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
	502520	A. BUILDING _____ B. WING _____	05/09/2013

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NKC - AUBURN KIDNEY CENTER	1501 WEST VALLEY HIGHWAY N AUBURN, WA 98001

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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 recertification was conducted on May 7 through May 9, 2013 by Marieta Smith, RN, MN; Paul Throne, DrPH, PHA; and Elizabeth Gordon, RN, MN.. During this on-site survey, Department of Health staff reviewed all the Medicare Conditions for Coverage set forth in 42 CFR 494, End Stage Renal Disease Facilities. During the course of the survey, the surveyors determined that NKC Auburn Kidney Center was NOT IN COMPLIANCE with the following Conditions for Coverage: 42 CFR 494.40 Water and Dialysate Quality 42 CFR 494.180 Governance Day 45 = June 23, 2013 Day 60 - July 8, 2013 Day 90 = August 7, 2013 In addition, standard-level deficiencies are also cited below. Recertification will not be recommended until all Conditions for Coverage are met. Shell ID #GPKP11	V 000	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. 4. Return the original report with the required signatures.	
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	V 122		

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 122	Continued From page 1 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: Based on observation, interview and policy review, the dialysis facility (1) failed to ensure that its policies were followed regarding cleaning of dialysis machines between patient treatments, and (2) failed to label disinfection solutions clearly. Failure to clean dialysis machines properly between patient treatments risks infection through spread of disease or bacterial contamination. Failure to clearly label disinfection solutions risks ineffectual equipment disinfection through use of outdated solutions. Findings include: 1. During a tour of the dialysis facility on 05/07/2013, Surveyor #2 observed that at least 8 of 24 dialysis machines had an accumulation of white powder around the connection to the bicarbonate canister. The powder appeared to be an accretion of dried bicarbonate. Bicarbonate supports rapid growth of bacteria. In an interview on the same day, the facility biomedical technician confirmed that dialysis technicians are supposed to clean the bicarbonate canister connection so such accretions do not occur. Review of facility policy "Infection Control	V 122		

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V 122	Continued From page 2 Practices in the Clinical Units Principles and Applications" on 05/09/2013 (revised 07/11/2012) found that the policy stated "Disinfecting the Dialysis Station...All surfaces must be wiped down,...This includes...Wiping down the top, sides and front of the machines." 2. During a tour of the dialysis facility on 05/07/2013, Surveyor #2 observed that two plastic tubs were placed on the counter between the sinks near stations 13 and 14. The two tubs were labeled: "6000 H2O/60 cc bleach" and "8000 cc H2O/80 cc bleach" There was no date or time on the tubs indicating when the bleach solutions had been prepared. Dialysis technician #1 stated that he prepared the bleach solutions that morning and had not been instructed to label the tubs with the date and time that the solutions were prepared. Review of facility policies "Surface Disinfection" (revised 12/06/2012), "Infection Control Practices in the Clinical Units Principles and Applications" (revised 07/11/2012) and "Cleaning Soiled Instruments" (revised 05/09/2013) found that the policies did not require bleach solutions to be labeled with the date and time that they were prepared.	V 122		
V 175	494.40 CFC-WATER & DIALYSATE QUALITY This Condition is not met as evidenced by: CONDITION FOR COVERAGE - NOT MET Based on observation, review of facility policies and procedures, and staff interview, the dialysis facility failed to manage the quality of dialysis	V 175	THIS IS A CONDITION-LEVEL CITATION CORRECTION IS DUE BY JUNE 23, 2013	

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V 175	Continued From page 3 water and dialysate in a manner that ensures the quality and safety of the patients undergoing dialysis at the facility. Condition-level non-compliance resulted from nurses being unable to correctly describe the decision processes that follow testing water for patient safety. Failure to ensure the quality and safety of dialysis water risks serious injury to patients and is evidence that this Condition for Coverage was NOT MET. Cross-reference Tag V0260.	V 175		
V 260	494.40(a) PERSONNEL-TRAINING PROGRAM/PERIODIC AUDITS 9 Personnel: training program/periodic audits A training program that includes quality testing, the risks and hazards of improperly prepared concentrate, and bacterial issues is mandatory. Operators should be trained in the use of the equipment by the manufacturer or should be trained using materials provided by the manufacturer. The training should be specific to the functions performed (i.e., mixing, disinfection, maintenance, and repairs). Periodic audits of the operators' compliance with procedures should be performed. The user should establish an ongoing training program designed to maintain the operator's knowledge and skills.	V 260		

