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

July 3, 2012

Jane Davis, Administrator
NKC-Kent kidney Center
25316 74th Ave. South Ste. 101
Kent, WA 98032

Dear Ms. Davis:

This letter contains information regarding the recent survey of NKC-Kent Kidney Center by the Washington State Department of Health. Your Medicare survey was completed on June 27, 2012.

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 calendar 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 survey process, deficiencies cited, or completion of the Plan of Correction. I may be reached at (360) 371-7899.

I want to extend a special thanks to your staff for their time during the survey process.

Sincerely,

S. Mickschl

Stephen Mickschl, MS, RN

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

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

Office of Investigation & Inspections
Clinical Care Facilities

To: JANE DAVIS **Date: JULY 3, 2012**

Please find attached a STATEMENT OF DEFICIENCIES from your recent facility inspection. One (1) document is now required from your facility (the due dates are listed below).

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 **JULY 16 , 2012**.

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:
   AUGUST 27, 2012.

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
	502553	A. BUILDING _____ B. WING _____	06/27/2012

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 408	Continued From page 3 Failure to manage and monitor the facility's emergency medical kits of expired supplies places the patients at risk for receiving possible outdated medical supplies during an emergency or natural disaster. Findings: 1. During environmental rounds on 6/25/2012, Surveyor #1 observed that virtually all of the emergency intravenous fluid had a manufacturer's expiration date of September 2011. Neither Staff #5 nor the facility was unable to provide documentation that any of the emergency evacuation supplies had been checked from this date to 6/25/2012. 2. During environmental rounds on 6/26/2012, Surveyor #2 observed that the dialysis center's evacuation kit had three bottles of expired hydrogen peroxide. The expiration date on the three bottles was 3/20/2012.	V 408		

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V 407	Continued From page 2 1. During observational rounds on 6/25/2012 at 9AM, the following patients had their access sites covered so they could not be seen without removing the cover: Station #'s 2, 4, 5, 7, 9, and 14. The patient in Station #5 was observed to remove the cover over the access site on his/her own volition. Additional observation of access site visability were conducted at 11:20 AM and the patients in Stations # 7 and 13 were initially covered but staff uncovered them during rounds. 2. During observational rounds on 6/26/2012 at 8:12 AM, the following patients had their access sites covered so they could not be seen without removing the cover: Station #'s 1, 13, 14, and 15. The patient access site, in Station #13, was observed to be uncovered at 8:14 AM, when staff were verifying the Surveyor's previous observations.	V 407		
V 408	494.60(d) PE-EMERGENCY PREPAREDNESS-PROCEDURES The dialysis facility must implement processes and procedures to manage medical and non medical emergencies that are likely to threaten the health or safety of the patients, the staff, or the public. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This Standard is not met as evidenced by: Based on observation and interview with administrative staff, the dialysis center failed to implement processes to manage medical emergencies that could threaten the health and safety of the patients.	V 408		

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V 113	Continued From page 1 Findings: 1. Observations of Staff #1 on 6/26/2012 at 8:19 AM showed that the staff member was providing education to a patient at Station #2 during the dialysis treatment. During the observation time period of five (5) minutes, Staff #1 was observed to touch the patient's chair, the dialysis machine and the machine tubing with an un-gloved hand. Staff #1 was also observed to touch the patient with an instruction paper; touch the patient's side table and actually rested his/her hands on the table without the protection of a "gloved hand". Per conversation with Staff #2 on this date, the staff member should have been "gloved" prior to touching the patient, patient's station and dialysis machine.	V 113		
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). This Standard is not met as evidenced by: Surveyor #1 Based on observations and administrative staff interview, the facility failed to ensure that staff maintained view of patient access areas. Failure to maintain view of patient dialysis access areas places them at risk of harm should a needle dislodge and the patient bleed while not being seen by staff to immediately intervene. Findings:	V 407		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 000	INITIAL COMMENTS MEDICARE RE-CERTIFICATION SURVEY FOR END-STAGE RENAL DISEASE This survey for Medicare End State Renal Disease facility re-certification was conducted June 25-27, 2012 by Lee Malmberg, RS, and Stephen Mickschl, MS, RN. During this on-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 NKC-Kent Kidney Center in substantial compliance with all the Conditions except as listed below: Shell # TBZZ11	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 observations and administrative staff interview, the facility failed to ensure that clinical care staff wore gloves when touching patient equipment. Failure to ensure that proper infection control procedures are consistently implemented places all patients at risk of harm related to the possibility of infection transmission.	V 113		

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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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

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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.