STATE OF WASHINGTON

DEPARTMENT OF HEALTH

PO Box 47852 • Olympia, Washington 98504-7852

Facilities and Services Licensing
Investigations and Inspection Office

To: **Deborah Kuhlman Clinical Director** **Broadway Kidney Center** Date: July 17, 2012

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 working days from the date you receive the Statement of Deficiencies.

   Your PLAN OF CORRECTION should be returned approximately by: July 27, 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: September 12, 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.

PROGRESS REPORT

REQUIREMENTS:

1. The Progress report is due when all items are corrected, but no later than 90 days from the survey exit date. The Progress report is due by: NA
2. The Progress Report must address all items listed in the Plan of Correction. It must:
   - Include the regulation or tag numbers;
   - Identify the actual completed dates of all items; and
   - Report the summary results of your monitoring activities that demonstrate compliance.

HELPFUL HINTS:

1. Additional progress reports may be required if the Department agreed to extend completion dates for some items. The survey Team Leader will inform you if additional reports are required.
2. You must include the reference numbers in order for all paperwork to be completed.

Please return the completed reports to: **Lee Malmberg, RS, Department of Health, PMB 337, 6947 Coal Creek Parkway SE Newcastle, WA 98059-3159**
If you have any questions, please call me at (425) 254-0895

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
	502556	A. BUILDING _____ B. WING _____	07/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NKC - BROADWAY KIDNEY CENTER - ELLIOT	700 BROADWAY SEATTLE, WA 98122

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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 on July 10-12, 2012 by Lee Malmberg, RS, Stephen Mickschl, MS, RN and Larry Anderson, RS. 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 Broadway Kidney Center in substantial compliance with all the Conditions except as listed below: Shell # LECY11	V 000		
V 354	494.50(b)(1) MONITOR-DIALYSIS/PT'S CLINICAL COURSE 13 Monitoring 13.1 Dialysis: patient's clinical course The clinical course of the patient should be observed and recorded during each dialysis to identify possible complications caused by new or reprocessed dialyzers. Dialyzer failures should be recorded and systematically evaluated. Applicable home dialysis patients and their assistants should be instructed in the appropriate observation, recording requirements, and reporting procedures. This Standard is not met as evidenced by: Surveyor #1 Based on medical record review, as verified by staff providing access to the electronic record, the facility failed to ensure that the clinical course of	V 354		

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 354	Continued From page 1 the patient was adequately observed and recorded during each dialysis treatment for 4 of 7 records reviewed for treatments (Patient #1, #2, #3, #8). Failure to adequately monitor patients places them at risk of harm should staff fail to identify possible complications. Reference: Per review of facility policy and procedure titled "Setting Up and Priming Dialyzers" #HDP-S19012, it states "Heparin: it is important to read the heparin syringe on an hourly basis and then determine whether or not the patient is getting the ordered hourly dose". Findings: 1. Per record review, Patient #1 was a 62 year old receiving hemodialysis. Per physician order, dated 6/19/2012, the patient was to be given a pre-bolus of 1500 units of heparin and then receive 500 units per hour with the infusion to stop 60 minutes before the end of the treatment time (4.5 hours later). Per review of the hemodialysis charting screen in the electronic medical record, the dialysis start time was at 6:14 AM on 7/2/2012. The charting showed the "remaining heparin" to be infused was 1500 units at 6:16 AM, 1000 units at 7:15 AM, and 500 units at 8:16 AM. However, at 8:46 the record shows that the remaining heparin is "0" and remained "0" for the last 90 minutes of the treatment period. There was no documentation in the record to address any of the following: a) why the apparent rate of heparin infusion doubled after 8:16 AM; b) was the "remaining heparin" amount of heparin mis-read in the syringe; c) were licensed staff aware of any problem associated with the heparin	V 354		