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V 260	Continued From page 4 This Standard is not met as evidenced by: Based on interview and policy review, the dialysis facility failed to ensure that personnel involved in water system quality tests were knowledgeable the appropriate response to unacceptable chlorine test results. Failure to properly identify the appropriate response to unacceptable chlorine test results leaves personnel unable to react responsibly to unacceptable water quality results. Findings include: 1. On 05/07/2013, four registered nurses who conduct chlorine/chloramine checks on the dialysis product water system were interviewed. Each nurse was asked what should be done if the initial test on the worker carbon tanks showed a reading of 0.1 or higher. a. RN #1 stated "we have to stop." He/she did not mention testing the second (polisher) carbon tank or the reverse osmosis machine as part of the decision process. b. RN #2 stated "take patients off." He/she also did not mention testing the second (polisher) carbon tank or the reverse osmosis machine as part of the decision process. When asked if there was ever a time that the second carbon tank should be tested, he/she stated "we have a policy that says when to do that." c. RN #3 stated that dialysis should be discontinued. When asked what should happen if the polisher tank test was within acceptable limits, he/she stated that dialysis could still not continue.	V 260	THIS IS A CONDITION-LEVEL CITATION CORRECTION IS DUE BY JUNE 23, 2013	

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V 260	Continued From page 5 d. RN #4 stated that a test of 0.1 or higher on the worker tank and 0.1 or higher on the polisher tank meant that he/she could "continue dialysis" as long as the reverse osmosis water tested at acceptable levels. 2. Review of facility policy "Chlorine Testing Via Test Strips" on 05/07/2013 (revised 04/02/2013) found that the policy stated "If a positive results is obtained from a worker carbon tank, test again from the sample port following the corresponding polisher carbon tank. Record the results on the appropriate log sheet. If the test result from the polisher carbon bank is negative, operations may be continued for a short time (up to 72 hours) until a replacement tank(s) is installed. During this time, increased testing of the polisher carbon tanks(s) should occur at the frequency of every two hours....If a positive test result is obtained from a polisher carbon tank, dialysis must be discontinued." 3. Review of inservice training records on 05/08/2013 found that the four RNs referenced above had all received satisfactory results on the Water Treatment Training and Review Checklist within the past six months.	V 260		
V 544	494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE Achieve and sustain the prescribed dose of dialysis to meet a hemodialysis Kt/V of at least 1.2 and a peritoneal dialysis weekly Kt/V of at least 1.7 or meet an alternative equivalent professionally-accepted clinical practice standard for adequacy of dialysis. This Standard is not met as evidenced by: Based on record review and interview, the	V 544		

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V 544	Continued From page 6 dialysis facility failed to ensure that staff members followed the physician's plan for care by following the dialysis prescription for anticoagulation for 3 of 5 patient records reviewed (Patients #1, #2, #3). Failure to follow the physician's prescription for anticoagulation when performing dialysis risks inadequate dialysis treatment and patient harm. THIS IS A REPEAT CITATION Findings: 1. Review of 10 treatments between April 8, 2013 and May 13, 2013, for 5 dialysis patients revealed the following: a. Patient #1's dialysis prescription specified that the patient was to receive 500 units of heparin per hour during 2 hours of treatment with the heparin turned off 30 minutes prior to end of treatment (Total: 750 units). The patient's treatment record indicated that he/she received a total of 2000 units of heparin on 4/16/2013. Similar findings were found in Patient #1's treatment record on 4/21/2013, 4/23/2013, and 5/2/2013. On 4/30/2013 and 5/5/2013 Patient #1's hourly treatment of heparin was not administered due to concern about bleeding after the last treatment. There was no physician's order in the patient's medical record to discontinue the hourly treatment of heparin. b. Patient #2's dialysis prescription specified that the patient was to receive 1000 units of heparin per hour during 4 hours of treatment with the	V 544		

