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April 23, 2015

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

Provider #132514

Dear Ms. Harris:

An unannounced on-site complaint investigation was conducted fromApril 6, 2015 to April 9, 2015 at Liberty Dialysis Idaho Falls. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00006916**

**Allegation #1:** The facility does not accommodate patients' requests to reschedule missed treatments.

**Findings #1:** During the investigation facility records were reviewed and patient and staff interviews were conducted, with the following results:

A facility report titled "Absence and Hospitalization" was reviewed with data collected from 2/2/15 - 4/7/15. The report listed all regularly scheduled patient treatments that had been missed, the reasons for the missed treatments, and which treatments had been rescheduled. For example, the report included one patient who had missed a scheduled treatment on 3/13/15 and was rescheduled for replacement treatment time on 3/14/15.

Additionally, 5 patients were interviewed on 4/7/15 and 4/8/15. When asked, all five patients said they had needed to reschedule a treatment in the past. They said the facility had been willing and able to offer treatment time on an alternate day.

Two Registered Nurses (RNs) were interviewed on 4/8/15 at 9:00 a.m.. They stated that rescheduling missed treatments for patients was done by the RNs. They further stated that if first and second shifts were full, third shift was always available for rescheduling patient treatments on the six days of the week the facility was open. One RN stated there had been an incident involving a patient who ended a phone conversation with the RN before a treatment time could be rescheduled. The Clinical Manager was made aware of the situation. She contacted the patient's family and rescheduled an alternate treatment time for the patient.

It could not be established that the facility failed to reschedule patients' missed treatments. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

**Conclusion #1:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #2:** Patients are moved from their treatment station and left unattended between treatment termination and discharge.

**Findings #2:** During the investigation, patient care was observed and staff and patient interviews were conducted, with the following results:

Patient care observations were completed for a cumulative 7 hours on 4/7/15 and 4/8/15. The observations included two "turnover," periods when morning treatments were ended, patients were stabilized and discharged, and dialysis stations were prepared for afternoon patient treatments. This included the termination of 40 treatments during the two days of observation. No patients were observed to be moved from their dialysis station or left unattended between termination of treatment and discharge.

Five patients were interviewed on 4/7/15 and 4/8/15. When asked, all five patients said they were not moved from their dialysis stations between termination of treatment and discharge.

Four Patient Care Technicians were interviewed on 4/8/15 between 8:00 a.m. and 12:30 p.m. When asked, all technicians said enough time was allowed for patients to remain in their dialysis station until their blood pressure was stable and their access was clotted and dressed before they were discharged.

It could not be established that the facility removed patients from the dialysis station, leaving them unattended after treatment. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

**Conclusion #2:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #3:** Staff decrease patients' ultrafiltration goals and administer excessive fluid to increase blood pressure prior to discharge.

**Findings #3:** During the investigation, patient care was observed, patient records were reviewed, and staff interviews were conducted, with the following results:P
When asked, during an interview on 4/8/15 at 9:00 a.m., a staff nurse stated the facility's protocol required all patients have a systolic blood pressure reading of 100 mm Hg (millimeters of mercury) or greater before being discharged. She stated occasionally, a patient's fluid removal goal was decreased due to patient symptoms, such as low blood pressure and sometimes it was necessary for staff to administer IV fluid to patients in order to attain an adequate blood pressure reading. The nurse also stated extra treatment time was offered to patients who were unable to attain their prescribed estimated dry weight.

Patient care observations were completed for a cumulative 7 hours on 4/7/15 and 4/8/15. During the observations on 4/8/15 at approximately 11:00 a.m., one patient did require the administration of IV fluid in order to attain a systolic blood pressure reading of 100 mm Hg post treatment and prior to discharge.

Nine patient records were reviewed. None of the records documented that patients were consistently being discharged post treatment with excessive fluid retention.

It could not be established that the facility administered excessive fluid to patients prior to discharge. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

**Conclusion #3:** 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
Co-Supervisor
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TO/pmt