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March 6, 2015

Shelby Wright, Administrator
Liberty Dialysis Caldwell
4620 Enterprise Way, Suite 101
Caldwell, ID 83605-6764

Provider #132523

Dear Ms. Wright:

An unannounced on-site complaint investigation was conducted fromFebruary 17, 2015 to February 18, 2015 at Liberty Dialysis Caldwell. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006841

Allegation #1: Patients' peritoneal dialysis (PD) cyclers were programmed incorrectly resulting in patients experiencing weight gain.

Finding #1: During the investigation patient records were reviewed and staff interviews were conducted.

Six home therapy patient records were reviewed and included home peritoneal dialysis orders and nursing notes. All records included documentation of compliance with patients' plans of care and nursing progress notes consistent with physician's orders.

Six of 6 patient records included documentation of comprehensive patient training including maintaining peritoneal dialysis cycler set-up and programming, fluid balance, with signature verification by the patients and the training nurse.

One patient, who had completed PD training on 9/8/14, showed a 12 pound weight gain during four months of PD treatment. This patient's record documented a 12/8/14 nurse note stating "some swelling noted to face and abdomen...Adjusted cycler for last fill of green and will put in purple bag mid-day for fluid control. However, none of the six records reviewed included documentation of excessive weight gain.

In an interview on 2/18/15 at 11:00 a.m., the Home Program Manager confirmed the patient had successfully completed peritoneal dialysis training.

It could not be established that the facility failed to provide comprehensive peritoneal dialysis patient training or that patients experienced excessive weight gain due to cyclers being programmed incorrectly. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Patients' transfer sets were not being changed resulting in patients experiencing peritonitis (an infection of the abdomen).

Findings #2: During the investigation patient records, facility policies, and infection logs were reviewed and staff interviews were conducted.

A policy titled Peritoneal Catheter Extension /Transfer Set Change, dated 5/18/11, stated "Extension/transfer sets will be changed at a minimum of every 6 months or sooner if contaminated or damaged."

Six of 6 patient records reviewed included documentation of timely transfer set changes per policy by the nurse, as well as documentation of patient training on care of the transfer set. One patient's record showed a nursing assessment note, dated 10/14/14 at 12:05 p.m. which stated the patient had a PET test (a test to determine peritoneal membrane transport function). The note documented the patient "...states she woke up to do exchange and fell asleep. Did exchange and then forgot to cap off transfer set. Educated on the importance of caps. Drain effluent noted to be slightly cloudy, will send samples off to lab. Patient anxious to leave, transfer set change missed, called patient to come back in, stated if I have time later. Neglected to come in or call back." The facility infection log showed the patient was treated with antibiotics empirically.

A second nursing assessment note for the same patient, dated 12/2/14, documented "Patient in for monthly lab visit, extreme abdominal pain...Cultures of PD fluid obtained, flushed peritoneum with new solution and started antibiotics per protocol."

A clinical note by the LPN for the same patient, dated 12/08/14 at 3:33 PM, stated the patient was "...in for monthly labs and transfer set change d/t (due to) peritonitis. While I was cleaning the connection of the transfer set and catheter end, I noted the titanium piece had a gap where it should be tight. I poured {name of disinfectant} over the connection of the set. I re-instructed the pt that she needs to inspect and hand tighten this daily while she is cleaning the exit site."

A nursing assessment note also dated 12/8/14, noted the patient received "education on hand washing and checking PD catheter connections. Discussed bacteria culture r/t (related to) peritonitis. Patient reports doing a lot of work around property that includes contact with various livestock, birds and dogs. Re-educated patient on importance of hand washing." The facility infection log showed the patient was again treated with appropriate antibiotic therapy.

In an interview on 2/18/15 at 11:00 a.m., the Home Program Manager confirmed the patient had successfully completed peritoneal dialysis training and had been treated for peritonitis 2 times with appropriate treatment per protocol.

It could not be established that the facility failed to provide comprehensive peritoneal dialysis patient training or that transfer sets were not being changed resulting in patients experiencing peritonitis. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Patients' adverse symptoms such as difficulty breathing and memory loss were not being addressed and patients were given inappropriate medications to treat peritonitis.

Finding #3: During the investigation patient records, facility policies, and infection logs were reviewed and staff interviews were conducted.

Six records of home peritoneal dialysis patients were reviewed. Six of 6 records documented adverse symptoms had been addressed by nursing interventions such as drawing labs, adjusting peritoneal dialysis cycler, re-educating patients, and informing the physician. For example, one patient record documented, on 10/28/14, a patient complaint of shortness of breath, heart racing and overall feeling poorly. The physician was notified and he ordered a medication change, electrocardiogram and ultrasound of the heart.