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V 544	Continued From page 7 heparin turned off 30 minutes prior to the end of treatment (Total: 3500 units). The patient's treatment ran for 3.5 hours instead of 4 hours. The patient's heparin dose should have been reduced by 500 units (Total: 3000 units). The patient's treatment record indicated that he/she received a total of 3500 units of heparin on 4/19/2013. The dose of heparin was not reduced. c. Patient #3's dialysis prescription specified that the patient was to receive 1400 units of heparin per hour during 4 hours of treatment with the heparin turned off 1 hour prior to the end of treatment (Total: 4200 units). On 4/22/2013 the patient's dialysis run was reduced by 1 hour. The total units of heparin administered should have been reduced by 1400 units (Total: 2800 units). The patient's treatment record indicated that he/she received a total of 4200 units of heparin. The dose of heparin was not reduced. Similar findings were found in Patient #2's treatment record on 4/24/2013 and 5/1/2013. 2. These findings were confirmed by the Clinical Manager (Staff Member #1) and the Unit Manager (Staff Member #2).	V 544		
V 560	494.90(b)(4) POC-PTS SEEN BY MED STAFF 1X/MO The dialysis facility must ensure that all dialysis patients are seen by a physician, nurse practitioner, clinical nurse specialist or physician's assistant providing ESRD care at least monthly, as evidenced by a monthly progress note placed in the medical record, and periodically while the hemodialysis patient is receiving in-facility dialysis.	V 560		

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V 560	Continued From page 8 This Standard is not met as evidenced by: Based on record review, interview, and review of facility policies and procedures, the dialysis facility failed to ensure that 1 of 8 physicians reviewed provided evidence that s/he saw and evaluated 3 of 3 of his/her patients monthly and at least quarterly while on dialysis as directed by facility policy (Physician #1; Patients #4, #5, #6) Failure to evaluate the patient's condition monthly and periodically while on dialysis risks non-detection of health problems and maladjustment to dialysis. Findings: 1. The dialysis facility's policy and procedure entitled "Physician/Patient Encounters" (Reviewed 3/11/2011) stated that all in-center dialysis patients were to be seen at least monthly in the physician's office or in the dialysis unit, and once a quarter in the dialysis unit before, during or after a hemodialysis treatment. A progress note was to be placed in the patient's electronic medical record as evidence of these patient encounters. 2. Review of the electronic medical records of three patients under the care of Physician #1 revealed the following: a. There was no evidence in the records of Patient #4 that Physician #1 had seen the patient in the office or in the dialysis unit during the months of November 2012 or January, March and April 2013. There was no evidence that Physician #1 had seen the patient in the dialysis unit since the patient was admitted on 7/16/2012.	V 560		

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V 560	Continued From page 9 b. There was no evidence in the records of Patient #5 that Physician #1 had seen the patient in the dialysis unit since the patient was admitted on 8/31/2007. c. There was no evidence in the records of Patient #6, who was admitted on 11/2/2011, that Physician #1 had seen the patient in the office or in the dialysis unit during the months of June 2012 or February 2013. There was no evidence that Physician #1 had seen the patient in the dialysis .unit during the third and fourth quarters of 2012 or the first quarter of 2013. 3. The findings above were confirmed by the facility's Clinical Director (Staff Member #1) and the dialysis corporation's Vice President of Clinical Services (Staff Member #3) during an interview on 5/8/2013 at 11:40 AM.	V 560		
V 638	494.110(b) QAPI-MONITOR/ACT/TRACK/SUSTAIN IMPROVE The dialysis facility must continuously monitor its performance, take actions that result in performance improvements, and track performance to ensure that improvements are sustained over time. This Standard is not met as evidenced by: Based on medical record reviews, the dialysis facilty failed to ensure that the system implemented to monitor corrective actions, regarding previously identified inspection deficiencies, was robust enough to keep the identified problem at an acceptable level of compliance. Failure to monitor corrective actions and	V 638		

