DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
2201 Sixth Avenue
Seattle, WA 98121

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

WESTERN CONSORTIUM – DIVISION OF SURVEY, CERTIFICATION, AND ENFORCEMENT

IMPORTANT NOTICE - PLEASE READ CAREFULLY

January 24, 2013

Palmer Pollock, Vice President of Planning
Northwest Kidney Centers
700 Broadway
Seattle, WA 98122

RE: NKC – Kent Kidney Center
25316 74th Avenue South, Suite 101
Kent, WA 98032
CMS Certification Number: 50-2553

Dear Mr. Pollock:

Effective date January 15, 2013, we have confirmed that NKC - Kent Kidney Center has 18 approved stations. We will notify Noridian Administrative Services, LLC of this change.

NKC - Kent Kidney Center has been approved as a renal dialysis facility to furnish the following Services:

Services	Approved Stations
In-center Hemodialysis	18

If you have any questions, please call Gary Keopanya at (206) 615-2321.

Sincerely,

Christopher Martin
Acting Manager, Survey, Certification and Enforcement Branch

cc: Office of Licensing and Certification
Noridian Administrative Services
Network 16

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	502553	A. BUILDING _____ B. WING _____	12/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NKC - KENT KIDNEY CENTER	25316 - 74TH AVENUE SOUTH. SUITE 101 KENT, WA 98032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 000	INITIAL COMMENTS MEDICARE END-STAGE RENAL DISEASE (ESRD) EXPANSION SURVEY TO ADD ONE (1) ADDITIONAL PATIENT STATION. This Medicare ESRD expansion survey to add one [1] additional patient dialysis station to the existing seventeen [17] patient dialysis stations was conducted at NKC - Kent Kidney Center, 25316 - 74th Avenue South, Kent, Washington 98032, by Larry Anderson, RS on 12/5/2012. NKC - Kent Kidney Center was granted a Certificate of Need for one (1) additional dialysis station by the WA State Department of Health on June 11, 2012, to allow for a total of eighteen (18) dialysis stations. During the on-site survey conducted on 12/5/2012, at NKC - Kent Kidney Center, Department of Health staff reviewed the following Medicare Conditions of Participation: 42 CFR 494.40 Condition: Water and Dialysate Quality; and 42 CFR 494.60 Condition: Physical Environment. As a result, the Department of Health found the facility in substantial compliance with the Conditions reviewed. The state agency recommends Medicare certification of one (1) additional patient dialysis station based on the attached documentation.	V 000	No deficiencies were cited. Therefore, no Plan of Correction is required. NOTE: The administrator or representative's signature and date are required on the bottom of this report. Return to: mailed 12/12/12 gb Larry L. Anderson, RS Department of Health Investigation and Inspection Office PO Box 47874 Olympia, WA 98504-7874	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jane Davis BSN RN	Clinical Director	12/12/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0360

END STAGE RENAL DISEASE APPLICATION AND SURVEY AND CERTIFICATION REPORT – Version 2

PART 1 – APPLICATION – TO BE COMPLETED BY FACILITY

1. Type of Application/Notification (check all that apply; if "Other," specify in "Remarks" section [Item 33]): (V1)
☐ 1. Initial ☐ 2. Recertification ☐ 3. Relocation ☒ 4. Expansion/change of services ☐ 5. Change of ownership
☐ 6. Other, specify: add 1 station

2. Name of Facility: Northwest Kidney Center – Kent Kidney Center		3. CCN: 50 2553.
4. Street Address: 25316 74th Ave So Suite 101		5. NPI: 1164675112
6. City: Kent.	7. County: King	8. Fiscal Year End Date: 6/30/2013.
9. State: WA	10. Zip Code: 98032.	11. Administrator's Email Address: J.Davis@nwkidney.org
12. Telephone No.: 253-850-6810	13. Facsimile No.: 253-850-6815	14. Medicare Enrollment (CMS 855A) completed? ☑ Yes ☐ No ☐ NA

15. Facility Administrator Name: Jane Davis
Address: 25316 74th AVE So Suite 101
City: Kent State: WA Zip Code: 98032 Telephone No: 253-850-6820

