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September 15, 2015

Susan Pendlebury, Administrator
Twin Falls Dialysis Center
582 Pole Line Road
Twin Falls, ID 83301-3007

Provider #132505

Dear Ms. Pendlebury:

An unannounced on-site complaint investigation was conducted fromAugust 31, 2015 to September 3, 2015 at Twin Falls Dialysis Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00007121

Allegation #1: The facility does not manage patients' dialysis adequacy.

Findings #1: Ten medical records were reviewed. Three were records of patients who no longer received dialysis at the facility, and seven were records of patients who were currently receiving dialysis at the facility.

Record review showed laboratory values, indicating the adequacy of dialysis treatments, were drawn on all patients at monthly intervals. If the laboratory result showed inadequate dialysis, a Kt/V < 1.2 as the recommended standard, a second blood sample was drawn for verification during the patient's next treatment. If low adequacy was confirmed, the patient's dialysis prescription was changed. All patients received regular education on how missing dialysis time could affect adequacy.

In an interview on 9/1/15 at 9:00 a.m., the Clinical Coordinator said aspects of patients' adequacy were individualized in the patient's Plan of Care as determined by the Interdisciplinary Team. These included treatment time, treatment frequency, dialyzer size, blood flow rate and dialysate flow rate. Laboratory values were reviewed for all patients' adequacy on a monthly basis and changes were made as indicated.

For example, one patient had started treatments, on 4/28/14, twice a week for 3.5 hours/treatment using a Rexeed 18S non-reuse dialyzer, a dialysate flow rate of 600 ml/minute, and a blood flow rate of 300 ml/minute through a Central Venous Catheter. When laboratory results showed low adequacy, his frequency was increased to three times a week. When laboratory results again showed low adequacy his treatment time was extended to 4 hours/treatment. Blood flow rate was increased to 500 ml/minute when an arteriovenous fistula was established. Adequacy was determined to be within normal limits as recently as 6/2/15.

Additionally, the patient voluntarily shortened his treatment 14 times, as documented from 1/1/15 - 6/22/15. He was counseled by staff each time as to the importance of completing all dialysis treatments in order to attain adequacy.

It could not be determined the facility failed to manage patients' dialysis adequacy. Therefore, the allegation was unsubstantiated.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The facility does not adequately manage patients' fluid removal.

Findings #2: Ten medical records were reviewed. Three were records of patients who no longer received dialysis at the facility, and seven were records of patients who were currently receiving dialysis at the facility.

Each patient's Estimated Dry Weight (EDW) was routinely evaluated by Patient Care Technicians and Registered Nurses (RNs) before, during, and after each treatment. The patients were assessed for signs and symptoms of fluid overload, as verified by observations on 9/2/15 from 2:00 - 4:00 p.m.

Additionally, the Nurse Practitioner was on site at the facility four days a week during treatment hours and was accessible to patients for consultation. EDW was changed as indicated by patients' symptoms.

In an interview on 9/1/15 at 10:00 a.m., the Clinical Coordinator said the Registered Dietician followed fluid gains for all patients and educated them on a monthly basis concerning fluid balance. She also stated fluid management was addressed in Plans of Care with a goal to regularly attain a post dialysis weight within 1 kg of prescribed EDW, and a goal to limit fluid gain between dialysis treatments to < 5% of EDW.

For example, one patient did not meet his fluid management goal on his Plan of Care, dated 5/27/14. The patient was educated on fluid control and necessary fluid removal, and subsequently met the fluid management goal on a follow up Plan of Care, dated 9/16/14. However, the patient's record showed he was hospitalized on 10/13/14, for fluid overload, indicated by an admitting diagnosis of extracellular fluid volume expansion. The facility reeducated the patient on the importance of fluid management and no further hospitalizations related to fluid overload were documented. Additional fluid management was documented in progress notes by staff and on 6/18/15, the Registered Dietician noted the patient was meeting goal with an average fluid gain of 1.7% - 1.9% between treatments.

It could not be determined the facility failed to managed patients' volume status. Therefore, the allegation was unsubstantiated.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: The facility does not adequately manage patients' hypertension.

Findings #3: Ten medical records were reviewed. Three were records of patients who no longer received dialysis at the facility, and seven were records of patients who were currently receiving dialysis at the facility.

In interviews on 9/2/15 from 2:00 - 4:00 p.m., three Patient Care Technicians and one RN confirmed patients' blood pressures were evaluated before and after dialysis treatments, as well as monitored during treatment. The four staff stated excessively high or low systolic blood pressure readings, above 180 mm Hg or below 90 mm Hg, would be reported to the RN, the Nurse Practitioner, or the physician for further evaluation and possible intervention. The Nurse Practitioner was on site at the facility four days a week during treatment hours and was accessible to patients for consultation.

Additionally, blood pressure control was addressed in all patients' Plans of Care with a goal to maintain blood pressure readings <140/90 mm Hg pre dialysis. Notation was made whether goal had been met or not met. If the goal was not met, the Plan of Care was changed.

For example, one patient did not meet the goal of blood pressure readings <140/90 mm Hg pre dialysis when assessed for his Plan of Care on 5/27/14, and again on 9/16/14. Plan of Care changes were instituted on both occasions, including increased fluid control and antihypertensive medication changes. Further, the patient's record documented he was hospitalized on 4/7/15 and again on 6/18/15 for treatment of hypertensive crisis, a condition that occurs in 1% of patients with high blood pressure. Episodes of hypertensive crisis cannot be anticipated and cause is often unknown. However, the patient's medication record documented 21 antihypertensive medication changes or adjustments were made from 5/1/14 - 6/22/15 and multiple instances of patient education by staff concerning intradialytic fluid control were documented.

It could not be determined the facility failed to adequately manage patients' hypertension. Therefore, the allegation was unsubstantiated.

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
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

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