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V 638	Continued From page 10 implement newer corrective action when it is shown that compliance levels are not being maintained places all patients at risk of harm related to a potential, negative outcome associated with previous non-compliance. Findings: The facility received a deficiency for failing to follow physician's dialysis prescription for anticoagulation in September of 2010. Cross-reference Tag V 544.	V 638		
V 750	494.180 CFC-GOVERNANCE This Condition is not met as evidenced by: CONDITION FOR COVERAGE - NOT MET Based on observation, record review, review of facility policies and procedures, and staff interview, the Governing Body failed to ensure that the dialysis facility met all Conditions for Coverage at 42 CFR 494 End Stage Renal Dialysis Facilities. Condition-level non-compliance was present due to the failure of the dialysis facility to comply with Conditions for Coverage for 42 CFR 494.40 Water and Dialysate Quality. Failure to ensure that requirements at 42 CFR 494.40 Water and Dialysate Quality were met risked serious injury to patients and is evidence that the Condition for Governance was NOT MET.	V 750	THIS IS A CONDITION-LEVEL CITATION CORRECTION IS DUE BY JUNE 23, 2013	

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V 750	Continued From page 11 Cross-reference Tags V0175, V260.	V 750		
V 763	494.180(c)(2),(3) GOV-GB INFORMS MED STAFF OF P&P/QAPI PROG The governing body- (2) Ensures that all medical staff who provide care in the facility are informed of all facility policies and procedures, including the facility's quality assessment and performance improvement program specified in §494.110. (3) Communicates expectations to the medical staff regarding staff participation in improving the quality of medical care provided to facility patients. This Standard is not met as evidenced by: Based on record review, interview, and review of facility policies and procedures, the dialysis facility failed to initiate corrective action according to facility policy for 1 of 8 physicians reviewed who did not provide evidence of seeing and evaluating his/her patients monthly and at least quarterly while on dialysis (Physician #1; Patients #4, #5, #6) Failure to evaluate the patient's condition monthly and periodically while on dialysis risks non-detection of health problems and maladjustment to dialysis. Findings: 1. The dialysis facility's policy and procedure entitled "Physician/Patient Encounters" (Reviewed 3/11/2011) stated that all in-center dialysis patients were to be seen at least monthly in the physician's office or in the dialysis unit, and	V 763		

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V 763	Continued From page 12 once a quarter in the dialysis unit before, during or after a hemodialysis treatment. A progress note was to be placed in the patient's electronic medical record as evidence of these patient encounters. Persistent lack of documentation compliance for seeing and evaluating patients monthly for over three or four months would result in a written warning from the facility governing body. If no documentation was completed in the following month, the physician's right to give verbal orders would be suspended until documentation was completed. If the documentation was not completed by the end of the next month, the physician's medical staff privileges would be suspended until the documentation was complete. At the end of each quarter, the facility's governing body would inform physicians if documentation requirements for seeing patient's quarterly in the dialysis unit were not met. Subsequent lack of documentation compliance over two or more quarters would result in suspension of verbal order privileges until documentation was complete. In the case of suspension of privileges, "the CEO" would send the physician a letter, a copy of which would be placed in the physician's medical staff file and the suspension reported at the time of the physician's medical staff reappointment. 2. Review of the electronic medical records of three patients under the care of Physician #1 revealed the following: a. There was no evidence in the records of Patient #4 that Physician #1 had seen the patient	V 763		

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V 763	Continued From page 13 in the office or in the dialysis unit during the months of November 2012 or January, March and April 2013. There was no evidence that Physician #1 had seen the patient in the dialysis unit since the patient was admitted in July 2012. b. There was no evidence in the records of Patient #5 that Physician #1 had seen the patient in the dialysis unit since the patient was admitted in August 2007. c. There was no evidence in the records of Patient #6, who was admitted in November 2011, that Physician #1 had seen the patient in the office or in the dialysis unit during the months of June 2012 or February 2013. There was no evidence that Physician #1 had seen the patient in the dialysis .unit during the third and fourth quarters of 2012 or the first quarter of 2013. 4. The findings above were confirmed by the facility's Clinical Director (Staff Member #1) and and the dialysis corporation's Vice President of Clinical Services (Staff Member #3) during an interview on 5/8/2013 at 11:40 AM. During this interview, the Vice President of Clinical Services stated that monthly and quarterly physician/patient encounters were tracked at the corporate level, and that the corporation's medical director was responsible for ensuring corrective action was taken. 4. A telephone interview on 5/8/2013 at 12:50 PM with the dialysis corporation's medical director (Physician #2) revealed physician/patient encounters had not been tracked nor had corrective action been taken against physicians since October of 2012.	V 763		