16. Ownership (V2) ☐ 1. For Profit ☒ 2. Not for Profit ☐ 3. Public

17. Is this facility owned and managed by a hospital and on the hospital campus (i.e., hospital-based)? (V3) ☐ 1. Yes ☒ 2. No
Is this facility owned and managed by a hospital and located off the hospital campus (i.e., satellite)? (V4) ☐ 1. Yes ☒ 2. No
Is this facility not owned or managed by a hospital (i.e., independent)? (V5) ☐ 1. Yes ☒ 2. No
If owned and managed by a hospital: hospital name: (V6) CCN: (V7)

18. Is this facility located in a SNF/NF (check one): (V8) ☐ 1. Yes ☒ 2. No
If Yes, SNF/NF name: (V9) CCN: (V10)

19. Is this facility owned &/or managed by a multi-facility organization? (V11) ☐ 1. No ☒ 2. Yes, Owned ☐ 3. Yes, Managed
If Yes, name of multi-facility organization: (V12) Northwest Kidney Centers
Multi-facility organization's address: 700 Broadway Seattle WA 98122

20. Current Services (check all that apply): (V13)
☑ 1. In-center Hemodialysis (HD) ☐ 2. In-center Peritoneal Dialysis (PD) ☐ 3. In-center Nocturnal HD ☐ 4. Reuse
☐ 5. Home HD Training & Support ☐ 6. Home PD Training & Support ☐ 7. Home Training & Support only (HD & PD)

21. New services being requested (check all that apply-home training & support only must provide both home PD & home HD): (V14)
☐ 1. N/A ☐ 2. In-center HD ☐ 3. In-center PD ☐ 4. In-center Nocturnal HD ☐ 5. Reuse
☐ 6. Home HD Training & Support ☐ 7. Home PD Training & Support ☐ 8. Home Training & Support only (HD & PD)

22. Does the facility have any home dialysis (PD/HD) patients receiving dialysis in long-term care (LTC) facilities?
(V15) ☐ 1. Yes ☒ 2. No
LTC (SNF/NF) facility name: (V16) CCN: (V17)
Staffing for home dialysis in LTC provided by: (V18) ☐ 1. This dialysis facility ☐ 2. LTC staff ☐ 3. Other, specify
Type of home dialysis provided in this LTC facility: (V19) ☐ 1. HD ☐ 2. PD
For additional LTC facilities, record this information and attach to the "Remarks" (item 33) section.

23. Number of dialysis patients currently on census:
In-Center HD: (V20) 87 In-Center Nocturnal HD: (V21) ____ In-Center PD: (V22) ____
Home PD: (V23) ____ Home HD <= 3x/week: (V24) ____ Home HD >3x/week: (V25) ____

24. Number of approved in-center dialysis stations: (V26) 17 Onsite home training room(s) provided? (V27) ☐ 1. Yes ☐ 2. N/A

25. Additional stations being requested: (V28) ☐ None In-center HD: (V29) 1 In-center nocturnal HD: (V30) ____
In-center PD: (V31) ____

INSTRUCTIONS FOR FORM CMS-3427

PART 1 – DOCUMENTATION NEEDED TO PROCESS FACILITY APPLICATION/NOTIFICATION TO BE COMPLETED BY APPLICANT

A completed request for approval as a supplier of End Stage Renal Disease (ESRD) services in the Medicare program (Part I – Form CMS-3427) must include:

- A narrative statement describing the need for the service(s) to be provided, and
- A copy of the Certificate of Need approval, if such approval is required by the state.

TYPE OF APPLICATION (ITEM 1)

Check appropriate category. A "change of service" refers to an addition or deletion of services. "Expansion" refers to addition of stations. If you relocate one of your services to a different physical location, you may be required to obtain a separate CCN for that service at the new location.

IDENTIFYING INFORMATION (ITEMS 2-24)

Enter the name and address *(actual physical location)* of the ESRD facility where the services are performed. If the mailing address is different, show the mailing address in Remarks (*Item 33*). Check the applicable blocks (*Item 17* and *Item 18*) to indicate the facility's hospital and/or SNF/NF affiliation, if any, If so, enter the CCN of the hospital and/or SNF/NF. Check whether the facility is owned and/or managed by a "multi-facility" organization (*Item 19*) and provide the name and address of the parent organization. A "multi-facility organization" is defined as a corporation or a LLC that owns more than one facility.

