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

October 14, 2013

Dear Ms. Morrison:

The Department of Health inspection team has reviewed and accepted your plan of correction for deficiencies found during your facility's Medicare ESRD Home Expansion certification inspection of September 20, 2013. Certification of the program will be recommended.

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

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
PO Box 1870 •Blaine, Washington 98231-1870

September 30, 2013

Joyce Jackson
NKC-Seattle
700 Broadway
Seattle, WA 98122-4302

Dear Ms. Jackson;

This letter contains information regarding the recent ESRD Expansion survey of NKC-Seattle by the Washington State Department of Health. Your survey was completed on 9/20/2013.

During the survey, deficient practice was found in the areas listed on the attached Statement of Deficiencies. Enclosed are directions and due dates for completing the Plan of Correction to address those deficient practices. The Plan of Correction must be completed and returned to the address above within ten business days of receipt of this letter.

Please carefully complete the Plan of Correction. Be sure that each correction includes all four necessary elements as described in the instructions. We will return your Plan of Correction that is missing vital information, as incomplete and unacceptable.

Please feel free to have staff contact me if there are questions regarding the deficiencies cited, or completion of the Plan of Correction. I may be reached at (360) 371-7899.

Sincerely,

S. Mickschl

Stephen Mickschl, MS, RN

Enclosures: Instructions for completing the Plans of Correction
Statement of deficiencies (Medicare)

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

PO Box 1870 • Blaine, Washington 98231-1870

Office of Investigation & Inspections
Clinical Care Facilities

To: JOYCE JACKSON **Date: SEPTEMBER 30, 2013**

Please find attached a STATEMENT OF DEFICIENCIES from your recent facility inspection. Two documents are now required from your facility (the due dates are listed below): PLAN OF CORRECTION and PROGRESS REPORT.

PLAN OF CORRECTION

REQUIREMENTS:

1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies.

2. EACH plan of correction statement **must include** the following:
   - The regulation number and/or the tag number;
   - **HOW** the deficiency will be corrected;
   - **WHO** is responsible for making the correction;
   - **WHAT** will be done to prevent reoccurrence and how you will monitor for continued compliance; and
   - **WHEN** the correction will be completed.

3. Your PLAN OF CORRECTION must be returned within 10 **calendar** days from the date you receive the Statement of Deficiencies.

   Your PLAN OF CORRECTION should be returned approximately by **OCTOBER 16, 2013**.

4. **The Administrator or Representative's signature is required on the first page of the original. Each subsequent page must be INITIALED IN THE LOWER RIGHT HAND CORNER.**

5. Return the original report with the required signatures.

HELPFUL HINTS:

1. An incomplete and or incorrectly completed PLAN OF CORRECTION cannot be accepted and may be returned to the facility.

2. The regulation number immediately precedes the text of the statement of deficiency. The "Tag" number is found in the margin to the far left of the statement of deficiency. Your plan of correction cannot be processed without the reference numbers.

   PLEASE NOTE: Completion dates for required corrections must not exceed 60 days from the date of the survey EXIT without prior approval of the survey Team Leader.

   The Required Date of Correction must be no later than: **NOVEMBER 20, 2013**.

3. Keep a copy of the Statement of Deficiencies and your Plan of Correction for your records.

4. The first page of the original report must be signed, and each subsequent page **must** be initialed to avoid being returned.

Please return the completed reports to: Stephen B. Mickschl, MS, RN P.O. Box 1870, Blaine, WA. 98231-1870
If you have any questions, please call me at (360) 371-7899.