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V 354	Continued From page 2 infusion; d) were staff aware that the termination time of the infusion was not documented; and e) why was the amount of heparin, originally put into the infusion syringe (1500 units), insufficient to meet the infusion rate of 500 units per hour for 3.5 hours (should have been 1750 units). Per review of the hemodialysis charting screen in the electronic medical record, the dialysis start time was at 6:10 AM on 7/4/2012. The charting showed the "remaining heparin" to be infused was 1000 units at 6:14 AM, 1000 units at 6:42 AM, 500 units at 7:12 AM, 500 units at 7:42 AM; and "0" units at 8:12 AM. There was no documentation in the record to address any of the following: a) why the remaining amount of the infusion was still 1000 units after 30 minutes; b) why the remaining amount of the infusion was 500 units at 7:12 AM and documented as still 500 units at 7:42 AM; c) why the remaining amount of the infusion was never documented from 7:42 AM to 9:20 AM; d) was the "remaining heparin" amount of heparin mis-read in the syringe; e) were licensed staff aware of any problem associated with the heparin infusion; f) were staff aware that the termination time of the infusion was to be at 9:36 AM and there was apparently no heparin being infused from 8:12 AM to 10:36 AM ; and g) why was the amount of heparin, originally put into the infusion syringe (1000 units), insufficient to meet the infusion rate of 500 units per hour for 3.5 hours (should have been 1750 units). 2. Per record review, Patient #2 was a 57 year old receiving hemodialysis. Per physician order, dated 6/19/2012, the patient was to be given a pre-bolus of 3800 units of heparin and then receive 750 units per hour with the infusion to stop 60 minutes before the end of the treatment time (4 hours later).	V 354		

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V 354	Continued From page 3 Per review of the hemodialysis charting screen in the electronic medical record, the dialysis start time was at 5:57 AM on 7/9/2012. The charting showed the "remaining heparin" to be infused was 3000 units at 5:58 AM, 2300 units at 6:58 AM, 1600 units at 7:58 AM, 800 units at 8:58 AM, and "0" at 9:58 AM with a treatment stop time of 10:01 AM. However, per physician's order, the infusion should have been stopped at 9:01 AM. Thus, the infusion continued for another hour after the physician's ordered stop time. There was no documentation in the record to address any of the following: a) why the initial heparin amount was "3000 units" was placed in the syringe instead of "2250 units" to meet the physician's order requirements; b) were licensed staff aware of any problem associated with the heparin infusion; c) why was the amount of heparin, originally put into the infusion syringe (3000 units), in excess of the amount to meet the infusion rate of 750 units per hour for 3 hours (should have been 2250 units). 3. Per record review, Patient #3 was a 52 year old receiving hemodialysis. Per physician order, dated 6/19/2012, the patient was to be given a pre-bolus of 1000 units of heparin and then receive 500 units per hour with the infusion to stop 90 minutes before the end of the treatment time (4 hours later). Per review of the hemodialysis charting screen in the electronic medical record, the dialysis start time was at 6:08 PM on 7/6/2012. The charting showed the "remaining heparin" to be infused was 1000 units at 6:10 PM, and 500 units at 10:10 PM. However, per physician's order, the infusion should have been stopped at 9:12 PM. Thus, the infusion apparently continued for another hour after the physician's ordered stop time.	V 354		

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V 354	Continued From page 4 There was no documentation in the record to address any of the following: a) why the initial heparin amount was "1000 units" was placed in the syringe instead of "1250 units" to meet the physician's order requirements; b) were licensed staff aware of any problem associated with the heparin infusion. 4. Per record review, Patient #8 was a 54 year old receiving hemodialysis. Per physician order, the patient was to receive 1000 units per hour. Per review of the hemodialysis charting screen in the electronic medical record, the dialysis start time was at 6:52 AM on 7/2/2012. The charting showed the "remaining heparin" to be infused was 2000 units at 8:54 AM and no documentation of infused heparin was made until 10:25 AM (31 minutes late). At 10:54 AM the remaining heparin should have been documented as "0", but the record had no documentation that the amount had been infused.	V 354		
V 403	494.60(b) PE-EQUIPMENT MAINTENANCE-MANUFACTURER'S DFU The dialysis facility must implement and maintain a program to ensure that all equipment (including emergency equipment, dialysis machines and equipment, and the water treatment system) are maintained and operated in accordance with the manufacturer's recommendations. This Standard is not met as evidenced by: Surveyor #2 Based on observation the dialysis center failed to ensure equipment is maintained and operated in accordance with the manufacturer's recommendations.	V 403		

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V 403	Continued From page 5 Failure to ensure ancillary equipment such as glucometers are maintained in accordance with the manufacturer's instructions places the patients at risk for equipment failure and inaccurate test results. Finding: On 7/10/2012 during environmental rounds at 3::05 PM the surveyor found that the level 1 and level 2 test solution bottles for the glucometer were opened and in use, but the test solutions were not dated on the bottles when opened. The manufacturer recommended the glucometer test solution bottles (level 1 and level 2) expire 30 days after opening. There was no date on the two bottles to assure that the solutions were not outdated and expired. Surveyor #1 Based on observations, the facility failed to ensure that supplies used to test fluid conductivity and residual chloramines/chlorine were maintained in accordance with the manufacturer recommendations. Failure to maintain supplies for testing of dialysis fluids places all patients at risk for harm related to the potential of harmful fluids being injected into the patient. Findings: During environmental rounds on 7/10/2012 the following was noted: a) a container of Myron L 14.0 Millisiemens standardized solution for conductivity testing was found with a manufacturer's expiration date of 5/11/2012; and	V 403		

