STATE OF WASHINGTON
DEPARTMENT OF HEALTH
PO Box 1870 Blaine, WA. 98231-1870

May 30, 2013

Deb Kuhlman
NKC-Seattle Kidney Center
548 15th Ave.
Seattle, WA 98122-5609

Ms. Kuhlman:

The Department of Health inspection team has reviewed and accepted your plan of correction for deficiencies found during your facility's Medicare re-certification inspection of May 6-8, 2013.

No further reporting is due at this time.

Please call me with any questions at (360) 371-7899 and mail the Progress Report to the address listed in the header.

Sincerely,

S. Mickschl

Stephen B. Mickschl, MS, RN

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
	502500	A. BUILDING _____ B. WING _____	05/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NKC - SEATTLE KIDNEY CENTER	548 - 15TH AVENUE SEATTLE, WA 98122

(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) SURVEY CERTIFICATION This Medicare ESRD Re-certification Survey was conducted at NKC-Seattle Kidney Center by Larry Anderson, RS, Lisa Mahoney, MPH, and Stephen Mickschl, MS, RN on 5/6-8/2013. The State Agency recommends Medicare Re-Certification, based on the attached documentation. Shell #Y09511	V 000		
V 113	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station. This Standard is not met as evidenced by: Surveyor #1 Based on observation, facility staff failed to ensure that hand hygiene was performed according to CDC guidelines when caring for patients during dialysis procedures on multiple patients. Failure to utilize proper infection control precaution during dialysis risks transmission of communicable diseases between patients and staff. Ref: Centers for Disease Control and Prevention. Guideline for Hand Hygiene in Health-Care	V 113		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	502500	A. BUILDING _____ B. WING _____	05/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NKC - SEATTLE KIDNEY CENTER	548 - 15TH AVENUE SEATTLE, WA 98122

(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 113	Continued From page 1 Settings: Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. MMWR 2002;51(No. RR-16): page 32. Reference(s): Per facility policy and procedure titled "Infection Control Practices In The Clinical Units Principles And applications" #HDP-I19305, last revised 7/11/12, it states: a) "Gloves are changed and hand hygiene is done... When moving between patients or stations; and b) "Hand hygiene is necessary after glove removal because hands can become contaminated through small defects in gloves and from the outer surface of gloves during glove removal". Findings: 1. During 5/6/13 environmental observations on the 3rd floor at 9:15 AM, Staff #1 was observed providing patient care. The staff member was wearing gloves, at the time. The staff member was seen leaving Station #1 and proceed to Station #4 to investigate why the dialysis machine was alarming. The staff member did not remove his/her dirty gloves when leaving Station #1. He/she proceeded to touch the machine at Station #4 with the same dirty gloves he/she had on at Station #1. Only when Staff #1 left Station #4 did he/she change gloves. The staff member was observed setting up the dialysis machine at Station #7 with new tubing and dialyzer at 10:39 AM while wearing gloves. The staff member left the station and walked directly to Station #5 and proceeded to start cleaning this machine by removing used and dirty dialysis tubing and wiping down the machine with a disinfectant. The staff member never changed gloves when he/she left Station #7 and moved to	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	502500	A. BUILDING _____ B. WING _____	05/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NKC - SEATTLE KIDNEY CENTER	548 - 15TH AVENUE SEATTLE, WA 98122

(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 113	Continued From page 2 work on equipment at Station #5. 2. During 5/6/13 environmental observations on the second floor at 11:25 AM, Staff #5 was observed cleaning a dialysis machine at Station #11. The staff member was wearing gloves and proceeded to remove a "Kardex" piece of paper that had been on the machine throughout the entire dialysis treatment time and touched by various staff members with dirty gloves. The staff member carried the piece of paper to a table across from the station. After finishing the machine and station cleaning, the staff member removed his/her gloves. Staff #5 then picked up the "dirty" piece of paper with his/her bare hands and carried it to the shredding container box located by the reception area. 3. On 05/06/13 at 1:40 PM Surveyor #3 observed Staff #1 perform multiple glove changes during the course of providing care to multiple patients without performing hand hygiene after each glove removal.	V 113		
V 115	494.30(a)(1)(i) IC-GOWNS, SHIELDS/MASKS-NO STAFF EAT/DRINK Staff members should wear gowns, face shields, eye wear, or masks to protect themselves and prevent soiling of clothing when performing procedures during which spurting or spattering of blood might occur (e.g., during initiation and termination of dialysis, cleaning of dialyzers, and centrifugation of blood). Staff members should not eat, drink, or smoke in the dialysis treatment area or in the laboratory. This Standard is not met as evidenced by: Surveyor #1 Based on observations and administrative staff	V 115		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	502500	A. BUILDING _____ B. WING _____	05/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NKC - SEATTLE KIDNEY CENTER	548 - 15TH AVENUE SEATTLE, WA 98122