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 _____	09/20/2013

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 ESRD HOME PROGRAM EXPANSION SURVEY This survey of the Home Dialysis Program at NKC-Seattle Kidney Center was conducted by Stephen Mickschl, MS, RN on 9/20/2013. This on-site survey was to approve expansion of services to include home peritoneal dialysis in a long-term care facility. During the on-site survey, Department of Health staff reviewed the Condition of Participation's set forth in 42 CFR Part 494 Conditions for Coverage of Suppliers of End-Stage Renal Disease (ESRD) Services Section 494.100 Care at Home as well as requirements identified in the CMS Survey & Certification (S&C) Letter # 04-24, March 19, 2004. NKC-Seattle is in substantial compliance with the requirements of 42 CFR Part 494 Conditions for Coverage of Suppliers of End-Stage Renal Disease (ESRD) Services Section 494.100 Care at Home, and S&C Letter # 04-24. Certification of the home peritoneal dialysis program to provide services to peritoneal dialysis patients in long-term care facilities will be recommended upon receipt of an acceptable Plan of Correction for standard-level deficiencies identified in this report. ASE# FGHM11	V 000		
V 520	494.80(d)(2) PA-FREQUENCY REASSESSMENT-UNSTABLE Q MO In accordance with the standards specified in paragraphs (a)(1) through (a)(13) of this section, a comprehensive reassessment of each patient and a revision of the plan of care must be conducted-	V 520		

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.

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V 520	Continued From page 1 At least monthly for unstable patients including, but not limited to, patients with the following: (i) Extended or frequent hospitalizations; (ii) Marked deterioration in health status; (iii) Significant change in psychosocial needs; or (iv) Concurrent poor nutritional status, unmanaged anemia and inadequate dialysis. This Standard is not met as evidenced by: Findings: Per record review, Patient #1 was identified by the facility as being "unstable" on 8/14/2013. A review of the record did not provide evidence that a monthly care assessment/plan was accomplished, as of 9/20/2013. The record did not show that the patient had returned to a stable status, thus a monthly assessment/care plan was required.	V 520		
V 586	494.100(b)(1) H-PT/CAREGIVER DEMO COMPREHEND TRAINING The dialysis facility must - (1) Document in the medical record that the patient, the caregiver, or both received and demonstrated adequate comprehension of the training; This Standard is not met as evidenced by: Findings: 1. Per record review, Patient #1 received peritoneal dialysis in a Skilled Nursing Facility (SNF) following a hospitalization. The record contained a form that documented the dates that home therapy was provided to the patient.	V 586		

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V 586	Continued From page 2 However, the form only contained staff initials and not a full name, so verification that the staff person was a person certified by the dialysis facility to provide dialysis was not possible during the survey. In addition, another copy of the form was found that did not have full names for verifying treatment was by a certified staff member. 2. Per record review, a form titled "CCPD Monthly Log" was reviewed and it showed that the information for 4 of 17 dates of dialysis in August had not been completed on the form. 3. Per record review, forms titled "CCPD Monthly Log" were reviewed and 2 of 3 forms did not have a month or year on them to allow verification of when the documented treatments were actually accomplished.	V 586		
V 589	494.100(c)(1)(i) H-MONITOR HOME ADAPT;HOME VISIT=POC Services include, but are not limited to, the following: (i) Periodic monitoring of the patient's home adaptation, including visits to the patient's home by facility personnel in accordance with the patient's plan of care. This Standard is not met as evidenced by: Findings: Per record review, Patient #1 received peritoneal dialysis in a skilled nursing facility (SNF) following a hospitalization. The record did not contain evidence that a home dialysis environmental visit had been conducted at the initiation of home	V 589		

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V 589	Continued From page 3 therapy.	V 589		
V 599	494.100(c)(2) H-RECORDKEEPING SYSTEM (2) The dialysis facility must maintain a recordkeeping system that ensures continuity of care and patient privacy. This includes items and services furnished by durable medical equipment (DME) suppliers referred to in §414.330(a)(2) of this chapter. This Standard is not met as evidenced by: Findings: 1. Per record review, Patient #1 was receiving home dialysis care from Skilled Nursing Facility (SNF) staff on 8/1/2013. A licensed nurse note, from the dialysis facility, on 8/1/2013 identified that SNF staff had called the Home Dialysis Consulting Nurse, on two occasions, with problems relating to dialysis machine alarms. The note includes the following: "Pt (patient) was repositioned with no resolution to alarm. Unable to fix alarm tx (treatment) ended and PCN notified in am." There was no documentation concerning why the consulting nurse could not fix the problem which led to the patient not receiving dialysis as ordered by the physician. 2. There was another note, dated 8/1/2013 by another licensed nurse stating that the consulting nurse instructed the SNF license nurse to alter the patient's dialysis fluid composition and to "reassess the PD catheter". There was no documentation in the record to show that this re-assessment had been accomplished. 3. Per review of the "CCPD Monthly Log" form, in August 2013 there were 4 of 17 days of dialysis	V 599		