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

May 13, 2013

Jane Davis, Clinical Director
NKC Auburn Kidney Center
1501 West Valley Highway North
Auburn, Washington 9800

Dear Ms. Davis:

This letter contains information regarding the recent Medicare Recertification Survey of NKC Auburn Kidney Center by the Washington State Department of Health (DOH). The survey conducted on May 7, 2013, through May 9, 2013 resulted in findings of failure to meet two Conditions for Coverage (CFC):

- 42 CFR 494.40 Water and Dialysate Quality
- 42 CFR 494.180 Governance

CFCs are major requirements in organization, management, care and safety. Failure to take proper and timely action could result in the termination of your Medicare provider agreement within **90** days from the survey exit date, which is **August 7, 2013.**

Condition level deficiencies must be corrected by **June 23, 2013**, which is **45 days** from the exit date of May 9, 2013. The condition level deficiencies must be completely corrected with sufficient time for the Department of Health (DOH) to revisit your facility and confirm the corrections by the corrections due date.

Please send DOH a Letter of Credible Allegation stating you have corrected all Condition level deficiencies on or before **June 17, 2013**, in time to reach us so we can schedule a return visit by June 23, 2013 to confirm corrections. Failure to correct or notify within time frames may result in the Centers for Medicare and Medicaid (CMS) proceeding with the termination process. I am enclosing a sample letter of credible allegation for your reference.

The survey also resulted in several standard level deficiencies. Standard-level deficiencies must be corrected by **July 8, 2013, 60 days** from the survey exit date.

Please complete a Plan of Correction and submit it to DOH within **10** calendar days from the receipt of this Statement of Deficiencies. Your Plan of Correction is due at DOH by **May 24, 2013.** Mail your Plan of Correction, together with your Statements of Deficiencies signed by your owner or administrator, to the address below:

Marieta Smith, RN, MN
Washington State Department of Health
Office of Investigations and Inspections
Davenport Field Office
P.O. Box 114
Davenport, Washington 99122

A Progress Report explaining how the corrections were completed together with documentation of meeting minutes, policy updates, audits and any other supporting documentation is due on or before **August 7, 2013, 90 days** from the completed survey date.

I am enclosing an instruction sheet for your Plan of Correction.. You can call me with any questions at (509)725-0443 or email me at Marieta.Smith@doh.wa.gov.

Sincerely,

Marieta Smith, RN, MN
Survey Team Leader

Enclosures:
Statement of Deficiencies
Instructions for completing the Plan of Correction and Progress Report
Sample Letter of Credible Allegation of Correction

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	502520	A. BUILDING _____ B. WING _____	05/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NKC - AUBURN KIDNEY CENTER	1501 WEST VALLEY HIGHWAY N AUBURN, WA 98001

(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 544	Continued From page 7 heparin turned off 30 minutes prior to the end of treatment (Total: 3500 units). The patient's treatment ran for 3.5 hours instead of 4 hours. The patient's heparin dose should have been reduced by 500 units (Total: 3000 units). The patient's treatment record indicated that he/she received a total of 3500 units of heparin on 4/19/2013. The dose of heparin was not reduced. c. Patient #3's dialysis prescription specified that the patient was to receive 1400 units of heparin per hour during 4 hours of treatment with the heparin turned off 1 hour prior to the end of treatment (Total: 4200 units). On 4/22/2013 the patient's dialysis run was reduced by 1 hour. The total units of heparin administered should have been reduced by 1400 units (Total: 2800 units). The patient's treatment record indicated that he/she received a total of 4200 units of heparin. The dose of heparin was not reduced. Similar findings were found in Patient #2's treatment record on 4/24/2013 and 5/1/2013. 2. These findings were confirmed by the Clinical Manager (Staff Member #1) and the Unit Manager (Staff Member #2).	V 544		
V 560	494.90(b)(4) POC-PTS SEEN BY MED STAFF 1X/MO The dialysis facility must ensure that all dialysis patients are seen by a physician, nurse practitioner, clinical nurse specialist or physician's assistant providing ESRD care at least monthly, as evidenced by a monthly progress note placed in the medical record, and periodically while the hemodialysis patient is receiving in-facility dialysis.	V 560		

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
	502520	A. BUILDING _____ B. WING _____	05/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NKC - AUBURN KIDNEY CENTER	1501 WEST VALLEY HIGHWAY N AUBURN, WA 98001