(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 115	Continued From page 3 interview, the facility failed to ensure that staff used appropriate personal protective equipment (PPE) when providing care to patients. Failure to ensure that staff follow requirements for use of PPE places patients at risk of contacting infectious diseases from staff that were not using appropriate PPE. Findings: 1. Third floor observations of Staff #2 on 5/6/13 at 10:42 AM showed the staff member leaning on the dialysis machine at Station #9 with his/her left arm resting on top of the machine. The staff member had an overcoat (PPE) on at the time, but did not discard the coat after leaving the station so that there was no possibility of cross-contaminating other areas of the unit. 2. Second floor observations of Staff #6 on 5/6/13 at 11:05 AM showed the staff member was providing patient care at Station #6 and had gloves (dirty) on both hands. After completing the care, the staff member then proceeded to remove his/her personal glasses and clean them with the material from the overcoat (PPE) that he/she was wearing when providing patient care. These actions created situations were the possibility of cross-contamination was increased. 3. Second floor observations of Staff #7 on 5/6/13 at 11:30 AM showed the person was engaged in conversation with the patient and family members at Station #1. The person was observed to touch the patient's dialysis bed with un-gloved hands. The person was also noted to touch the end of the bed with his/her thigh. The person was not wearing any PPE overcoat. These actions created situations were the possibility of	V 115		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	502500	A. BUILDING _____ B. WING _____	05/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NKC - SEATTLE KIDNEY CENTER	548 - 15TH AVENUE SEATTLE, WA 98122

(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 115	Continued From page 4 cross-contaminating other patients was increased.	V 115		
V 122	494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [The facility must demonstrate that it follows standard infection control precautions by implementing- (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment. This Standard is not met as evidenced by: Surveyor #1 Based on observations, the facility failed to ensure that staff followed procedures to prevent contamination of cleaned and disinfected machines and supplies during the change-over time between patients using the same machine and chair. Failure to ensure that machines and supplies remain free of possible contamination between patients places all patients at risk of harm related to potentially acquiring an infection from another patient. Reference: Per facility policy and procedure titled "Infection Control Practices In The Clinical Units Principles And Applications" #HDP-I19305, last revised 7/11/12, it states, "If patient remains in the chair/bed while the machine is prepared for the next patient... Turn the machine to the side so any blood spray from the patient's access will not hit the clean front of the machine you are setting up".	V 122		

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
	502500	A. BUILDING _____ B. WING _____	05/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NKC - SEATTLE KIDNEY CENTER	548 - 15TH AVENUE SEATTLE, WA 98122

(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 122	Continued From page 5 Findings: 1. During observational rounds on 5/6/13 at 10:30 AM, Staff #1 was observed cleaning a dirty dialysis machine and removing dirty tubing from the machine at Station #7. The staff member then proceeded to put new tubing on the machine intended for the next patient. The practice occurred while the previous patient was still sitting at the station awaiting fistula punctures to clot. The machine was never turned away from the patient, as required. When Staff #1 removed the pressure clamps and dressings to finally secure the puncture sites, this was also done while the patient was sitting in close proximity (approximately 2 feet) from the cleaned and disinfected machine and supplies and the machine was not turned away from the patient. 2. During observational rounds on 5/6/13 at 10:44 AM, Staff #3 was observed cleaning a dirty dialysis machine and removing dirty tubing from the machine at Station #10. The staff member then proceeded to put new tubing on the machine intended for the next patient. The practice occurred while the previous patient was still sitting at the station awaiting fistula punctures to clot approximately 18 inches from the front of the machine. The machine was never turned away from the patient.	V 122		
V 407	494.60(c)(4) PE-HD PTS IN VIEW DURING TREATMENTS Patients must be in view of staff during hemodialysis treatment to ensure patient safety, (video surveillance will not meet this requirement).	V 407		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	502500	A. BUILDING _____ B. WING _____	05/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NKC - SEATTLE KIDNEY CENTER	548 - 15TH AVENUE SEATTLE, WA 98122