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V 599	Continued From page 4 monitoring that had not been completed, on the form.	V 599		
V 626	494.110 QAPI-COVERS SCOPE SERV/EFFECTIVE/IDT INVOL The dialysis facility must develop, implement, maintain, and evaluate an effective, data-driven, quality assessment and performance improvement program with participation by the professional members of the interdisciplinary team. The program must reflect the complexity of the dialysis facility's organization and services (including those services provided under arrangement), and must focus on indicators related to improved health outcomes and the prevention and reduction of medical errors. The dialysis facility must maintain and demonstrate evidence of its quality improvement and performance improvement program for review by CMS. This Standard is not met as evidenced by: Findings: The facility was unable to provide evidence that a system was in-place to show that Skilled Nursing Facility (SNF) staff, who were providing home dialysis care, would be periodically re-assessed for their competence. No documentation could be provided by the facility to show that this system had been developed and was ready for implementation.	V 626		

NORTHWEST Kidney Centers

V520 – 494.80

How: Unstable patient care plans will be completed monthly.

Who: Unstable patient care plans will be completed by all disciplines.

What: Monthly audits will be done by the Manager to ensure the unstable care plans are completed.

When: Correction will be completed by 10/8/2013

V586 – 494.100 (b)(1)

How: All SNF forms that apply to dialysis of NKC PD patients will be completely filled out.

Who: The SNF staff providing dialysis care to NKC PD patients will completely fill out the forms.

What: The NKC PCN/Home dialysis consulting nurse will be responsible for record/form review on a routine weekly basis.

The PD Manager will audit all SNF records for completion on a monthly basis.

When: 10/8/2013

V589 – 494.100 (c)(1)(i)

How: A home dialysis environmental visit will be conducted at the initiation of home therapy in the SNF.

Who: The NKC PCN/Home dialysis consulting nurse will be responsible to enter this information into the patient record.

What: The PD Manager will audit each patient SNF admission to be certain this information has been included.

When: 11/1/2013

NORTHWEST Kidney Centers

V599 – 494.100 (c)(2)

How: All calls from the SNF relating to patient care issues will be documented by the NKC PCN/Home dialysis consulting nurse in the patient Progress Note, including any machine repair follow-up, MD notification, and resolution of problem, etc., to facilitate continuation of patient care.

The SNF will complete in entirety the CCPD Monthly Log form

Who: The PD PCN will correct, follow-up, and document any notification by the SNF of patient care issues.

SNF will ensure the completion of NKC required treatment records. The SNF will entirely complete the CCPD log form.

The PCN will review the CCPD log form for completeness.

What: The PD Manager will audit all SNF calls, and ascertain that resolution was completed, enabling continuity of patient care.

The Manager will review the CCPD Monthly Log form from the SNF for completion and accuracy.

When: Correction will be completed by 10/8/2013

V626 – 494.110

How: The deficiency will be corrected by putting in place a system to show that SNF staff are periodically re-assessed for their competence, and a SNF representative will be included in quarterly NKC PD QAPI meetings.

Who: The Clinical Director of the Home program is responsible for making the correction.

What: The Clinical Manager of the Peritoneal Program is responsible for monitoring SNF compliance with the terms of the agreement and obtaining and auditing on a semi-annual basis the records of SNF staff competencies.

When: 10/8/201