Additionally, of the 6 home peritoneal dialysis patient records reviewed, 3 records documented patient treatment for peritonitis.

A facility policy titled Peritonitis and Exit Site Infection Assessment and Treatment, dated 9/25/13, stated "patients must report cloudy effluent with or without abdominal pain or fever to the Home Therapies nurse immediately and be presumed to have peritonitis."

The policy directed the patients to follow the nurse's instructions for collecting a sample of cloudy effluent and for adding antibiotics to their dialysate bag. The policy noted that the nurses would follow MD antibiotic orders specific for each patient. Two antibiotics may be started immediately, one effective against Gram positive bacteria and one effective against Gram negative bacteria. When the causative bacteria was identified, through culture and sensitivity testing, ineffective antibiotics would be discontinued.

Of the six home peritoneal dialysis patient records reviewed, three records documented patient treatment for peritonitis.

One patient record showed the patient had been treated twice for peritonitis. The first episode occurred on 10/14/14 when the patient had a known exposure and was treated prophylactically. The second episode occurred on 12/2/14 when the patient presented with clear symptoms of peritonitis. The patient was initially treated with two antibiotics. When the causative bacteria was found to be Gram negative, the Gram positive antibiotic, being unnecessary, was discontinued.

In an interview on 2/17/15 at 11:00 a.m., the Home Therapy Manager confirmed the patient had been treated for peritonitis, on 2 occasions, according to the facility's peritonitis protocol.

It could not be established that the facility did not provide appropriate treatment for adverse symptoms and peritonitis. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: The facility canceled patients' supply orders resulting in patients being without adequate supplies when transferring to another facility.

Finding #4: During the investigation patient records and patient supply orders were reviewed and staff interviews were conducted.

The Home Therapy Manager was interviewed on 2/17/15 at 1:45 PM. She stated patients place their own supply order. If the patient's order is late, the facility is contacted by the supply company, and if there is a delay in the order the facility is charged a late fee. Therefore, the facility will place the order for the patient to avoid late fees.

She stated that patients order monthly and have an extra week of supplies in their home in case of shipping delays.

Six records of home peritoneal dialysis patients were reviewed. Two of the 6 records documented the patients had transferred to another facility. Of the 2 records, 1 documented supply ordering concerns, as follows:

1/6/15: The patient's record documented she did not attend her outpatient clinic appointment. She was contacted by telephone and informed the nurse she was transferring to another clinic.

1/9/15: The facility nurse spoke with the nurse at the clinic the patient stated she was transferring to. The record documented the new clinic would need to place an order for the patient's supplies as the patient's current supply account had been placed on hold when patient informed the facility she was moving to another clinic. The record documented the patient was scheduled to see the new physician on 1/14/15 in order to transfer care.

1/14/15: The record documented the facility nurse called the patient at 10:57 a.m. to inform her that her supply company account was on hold. The nurse explained to the patient that she needed either to come in to the facility or go to the new clinic to be admitted and see their physician. The patient stated, "I have nothing to do with your facility anymore, I spoke to the supply company, and my supplies are coming tomorrow."

1/16/15: The record documented the facility was notified by the new clinic that the patient had not seen the new physician on 1/14/15 and would not be admitted until she met with him. The facility was also notified by the supplier that the patient had placed a supply order on 1/16/15. The facility contacted the patient to let her know her supplies would not be delivered because the facility had closed her supply account and the new provider had not yet admitted her or opened a new account. Therefore, the patient did not have an active account with the supplier to receive product. The record documented the patient told the facility nurse "I'm out of town so I can't go to either clinic anyway."

1/20/15: The record documented the facility contacted the new clinic and was told the patient was scheduled to see the new physician on 1/23/15. The nurse at the new clinic also stated the patient had told her on 1/16/15 that she had not received her supply order. She also told the nurse not to place a new supply order for her because she was unsure if she wanted to continue with PD or transfer to hemodialysis.

The patient's prescription order summary showed, prior to her account being closed, the patient had ordered and received delivery of a full month of supplies on 12/16/14 and a partial month of supplies on 1/2/15.

Therefore, it could not be established that patients did not have adequate supplies to continue dialysis during the transfer process. The allegation was unsubstantiated and no deficient practice was identified.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

Trish O'Hara

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

NICOLE WISENOR
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TO/pmt