(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 407	Continued From page 6 This Standard is not met as evidenced by: Surveyor #1 Based on observations, the facility failed to ensure that staff monitored patients to the point that their dialysis access area was visible at all times. Failure to maintain view of patient dialysis access areas places them at risk of harm should a needle dislodge or tubing become disconnected causing a potentially lethal blood loss situation. Findings: 1. During third floor observational rounds on 5/6/13, the following patients had their access sites partially covered so they could not easily be seen without removing the cover: a) patient in Station #11 at 10:32 AM which was verified by staff present who immediately un-covered the site; b) patient in Station #4 at 10:53 AM which was verified by staff present who immediately un-covered the site; and c) patient in Station #4 at 1:17 PM which was verified by staff present who immediately un-covered the site; 2. During second floor observational rounds on 5/6/13, the access site for the patient in Station #10 at 11:13 AM could not be easily visualized. This was verified by staff present who immediately un-covered the access site. 3. During third floor observational rounds on 5/8/13, the access site for the patient in Station #4 at 7:50 AM could not be easily visualized. This was verified by staff present who immediately un-covered the site. 4. During second floor observational rounds on	V 407		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	502500	A. BUILDING _____ B. WING _____	05/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NKC - SEATTLE KIDNEY CENTER	548 - 15TH AVENUE SEATTLE, WA 98122

(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 407	Continued From page 7 5/8/13, the access site for the patient in Station #14 at 8:01 AM could not be easily visualized. This was verified by staff present who immediately un-covered the site.	V 407		
V 542	494.90(a) POC-IDT DEVELOPS PLAN OF CARE The interdisciplinary team must develop a plan of care for each patient. This Standard is not met as evidenced by: Surveyor #1 Based on medical record review and administrative staff interview, the facility failed to ensure that the Interdisciplinary Team (IDT) met and developed the patient care plan for 3 of 11 records reviewed for care planning (Patient #'s 3, 5 and 8). Failure to ensure that the required team members participate in meetings places patients at risk of harm related to the loss of planning information when team members are not present at meetings or arrangements are not made to include team members unable to be physically present. Findings: 1. Per medical record review, Patient #5 had a patient care plan dated 8/14/12. The care plan documentation showed that the physician did not identify completion of his/her assessment until 9/7/12 (28 days after the meeting). Thus, there was no evidence that the physician had completed the assessment by the team meeting date, thus enabling the team process of assessment review and patient care plan development. 2. Per medical record review, Patient #8 had a	V 542		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	502500	A. BUILDING _____ B. WING _____	05/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NKC - SEATTLE KIDNEY CENTER	548 - 15TH AVENUE SEATTLE, WA 98122

(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 542	Continued From page 8 patient care plan dated 11/27/12. The care plan documentation showed that the physician did not identify completion of his/her assessment until 12/20/12 (23 days after the meeting). Thus, there was no evidence that the physician had completed the assessment by the team meeting date, thus enabling the team process of assessment review and patient care plan development. 3. Per medical record review, Patient #3 had a patient care plan dated 9/18/12. The care plan documentation showed that page three of the assessment, containing information about bone disease and anemia that the physician was to assess and use for care plan discussion and development, was missing from the record. Per interview with Staff #4 on 5/8/13, the facility could not locate the missing information. It was finally determined that it was apparently lost at the physician's office and was not obtainable at this time to show that a care plan was needed or had been developed.	V 542		
V 546	494.90(a)(3) POC-MANAGE MINERAL METABOLISM Provide the necessary care to manage mineral metabolism and prevent or treat renal bone disease. This Standard is not met as evidenced by: Surveyor #1 Based on medical record review and administrative staff interview, the facility failed to ensure that the patient care plan accurately evaluated factors associated with renal bone disease for 4 of 11 records reviewed for assessment and care plans (Patient #'s 2, 4, 10, 11).	V 546		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	502500	A. BUILDING _____ B. WING _____	05/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NKC - SEATTLE KIDNEY CENTER	548 - 15TH AVENUE SEATTLE, WA 98122