(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 560	Continued From page 8 This Standard is not met as evidenced by: Based on record review, interview, and review of facility policies and procedures, the dialysis facility failed to ensure that 1 of 8 physicians reviewed provided evidence that s/he saw and evaluated 3 of 3 of his/her patients monthly and at least quarterly while on dialysis as directed by facility policy (Physician #1; Patients #4, #5, #6) Failure to evaluate the patient's condition monthly and periodically while on dialysis risks non-detection of health problems and maladjustment to dialysis. Findings: 1. The dialysis facility's policy and procedure entitled "Physician/Patient Encounters" (Reviewed 3/11/2011) stated that all in-center dialysis patients were to be seen at least monthly in the physician's office or in the dialysis unit, and once a quarter in the dialysis unit before, during or after a hemodialysis treatment. A progress note was to be placed in the patient's electronic medical record as evidence of these patient encounters. 2. Review of the electronic medical records of three patients under the care of Physician #1 revealed the following: a. There was no evidence in the records of Patient #4 that Physician #1 had seen the patient in the office or in the dialysis unit during the months of November 2012 or January, March and April 2013. There was no evidence that Physician #1 had seen the patient in the dialysis unit since the patient was admitted on 7/16/2012.	V 560		

Davis RN 5/16/13

Connie Anderson

From: Smith, Marieta (DOH) <Marieta.Smith@DOH.WA.GOV>
Sent: Wednesday, May 29, 2013 9:00 AM
To: Connie Anderson
Cc: Angelita Galban
Subject: RE: AKC addt survey ques

Thank you, Connie. That looks fine. I will send a POC acceptance letter soon.
Don't forget to send a Credible Allegation of Correction letter when you are ready for a revisit.

Marieta

From: Connie Anderson [mailto:Connie.Anderson@nwkidney.org]
Sent: Tue 5/28/2013 9:46 AM
To: Smith, Marieta (DOH)
Cc: Angelita Galban
Subject: AKC addt survey ques

Marieta,
Please see the attached responses to your questions.
Thank You,
Connie

Connie Anderson
Vice President of Clinical Operations
Administration
Northwest Kidney Centers
700 Broadway, Seattle, WA 98122 | Tel: 206-720-8506 | Fax: 206-860-5821
Connie.Anderson@nwkidney.org

TO: Marieta Smith, RN
FROM: Connie Anderson
DATE: May 28, 2013

RE: E-mail response to your questions

V122(1) - Will dialysis unit staff members be re-educated regarding cleaning the dialysis machines to ensure dried bicarbonate solution is not present?
Yes. Re-education of staff was conducted May 20-23, 2013 and completed.

V122(2) – Will dialysis unit staff members be re-educated regarding preparation and labeling of the bleach solution according to facility policy and procedure?
Yes. Re-education of staff was conducted May 20 and will be completed on May 28, 2013.

V544 – Please be more specific regarding your monthly and "ongoing" auditing process. How many records will be reviewed? Over what period of time? Who will perform the review? What is your target for compliance?

- Audit was conducted on May 13 - 17, 2013
- Based on the results, staff was re-educated on May 20-23, 2013.
- Monthly and on-going auditing process will be initiated May 31, 2013, covering 15 ++ patient records per month ongoing every month through the end of 2013. This will complete our current number of patient records of 108 (15 ++ x 7 months (June - December 2013) = 108 patient records. Target at 3 months will be 100% compliance.
- Process will continue through the following year on a monthly basis. Re-education will occur as needed until compliance is achieved.
- Angelita P. Galban, Unit Manager, will perform the review

Please let me know if you need anything else.

Thank you,
Connie Anderson

SAMPLE LETTER OF CREDIBLE ALLEGATION OF CORRECTION

Dear Ms. Foss:

This letter is notification that NKC Auburn Kidney Center has corrected the following Condition level deficiencies that were found during the May 7-9, 2013 Medicare ESRD recertification survey.

1. 42 CFR 494.40 Water and Dialysate Quality

   The corrections we have made are as follows:
   a. [Describe the corrections made here]
   b.
   c.

2. 42 CFR 494.180 Governance

   a. [Describe the corrections made here]
   b.
   c.