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V 403	Continued From page 6 b) three (3) containers of 'Water check strips for chlorine or peroxide" were found opened. The manufacturer states that they should be discarded after being opened within 30 days. None of the containers had an "opening or discard date" on them to alert staff that these products should no longer be used for patient care. These observations were verified by the clinic manager at the time of the observation.	V 403		
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: Surveyor #1 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. 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:	V 408		

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V 408	Continued From page 7 On 7/10/2012 during a review of the dialysis center's emergency medical kit the surveyor found the twelve (12) 1000 ml saline intravenous bags had a manufacturer's expiration date of September 2011. This observation was confirmed by staff responsible for checking the kits.	V 408		
V 558	494.90(b)(2) POC-IMPLEMENT UPDATE-15 DAYS P PT ASSESS 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 1 of 7 records reviewed for care planning (Patient #9). 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 #9's record, the nursing assessment was completed on 8/15/2011, the social work assessment was completed on 7/28/2011 and the dietary assessment was completed on 6/7/2011. The date of the care planning meeting was recorded on 8/16/2011. Thus, the meeting was held 32 days late.	V 558		
V 676	494.130 LAB-CLIA LABS/MEET NEEDS OF PTS The dialysis facility must provide or make	V 676		

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V 676	Continued From page 8 available, laboratory services (other than tissue pathology and histocompatibility) to meet the needs of the ESRD patient. Any laboratory services, including tissue pathology and histocompatibility must be furnished by or obtained from, a facility that meets the requirements for laboratory services specified in part 493 of this chapter. This Standard is not met as evidenced by: Surveyor #1 Based on observations, the facility failed to ensure that laboratory supplies, used for CLIA-waivered tests, were available for patient use. Failure to ensure that supplies are not expired and thus not available for patient use places all patients at risk of not having required laboratory procedures done in an acceptable timeframe. Findings: During environmental rounds on 7/10/2012, the following was noted: a) a container of "Hemastix" for urine analysis was found that had a manufacturer's expiration date of 12/2011; b) a container of "Hemocult developer" was noted with an expiration date of 11/2010.	V 676		
V 715	494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P The medical director must- (2) Ensure that- (i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and nonphysician providers;	V 715		

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V 715	Continued From page 9	V 715		

This Standard is not met as evidenced by:
Surveyor #1

Based on medical record review and review of policy and procedures, medical director failed to ensure that policies and procedures were followed by patient care staff for 2 of 7 records reviewed for treatments (Patient #1, #3).

Failure to ensure that policies and procedures are followed places all patients at risk of harm related to care and treatment may not be consistently delivered as prescribed in the policies and procedures.

Reference: Per review of facility policy and procedure titled 'Hemodialysis Monitoring" #CD-H1024, it states, " All patients will be monitored every half hour or more often if medically indicated... Monitoring during hemodialysis at NKC will include assessment of the patient and the delivery system...".

Findings:

1. Per record review, Patient #1 was a 62 year old receiving hemodialysis. Per review of the hemodialysis charting screen in the electronic medical record, the dialysis start time was at 6:10 AM on 7/4/2012. The screen showed "acknowledge time" spaces were the licensed nurse documents when the patient was assessed. The record showed that an assessment was documented at 7:18 AM and then not again until 8:36 AM (18 minutes late). The record then shows machine patient care parameters being collected at 8:42 AM, 8:51 AM, 9:12 AM, 9:20 AM and 9:42 AM. However, the

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V 715	Continued From page 10 licensed nurse documented time for assessing these parameters was at 9:43 AM for all of the collected parameters. Thus, no assessment was documented at 9:06 AM or 9:36 AM. The next documented license nurse assessment was at 11:53 AM (90 minutes late) which was when the patient's treatment had ended. 2. Per record review, Patient #3 was a 52 year old receiving hemodialysis. Per review of the hemodialysis charting screen in the electronic medical record, the dialysis start time was at 6:08 PM on 7/6/2012. The screen showed "acknowledge time" spaces were the licensed nurse documents when the patient was assessed. The record showed that an assessment was documented at 6:10 PM and then not again until 7:10 AM (30 minutes late). The next assessment was at 8:13 PM (30 minutes late) and again at 11:11 PM (30 minutes late).	V 715		
V 726	494.170 MR-COMPLETE, ACCURATE, ACCESSIBLE The dialysis facility must maintain complete, accurate, and accessible records on all patients, including home patients who elect to receive dialysis supplies and equipment from a supplier that is not a provider of ESRD services and all other home dialysis patients whose care is under the supervision of the facility. This Standard is not met as evidenced by: Surveyor #1 Based on medical record review, as verified by staff providing access to the electronic record, the facility failed to ensure that the medical record was complete and accurate for 4 of 7 records reviewed for treatments (Patient #1, #2, #3, #8).	V 726		