(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 546	Continued From page 9 Failure to ensure that care plan issues, identified as not meeting goals, are incorporated into the plan of care or that documentation exists identifying why a plan of care is not required for issues not meeting goals places all patients at risk of harm related to potentially harmful laboratory blood levels would not be addressed for care planning by the Inter-Disciplinary Team. Findings: 1. Per record review, Patient #10 had a "Comprehensive Assessment and Plan of Care" document signed by the physician on 1/29/13. The bone disease section identified that the patient had 2 of 3 laboratory blood values for phosphate that were higher than the assessment goal. In the care plan acknowledgement section, the box titled "Bone disease management acceptable, continue present plan and monitor response" was checked. There was no information identifying why the physician felt the patient's higher values were not to be included in the care plan. In addition, the anemia management section identified that the patient had 3 of 3 laboratory blood values for hemoglobin that were higher than the assessment goal. In the care plan acknowledgement section, the box titled "Anemia management acceptable, continue present plan and monitor response" was checked. There was no information identifying why the physician felt the patient's higher values were not to be included in the care plan. 2. Per record review, Patient #11 had a "Comprehensive Assessment and Plan of Care" document signed by the physician on 3/26/13. The bone disease section identified that the	V 546		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	502500	A. BUILDING _____ B. WING _____	05/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NKC - SEATTLE KIDNEY CENTER	548 - 15TH AVENUE SEATTLE, WA 98122

(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 546	Continued From page 10 patient had 6 of 6 laboratory blood values for phosphate that were higher than the assessment goal. In the care plan acknowledgement section, the box titled "Bone disease management acceptable, continue present plan and monitor response" was checked. There was no information identifying why the physician felt the patient's higher values were not to be included in the care plan. 3. Per record review, Patient #2 had a "Comprehensive Assessment and Plan of Care" document signed by the physician on 3/26/13. The bone disease section identified that the patient had 3 of 3 laboratory blood values for phosphate that were higher than the assessment goal. In the care plan acknowledgement section, the box titled "Bone disease management acceptable, continue present plan and monitor response" was checked. There was no information identifying why the physician felt the patient's higher values were not to be included in the care plan. 4. Per record review, Patient #4 had a "Comprehensive Assessment and Plan of Care" document signed by the physician on 9/24/12. The bone disease section identified that the patient had 3 of 3 laboratory blood values for phosphate that were higher than the assessment goal. In the care plan acknowledgement section, the box titled "Bone disease management acceptable, continue present plan and monitor response" was checked. There was no information identifying why the physician felt the patient's higher values were not to be included in the care plan.	V 546		
V 558	494.90(b)(2) POC-IMPLEMENT UPDATE-15 DAYS P PT ASSESS	V 558		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	502500	A. BUILDING _____ B. WING _____	05/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NKC - SEATTLE KIDNEY CENTER	548 - 15TH AVENUE SEATTLE, WA 98122

(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 558	Continued From page 11 Implementation of monthly or annual updates of the plan of care must be performed within 15 days of the completion of the additional patient assessments specified in §494.80(d). This Standard is not met as evidenced by: Surveyor #1 Based on record review, the facility failed to ensure that a patient's plan of care was implemented within 15 days of completion of the comprehensive patient assessment for 8 of 10 records reviewed for care planning (Patient #'s 1, 2, 3, 4, 5, 6, 7, 8). Failure to complete a comprehensive assessment of a dialysis patient's needs impairs the facility's ability to develop an effective plan for care. Findings: 1. Per review of Patient #4's record, the social service assessment recorded completion date was on 8/17/12, and the dietary assessment was recorded on 8/23/12. The date of the Inter-Disciplinary Team (IDT) meeting was recorded on 9/26/12. Thus, the meeting was at least 24 days late. 2. Per review of Patient #3's record, the social service assessment completion recorded date was on 8/23/12. The date of the IDT meeting was recorded on 9/18/12. Thus, the meeting was 16 days late. 3. Per review of Patient #5's record, the dietary assessment completion date was recorded on 7/6/12. The date of the IDT meeting was recorded on 8/14/12. Thus, the meeting was 15	V 558		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	502500	A. BUILDING _____ B. WING _____	05/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NKC - SEATTLE KIDNEY CENTER	548 - 15TH AVENUE SEATTLE, WA 98122