TYPES OF SERVICE, DIALYSIS STATIONS, AND DAYS/HOURS OF OPERATION (ITEMS 20-28)

Provide information on current services offered (*Item 20*). Check N/A or each New service for which you are requesting approval (*Item 21*). Note that facilities providing home therapies must provide both training and support. If you are requesting to offer home training and support only (*Item 21*), you must provide both home PD and home HD and have a plan/arrangement to provide backup dialysis as needed. A new "home training and support only (HD & PD)" service applies to initial applications. If you request any home training and support program (*Item 21*), you must also indicate "Yes" for a training room (*Item 24*). If you provide or support dialysis within one or more a LTC facilities (SNF/NF), list all LTCs (name, CCN, and address) participating in this service under Remarks (*Item 33*), and complete Item 22. Enter the number of stations for which you are asking approval (*Item 25*). Provide information on isolation *(Items 26-27)*. Provide all days and start time for the first shift of patients and end time for the last shift of patients (in military time) for each day of operation *(Item 28)*. Provide information on dialyzer reprocessing *(Item 29)*.

STAFFING (ITEM 30)

"Other" includes non-certified patient care technicians, administrative personnel, etc. To calculate the number of full-time equivalents of any discipline (*Item 30*), add the total number of hours that all members of that discipline work at this facility and enter that number in the numerator. Enter into the denominator the number of hours that facility policy defines as full-time work for that discipline. Report FTEs in 0.25 increments only. Example: An RD works 20 hours a week at Facility A. Facility A defines full time work as 40 hours/week. To calculate FTEs for the RD, divide 20 by 40. The RD works 0.50 FTE at Facility A.

REMARKS (ITEM 33)

You may use this block for explanatory statements related to Items 1-32.

LICENSING AND CERTIFICATE OF NEED

If your state requires licensing for ESRD facilities, include your current license number in Item 31. If your state requires a Certificate of Need (CON) for an initial ESRD or for the change you are requesting, mark the applicable box in Item 32 and include a copy of the documentation of the CON approval.

Upon completion, forward a copy of form CMS-3427 (Part I) to the State agency.

PART II - SURVEY AND CERTIFICATION REPORT TO BE COMPLETED BY STATE AGENCY

The surveyor should review and verify the information in Part I with administrator or medical director and complete Part II of this form.

Recognize that CMS cannot issue a CCN for an initial survey until all required steps are complete, including CMS-855A approved by the applicable MAC. Complete the Statement of Deficiencies (CMS Form 2567) in ASPEN. Complete the CMS-1539 in ASPEN entering recommended action(s). All required information must be entered in ASPEN and uploaded in order for the survey to be counted in the state workload.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
PO Box 47874 • Olympia, Washington 98504-7874

September 18, 2012

Joyce Jackson, Administrator
Nkc - Kent Kidney Center
25316 - 74th Avenue South, Suite 101
Kent, WA 98032

Re: Investigation #**38436**

Dear Ms. Jackson:

This letter informs you of the outcome of the completed complaint investigation conducted on August 2, 2012. After reviewing the complaint investigation, we determined there were no deficiencies pertinent to this complaint under WAC and/or 42 CFR regulations.

The investigation was conducted by:
Stephen Mickschl, Registered Nurse

Enclosed is your copy of the Statement of No Deficiencies. If you have any questions regarding the process or results of this investigation you may contact me at (360) 236-4983. Please include the investigation number of the facility.

Sincerely,

Rachael Lobstedt
for Cheri Carter
Facilities Medicare Certification Specialist
Investigation and Inspection Office

Enclosure

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 000	INITIAL COMMENTS	V 000		

MEDICARE COMPLAINT INVESTIGATION

This complaint investigation at NKC-Kent Kidney Center was conducted on August 2, 2012 by Stephen Mickschl, MS, RN.

During this off-site survey, Department of Health (DOH) staff reviewed all the Medicare Conditions for Coverage set forth in 42 CFR 494, End Stage Renal Disease Facilities. The Department staff found Kent Dialysis Center in substantial compliance with all the Conditions.

Shell # HKMH11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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