 minutes for staff to actually begin their dialysis.

Findings: Four patients and/or family members were interviewed during the survey on 8/1/06 and 8/2/06. Three of those patients complained their dialysis treatments were not started at the scheduled times. They said they had to wait up to 45 minutes after their assigned times for staff to start their dialysis. In addition, three of those patients interviewed stated staff did not closely check test strips. Facility policy stated 2 staff were to check test strips for the absence of germicide in dialyzers prior to connecting patients. The three patients said one staff would hold up a test strip and another staff member across the room would glance at it without really checking the strip. They said staff were too busy to cross the room and look closely at the strips.

Several short observations were made between 11 AM and 2:30 PM on 8/2/06. During that period, 3 machines alarmed, lasting between 1 minute 15 seconds and 1 minute 55 seconds, before staff checked the patient and the machine.

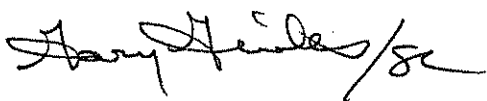
The administrator was interviewed on 8/1/06 at 2:20 PM. She stated the staffing ratio under the previous owners had been 1 dialysis technician to 3 patients. Under the new owners, that ratio had decreased to 1 dialysis technician to 4 patients. In addition, she stated the facility had changed dialysis machines in the past month and it was taking longer to set up these machines. She said some patients had been late to start dialysis during this time. The administrator was observed working the floor at 11:30 AM on 8/2/06. She stated she tried to work the floor during this time, rather than attend to administrative duties, in an attempt to keep staff from falling behind during the patient change of shifts.

Conclusion: The complaint was substantiated. A deficiency was cited at 42 CFR 405.2162 in relation to the lack of direct care staff.

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

Sincerely,



GARY GULES, R.N.
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Supervisor
Non-Long Term Care

GG/mlw