(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 558	Continued From page 12 days late. 4. Per review of Patient #1's record, the physician's recorded date of completed assessment was on 6/20/12. The date of the IDT meeting was recorded on 7/12/12. Thus, the meeting was 7 days late. 5. Additional findings similar to the above were also noted in the records of Patient #'s 2, 6, 7 and 8.	V 558		
V 628	494.110(a)(2) QAPI-MEASURE/ANALYZE/TRACK QUAL INDICATORS The dialysis facility must measure, analyze, and track quality indicators or other aspects of performance that the facility adopts or develops that reflect processes of care and facility operations. These performance components must influence or relate to the desired outcomes or be the outcomes themselves. This Standard is not met as evidenced by: Surveyor #1 Based on review of Dialysis Facility Reports (DFR), facility Quality Assessment and Process Improvement (QAPI) documents and administrative staff interview, the facility failed to have documentation that the 2012 DFR reported data had been reviewed, analyzed, and interventions developed to improve outcomes, where needed. Failure to review DFR data within the QAPI program places patients at risk of harm because the facility did not identify potential problem areas and put corrective action in place.	V 628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	502500	A. BUILDING _____ B. WING _____	05/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NKC - SEATTLE KIDNEY CENTER	548 - 15TH AVENUE SEATTLE, WA 98122

(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 628	Continued From page 13 Findings: Per review of the 2012 DFR, based on data from the Centers for Medicare & Medicaid Services (CMS), the facility was noted as having the following: a) a higher Standardized Mortality Rate (SMR) for the years 2008-2011; b) a higher first-year SMR of observed to expected deaths; c) a higher rate of hospitalized patients with septicemia during 2008-2011; d) a higher rate of HD patients with infections in 2011; e) lower rates of patients with dialysis adequacy numbers above the minimum for 2011; and f) a higher rate of patients with access catheters in place for more than 90 days as their only vascular access. Per review of the QAPI program documents, no evidence was found that the above identified issues had been incorporated into the program. Per interview with Staff #4 on 5/8/13, no evidence of investigation, analysis or corrective action could be produced to show that the data from the DFR had been incorporated into the QAPI program.	V 628		

V 113 (494.30(a) (1) IC- Wear Gloves/Hand Hygiene

Staff must remove gloves and wash hands between each patient and station.

HOW: All direct care providers will receive a review of NKC's hand hygiene policy/procedure. Manager will audit staff monthly based on the CDC Infection Control audit tool monthly to assure compliance. Infection Control department will provide a training session with emphasis on hand washing, hand hygiene and glove changing. Additional spot audit to occur by NKC Infection Control department staff.

WHO: Unit Manager's, Leah Barnum, RN, Seattle 3rd floor and Tanny Sisson, RN Seattle 2nd floor

WHAT: Staff to be in-serviced on NKC policy and procedure "Infection Control Practices in the Clinical Units Principles and Applications".

WHEN: Staff meeting, June 7, 2013.

V 115 (494.30(a) (1) (I) IC- Gowns, Shields/Masks-No Staff Eat/Drink

Staff members to wear PPE – gown/cover-ups, face shield, eye protection, or masks to protect themselves and prevent soiling of clothing. Staff to wear PPE when performing procedures during which blood exposure might occur

HOW: All direct care providers will receive a review of NKC's policy/procedure on the use of PPE wear. Manager will audit staff monthly based on the CDC Infection Control Audit tool to assure compliance. Additional spot audit to occur by NKC Infection Control department staff.

WHO: Unit Manager's, Leah Barnum, RN, Seattle 3rd floor and Tanny Sisson, Seattle 2nd floor.

WHAT: Staff to be in-serviced on NKC policy and procedure "Personal Protective Equipment" procedure IC-P6015. Additional reviews for the staff regarding clean vs. dirty as stated in the policy.

WHEN: Staff meeting, May 15, 2013.

V 122 (494.30(a) (4) (ii) IC- Disinfect Surfaces/Equipment

Staff members demonstrate that they follow standard infection control precautions when cleaning and disinfecting contaminated surfaces, medical devices, and equipment.