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V 726	Continued From page 11 Failure to ensure that records are complete and accurate places patients at risk of harm should staff fail to identify possible complications and provide a document accurately describing the patient's treatments. Findings: 1. Per record review, Patient #1 was a 62 year old receiving hemodialysis. Per review of the hemodialysis charting screen in the electronic medical record, the dialysis start time was at 6:14 AM on 7/2/2012. The charting showed the "remaining heparin" to be infused was "0" at 8:46 and remained "zero" for the last 90 minutes of the treatment period. There was no documentation in the record to address any of the following: a) was the "remaining heparin" amount of heparin mis-read in the syringe; b) were licensed staff aware of any problem associated with the heparin infusion; and c) were staff aware that the termination time of the infusion was not documented. Per review of the hemodialysis charting screen in the electronic medical record, the dialysis start time was at 6:10 AM on 7/4/2012. The charting showed the "remaining heparin" to be infused was 1000 units at 6:14 AM, 1000 units at 6:42 AM, 500 units at 7:12 AM, 500 units at 7:42 AM; and "0" units at 8:12 AM. There was no documentation in the record to address any of the following: a) why the remaining amount of the infusion was still 1000 units after 30 minutes; b) why the remaining amount of the infusion was 500 units at 7:12 AM and documented as still 500 units at 7:42 AM; c) why the remaining amount of the infusion was never documented from 7:42 AM to 9:20 AM; d) was the "remaining heparin" amount of heparin	V 726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	502556	A. BUILDING _____ B. WING _____	07/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NKC - BROADWAY KIDNEY CENTER - ELLIOT	700 BROADWAY 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 726	Continued From page 12 mis-read in the syringe; e) were licensed staff aware of any problem associated with the heparin infusion; f) were staff aware that the termination time of the infusion was to be at 9:36 AM and there was apparently no heparin being infused from 8:12 AM to 10:36 AM. 2. Per record review, Patient #2 was a 57 year old receiving hemodialysis. Per physician order, dated 6/19/2012, the patient was to be given a pre-bolus of 3800 units of heparin and then receive 750 units per hour with the infusion to stop 60 minutes before the end of the treatment time (4 hours later). Per review of the hemodialysis charting screen in the electronic medical record, the dialysis start time was at 5:57 AM on 7/9/2012. The charting showed the initial amount of infusing heparin to be 3000 units. There was no documentation about why the infusion was not stopped one hour prior to the treatment termination time, per physician's order. 3. Per record review, Patient #3 was a 52 year old receiving hemodialysis. Per physician order, dated 6/19/2012, the patient was to be given a pre-bolus of 1000 units of heparin and then receive 500 units per hour with the infusion to stop 90 minutes before the end of the treatment time (4 hours later). Per review of the hemodialysis charting screen in the electronic medical record, the dialysis start time was at 6:08 PM on 7/6/2012. The charting showed the "remaining heparin" to be infused was 1000 units at 6:10 PM. There was no documentation of the "amount infused" at 7:10 PM or at 8:10 PM. The record showed that "500 units" remained to be infused at 20:10 PM which was the time of termination. There was no documentation in the record to	V 726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	502556	A. BUILDING _____ B. WING _____	07/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NKC - BROADWAY KIDNEY CENTER - ELLIOT	700 BROADWAY 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 726	Continued From page 13 address any of the following: a) were licensed staff aware of any problem associated with the heparin infusion; and b) why was the heparin not terminated at the ordered time. 4. Per record review, Patient #8 was a 54 year old receiving hemodialysis. Per physician order, the patient was to receive 1000 units per hour. Per review of the hemodialysis charting screen in the electronic medical record, the dialysis start time was at 6:52 AM on 7/2/2012. The charting showed the "remaining heparin" to be infused was 2000 units at 8:54 AM and no documentation of infused heparin was made until 10:25 AM (31 minutes late). At 10:54 AM the remaining heparin should have been documented as "0", but the record had no documentation that the amount had been infused.	V 726		