We are ready for the survey team to make a return visit to our facility to verify that these Conditions of Participation are now met, and that the deficiencies have been substantially corrected.

Sincerely,

(Name of Facility Representative)

(Note: FAX the letter to Linda Foss at the Olympia office at (360)586-0123 and to Marieta Smith at (509)724-1141.

Send the original, signed copy to the Olympia office at the following address:

Linda Foss, Executive Manager
Department of Health, Investigation and Inspection Office
P.O. Box 47874
Olympia, WA 98504-7874

The corrections have been made as follows:

1. **An encounter audit of all physicians with patients at the AKC was completed 5/15/2013**

   The one physician out of compliance was notified on May 10, 2013 by the Chair of the Medical Staff Executive Committee.

   The physician completed her encounter by May 17, 2013

   The Physician/patient encounter policy was revised to better clarify the expectations and the formal audit process

   A second audit of all AKC admitting physicians was completed May 17, 2013. Two of 25 physicians (8%) were not in compliance. They were notified by the Chief Medical Officer and were to be in compliance by June 3, 2013. 100% compliance was reached by June 7, 2013. The Operations Committee granted one exception for a patient that had a prolonged hospitalization.

   All communications to medical staff regarding the encounter policy was reviewed. A reminder about the encounter policy will be sent from our CMO to all medical staff by June 14, 2013. It will be in the Physician Update newsletter and a formal notification letter will be sent via e-mail.

   Monthly audits will be conducted by the Operations Committee. The consequences outlined in the policy will be followed if physicians are not in compliance with their encounters.

We are ready for the survey team to make a return visit to our facility to verify that these Conditions of Participation are met and that the deficiencies have been substantially met.

Sincerely,

Jane Davis
Clinical Director – AKC

Joyce Jackson
President and CEO

NORTHWEST Kidney Centers

June 10, 2013

Linda Foss
Executive Director
Department of Health, Investigation, and Inspection Office
P.O. Box 47874
Olympia, Washington 98504-7874

Dear Ms. Foss,

This letter is notification that NKC Auburn Kidney Center has corrected the following Condition level deficiencies that were found during the May7-9, 2013 Medicare ESRD recertification survey.

1.42 CFR 494.40 Water and Dialysate Quality

The corrections we have made are as follows:

1. **All nurses performing water checks were given the "Water Treatment Learning Packet" on May 9th 2013 and completed by June 3rd 2013.**

   5/17/2013 Ruby Elenzano = 94%
   5/20/2013 Jennylou Manaois= 99%
   5/20/2013 Marlene Dulay =97%
   5/29/2013 Amy Yee = 98%
   5/29/2013 Lyn Villarin = 97%
   5/30/2013 Amabel Borillo=99%
   5/30/2013 Zenaida Arenas=99%
   5/31/2013 MaryAnn Vargas=99%
   6/3/2013 Catherin Estrera=98%

2. **May 15th NRAA Webinar : Water 101 Introduction to Water for Dialysis**

   Lyn Villiarin
   Catherin Estrera
   Amy Yee
   Ruby Elenzano
   MaryAnn Vargas
   Marlene Dulay
   Zenaida Arenas
   Jennylou Manaois

3. **May 17,2013 Chlorine Testing Flow Chart posted in Water Room**

4. **May 29th NRAA Webinar: Water 201 Advance Topics in Water For Dialysis**
   Lyn Villiarin
   Amy Yee
   Ruby Elenzano
   Catherin Estrera
   Jennylou Manaois
   Zenaida Arenas
   Marlene Dulay
   MaryAnn Vargas

5. **May 30th 2013 Water In-service presented by Dr Fung**
   Lyn Villiarin
   Amabel Borillo
   Jennylou Manaois
   Marlene Dulay
   MaryAnn Vargas
   Zenaida Arenas

6. **Weekly Chlorine/Chloramine testing skills and Competency requiring "teach back" to assure understanding Of Procedure and knowledge.**
   MaryAnn Vargas 5/8,20th,28th,6/5
   Amy Yee 5/9,20,29,6/3
   Ruby Elenzano 5/20,29,6/6
   Jennylou Manaois 5/20,,28,6/5
   Marlene Dulay 5/20,30,6/3
   Catherin Estrera 5/20,29
   Lynn Villarin 5/22,29,
   Zenaida Arenas 5/23,30,6/3
   Amabel Borillo 5/30, 6/3