HOW: All direct care providers will receive review of NKC policy/procedure with additional emphasis on 'machine repositioning'. Manager will audit staff monthly to assure compliance

with additional surveillance of machine positioning during treatment change over. Additional spot audit to occur by NKC Infection Control department staff.

WHO: Unit Manager, Leah Barnum, RN, Seattle 3rd floor.

WHAT: Staff to be in-serviced on NKC policy and procedures: "Infection Control Practices in the Clinical Units Principles and Applications" procedure HDP-I19305; "Uncoupling Procedure – Braun Long Form"; Uncoupling Procedure – Braun Short Form"; "Catheter Uncoupling".

WHEN: Staff meeting, May 30, 2013.

V 407 (494.60(c) (4) PE-HD Patients in View During Treatments

Patients must be in view of staff during hemodialysis treatment to ensure patient safety. Patients must keep their access area visible at all times to prevent risk of harm.

HOW: All direct care providers will receive review of NKC policy/procedure on the "Patient and access visible at all times." Manager will emphasize the point that patients not following the directive of keeping the access uncovered will have treatment session terminated and Nephrologist notified per NKC written policy. A patient plan of care will be developed for those patients that continue to cover their access by the IDT team. Manager will monitor patient compliance with spot audits.

WHO: Unit Manager's, Leah Barnum, RN, Seattle 3rd floor and Tanny Sisson, RN Seattle 2nd floor.

WHAT: Staff to be in-serviced on NKC policy and procedure "Visibility of Vascular Access" procedure CD V1129.

WHEN: Staff meeting, May 30, 2013.

V 542 (494.90(a) Patient Plan of Care – IDT Develops Plan of Care

Physician is to complete the patient assessment prior to the IDT meeting. The plan of care must be performed within 15 days of the meeting.

HOW: All physicians will receive written notification regarding the policy on the Comprehensive Assessment/Plan of Care as defined by CMS. Policy will be changed to reflect that the CA/P of C must be completed within 15 days of the plan of care meeting. The Operations Committee will review monthly the physicians' compliance with the plan of comprehensive assessment/plan of care call.

WHO: Operations Committee; Joyce Jackson, Chair

WHAT: Information will be provided to the physicians in 3 ways. By fax, e-mail, and in hard copy. An acknowledgement of receipt and understanding of the regulations will be required and placed in the physicians credentialing file.

WHEN: June 2013

V 546 (494.90(a) (3) Patient Plan of Care – Manage Mineral Metabolism

Physicians' assessment to address lab values for bone disease management. Assessment to provide a plan when is values are outside target range or statement to why values are acceptable for specific patient.

HOW: All physicians will have information provided to them regarding the requirements of the Plan of Care. NKC will change the format to include target ranges for each parameter. If a parameter is not in range the physician must document the reasons why it is acceptable to be outside the target range.

WHO: Operations Committee; Joyce Jackson, Chair

WHAT: Information will be provided to the physicians in 3 ways. By fax, e-mail, and in hard copy. An acknowledgement of receipt and understanding of the regulations will be required and placed in the physicians credentialing file.

WHEN: June 2013.

V 558 (494.90(b) (2) Patient Plan of Care – Implement Update – 15 days

Implementation of monthly or annual updates of the plan of care must be performed within 15 days of the additional patient assessments.

HOW: NKC policy on Comprehensive Assessment and Plan of Care was updated by the Operations Committee in March 2013 to comply with Conditions for Coverage. All registered dietitians (RDs) and social workers (MSWs) were informed of this policy change. Care Plans after March 20, 2013 will be in compliance with regulations. .

WHO: Mary McHugh, Vice President

WHAT: Auditing of care planning schedule for RD and MSW staff.

WHEN: June 2013.

V 628 (494.110(a) (2) QAPI-Measure/Analyze/Track Quality Indicators

Dialysis facility to review Dialysis Facility Reports during Quality Assessment and Process Improvement meeting.

HOW: The 2012 DRF report will be reviewed by all programs at Seattle Kidney Center under the direction of Dr. Michael Kelly to review, analyze, and create action plan(s) to improve outcomes where needed.
With the release of the 2013 DFR reported data the building will hold a meeting of all floors to review, analyze, and create action plan(s) to improve outcomes where needed.