7. **Written test on Chlorine/Chloramine Critical Questions Require 100% passing score.**
   MaryAnn Vargas =100%
   Amy Yee=100%
   Ruby Elenzano= 89% test repeated 100%
   Jennylou Manaois=100%
   Marlene Dulay= 100%
   Catherin Estrera 100%
   Lynn Villarin =100%
   Zenaida Arenas=100%
   Amabel Borrillo=100%

2. **42CFR 494.180 Governance**

The corrections have been made as follows:

1. **An encounter audit of all physicians with patients at the AKC was completed 5/15/2013**

   The one physician out of compliance was notified on May 10, 2013 by the Chair of the Medical Staff Executive Committee.

   The physician completed her encounter by May 17, 2013

   The Physician/patient encounter policy was revised to better clarify the expectations and the formal audit process

   A second audit of all AKC admitting physicians was completed May 17, 2013. Two of 25 physicians (8%) were not in compliance. They were notified by the Chief Medical Officer and were to be in compliance by June 3, 2013. 100% compliance was reached by June 7, 2013. The Operations Committee granted one exception for a patient that had a prolonged hospitalization.

   All communications to medical staff regarding the encounter policy was reviewed. A reminder about the encounter policy will be sent from our CMO to all medical staff by June 14, 2013. It will be in the Physician Update newsletter and a formal notification letter will be sent via e-mail.

   Monthly audits will be conducted by the Operations Committee. The consequences outlined in the policy will be followed if physicians are not in compliance with their encounters.

We are ready for the survey team to make a return visit to our facility to verify that these Conditions of Participation are met and that the deficiencies have been substantially met.

Sincerely,

Jane Davis
Clinical Director – AKC

Joyce Jackson
President and CEO

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

June 28, 2013

Jane Davis, Clinical Director
NKC Auburn Kidney Center
1501 West Valley Highway North
Auburn, Washington 98001

Dear Ms. Davis:

This letter contains information regarding the recent Medicare Recertification Survey of Auburn Kidney Center by the Washington State Department of Health (DOH). The survey conducted on May 7, 2013, through May 9, 2013 resulted in findings of failure to meet two Conditions for Coverage (CFC):

- 42 CFR 494.40 Water and Dialysate Quality
- 42 CFR 494.180 Governance

Auburn Kidney Center developed a plan of correction to correct condition-level and standard-level deficiencies cited during this survey. This plan of correction was approved on June 3, 2013.

Paul Throne, MSW/MPH, PHA performed an on-site follow-up survey on June 24, 2013, and verified that all Conditions for Coverage at 42 CFR 494 End Stage Renal Disease Facilities are now met. Recertification of Auburn Kidney Center has been recommended.

A Progress Report to verify that all deficiencies cited during the survey have been completed is due on or before **August 7, 2013**, 90 days from the completed survey date.

Please call me with any questions at (509)725-0443. You may also contact me by email at Marieta.Smith@doh.wa.gov.

Sincerely,

Marieta Smith, RN, MN
Survey Team Leader

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
PO Box 47852 • Olympia, Washington 98504-7852

August 12, 2013

Jane Davis, Clinical Director
NKC Auburn Kidney Center
1501 West Valley Highway North
Auburn, Washington 98001

Dear Ms. Davis:

Surveyors from the Washington State Department of Health conducted a Medicare End Stage Renal Dialysis recertification survey at NKC Auburn Kidney Center on May 7-9, 2013. The facility developed a plan of correction to correct deficiencies cited during this survey. This plan of correction was approved on May 22, 2013.

An onsite revisit was conducted on June 24, 2013, which verified successful implementation of the plan of correction. The facility sent a progress report dated August 2, 2013, which indicates that all deficiencies have been corrected.

The Department of Health accepts your attestation to be in compliance with 42 CFR Part 405, Subpart U, Conditions for Coverage of Suppliers of End-Stage Renal Disease Services (ESRD) and recommends continuance of your certification in the Medicare ESRD program.

The team sincerely appreciates your cooperation and hard work during the survey process and looks forward to working with you again in the future.

Sincerely,

Marieta L. Smith, RN, MN
Survey Team Leader