WHO: Operations Committee; Joyce Jackson, Chair

WHAT: Collectively review the statistical data for all patients cared for at the facility. Data to be provided by NKC's IT department so each modality can better assess findings. Following review of the data, action plan(s) to improve outcomes to be written. Each floor will note this meeting, findings and action plans in their individual QAPI paperwork.

WHEN: For 2012 DFR completion date will be June 2013 to analyze the data. For the 2013 DFR, completion date will be September 2013.

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:

2. Name of Facility: Northwest Kidney Centers dba Seattle Kidney Center		3. CCN: 502500
4. Street Address: 5248 - 15th Ave. NW or Broadway		5. NPI: 1346242542
6. City: Seattle	7. County: King	8. Fiscal Year End Date: 6/30/2013
9. State: Wa.	10. Zip Code: 98122	11. Administrator's Email Address
12. Telephone No.: 206-292-2771	13. Facsimile No.: 206-292-1126	14. Medicare Enrollment (CMS 855A) completed? ☒ Yes ☐ No ☐ NA

15. Facility Administrator Name: Deborah Kuhlman
Address: 700 Broadway
City: Seattle State: Wa Zip Code: 98122 Telephone No: 206-720-3956

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) 149 In-Center Nocturnal HD: (V21) 0 In-Center PD: (V22) 0
Home PD: (V23) 195 Home HD <= 3x/week: (V24) 2 Home HD >3x/week: (V25) 53

24. Number of approved in-center dialysis stations: (V26) 38 Onsite home training room(s) provided? (V27) ☒ 1. Yes ☐ 2. N/A

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

26. How is isolation provided? (V32)
☒ 1. Room ☐ 2. Area (established facilities only) ☐ 3. CMS Waiver/Agreement (Attach copy)

27. If applicable, number of hemodialysis stations designated for isolation: (V33) 5 isolation rooms

28. Days & time for in-center patient shifts (check all days that apply and complete time field in military time): (V34)
1st shift starts: (M) 0500 (T) 0500 (W) 0560 (Th) 0500 (F) 0500 (Sat) 0500 Sun
Last shift ends: (M) 0100 (T) 0100 (W) 0100 (Th) 0100 (F) 0100 (Sat) 0100 Sun

29. Dialyzer reprocessing system: (V35) ☐ 1. Onsite ☐ 2. Centralized/Offsite ☒ 3. N/A

30. Staff (List full-time equivalents):
Registered Nurse: (V36) 37.6
LPN/LVN: (V38) 6.6
Registered Dietitian: (V40) 2.5
Others: (V42) 5.25
Certified Patient Care Technician: (V37) 14.1
Technical Staff (water, machine): (V39) 1.8
Masters Social Worker: (V41) 4.6

31. State license number (if applicable): (V43) N/A

32. Certificate of Need required? (V44) ☒ 1. Yes ☐ 2. No ☐ 3. NA

33. Remarks (copy if more and attach additional pages if needed):
V42 OTHERS
Home Business Mgr .5
~~Technical Support~~
Clinical Assistants 4.0
Chaplain .75

34. The information contained in this Application Survey and Certification Report (Part I) is true and correct to the best of my knowledge. I understand that incorrect or erroneous statements may cause the request for approval to be denied, or facility approval to be rescinded, under 42 C.F.R. 494.1 and 488.604 respectively.

I have reviewed this form and it is accurate:

Signature of Administrator/Medical Director	Title	Date
Deborah Kuhlman	Clinical Director	5/6/13

PART II TO BE COMPLETED BY STATE AGENCY

35. Medicare Enrollment (CMS 855A approved by the MAC/FI)? (V45) ☐ 1. Yes ☐ 2. No
(Note: approved CMS 855A required prior to certification)

36. Type of Survey: (V46) ☐ 1. Initial ☐ 2. Recertification ☐ 3. Relocation ☐ 4. Expansion/change of services ☐ 5. Change of ownership ☐ 6. Complaint ☐ 7. Revisit ☐ 8. Other, specify

37. State Region: (V47)

38. State County Code: (V48)

39. Network Number: (V49)

My signature below indicates that I have reviewed this form and it is complete.

40. Surveyor Team Leader (sign)	41. Name/Number (print)	42. Professional Discipline *(Print)*	43. Survey Exit Date:

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.