Printed: 06/16/2010
FORM APPROVED
OMB NO. 0938-0391

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
	502511	A. BUILDING _____ B. WING _____	06/03/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELLIOTT BAY KIDNEY CENTER	600 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 408	Continued From page 1 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: 00210 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monitor the facility's emergency medical kits of expired supplies places the patients at risk for receiving possible outdated medical supplies during an emergency or natural disaster.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: On 6/2/2010 during a review of the dialysis center's two emergency kits the surveyor found expired glucometer control solutions and test strips. The expiration date on the Accu-Chek control solution bottle was marked, "use by 8/2009" and the expiration date on the test strip bottle was 7/31/2009. This was confirmed by the administrator during an interview by the surveyor on 6/3/2010.	V 408		
V 417	494.60(e)(1) FIRE SAFETY Except as provided in paragraph (e)(2) of this section, by February 9, 2009. The dialysis facility must comply with applicable provisions of the	V 417		

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V 417	Continued From page 2 2000 edition of the Life Safety Code of the National Fire Protection Association (which is incorporated by reference at §403.744(a)(1)(i) of this chapter). This Standard is not met as evidenced by: Surveyor: 00210 Based on record review and interview of administrative staff, the dialysis center failed to comply with the provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association related to quarterly fire drills. 20.7.1.2 Failure by the dialysis center staff to conduct quarterly fire drills on each shift reduces the ability of the staff to respond to an immediate emergency and places the patients at risk for possible injury in the case of a fire. On 6/3/2010 during a review of the fire drill logs the surveyor found that the facility staff did not participate in quarterly fire drills for the second quarter of 2009. This was confirmed by the administrator and the nurse manager during an interview by the surveyor on 6/3/2010.	V 417		
V 541	494.90 PATIENT PLAN OF CARE The interdisciplinary team as defined at §494.80 must develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the patient's needs, as identified by the comprehensive assessment and changes in the patient's condition, and must include measurable	V 541		

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V 541	Continued From page 3 and expected outcomes and estimated timetables to achieve these outcomes. The outcomes specified in the patient plan of care must be consistent with current evidence-based professionally-accepted clinical practice standards. This Standard is not met as evidenced by: Surveyor: 08982 Based on record review, review of facility policies and procedures, and interview, the facility failed to develop a process for development of an interdisciplinary patient plan of care that included a review of all care plan items for all patients. Failure to discuss all aspects of the patient's comprehensive assessment and to include the patient's nephrologist as part of this process limits the opportunity for team coordination and development of an effective, individualized plan of care for the patient. Findings: 1. During an interview with Staff member #1 on 6/1/2010 at 12:50 PM, the staff member stated that he/she did not attend meetings with the Inter-Disciplinary Team (IDT) to discuss individual patient's comprehensive assessment results and develop an interdisciplinary plan of care. Per review of patient care plans for Patient #s P1, P2, P6 and P7, no evidence was found that the IDT had met and/or discussed the total care plan prior to the patient signing the plan as being completed. This observation was confirmed by the administrator. Per interview with the facility administrator on 6/2/2010, the facility had changed its process of	V 541		

pue

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V 541	Continued From page 4 care planning to that of having a interdisciplinary "Care Team Meetings" on a monthly basis. The facility's medical director, a registered nurse, the social worker, and the dietician discussed individual patients that were not meeting facility target outcomes during these meetings. Any action plans developed during this meeting, to improve patient outcomes, were only recorded in Quality Assessment Process Improvement (QAPI) meeting minutes. Any outcomes or potential changes to patient's care plans were not recorded in the patient's medical record. Review of the facility's policy and procedure entitled "Plan of Care" (last reviewed 4/9/2009), it did not identify how the IDT was to work in an interdisciplinary manner to develop the patient's plan of care.	V 541		
V 552	494.90(a)(6) DEVELOPMENT OF PATIENT PLAN OF CARE The interdisciplinary team must provide the necessary monitoring and social work interventions. These include counseling services and referrals for other social services, to assist the patient in achieving and sustaining an appropriate psychosocial status as measured by a standardized mental and physical assessment tool chosen by the social worker, at regular intervals, or more frequently on an as-needed basis. This Standard is not met as evidenced by: Surveyor: 08982 Based on review of facility documents and administrative staff interview, the facility's Inter-Disciplinary Team (IDT) failed to ensure that the tool selected by the National Quality Forum	V 552		

pac

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V 552	Continued From page 5 and Centers for Medicare and Medicaid Services for adult patients (the KDQOL-36 assessment survey) was completed, any issues assessed and incorporated into the plan of care for 7 of 8 records reviewed (P1, P2, P4-P8). Failure to incorporate the information into the care planning process places patients at risk of not having any identified issues incorporated in the care plan. Findings: 1. Per record review, Patient #8 had evidence of a completed KDQOL survey dated 3/3/2010. The patient scored "below average" on the "Mental Component Summary" (MCS). The record did not contain evidence that an "assessment" of the patient regarding the score had been accomplished. The social work section of the patient's care plan had been completed on 2/25/2010 (6) days before the MCS score was received. No changes to the care plan were noted after the 2/25/2010 date. Per interview with facility Social Worker on 6/1/2010 at 1250, the staff person stated that he/she could not provide evidence that a specific assessment had been completed regarding the MCS score, after it had been received. 2. Per record review, Patient #7 had evidence of a completed KDQOL survey dated 1/7/2010. The patient scored "below average" on the MCS, Symptoms and Problems, and Effects of Kidney Disease on Daily Life sections. The record did not contain evidence that an "assessment" of the patient regarding any of the scores had been accomplished. The social work section of the patient's care plan had been completed on 12/22/2009 (16) days before the scores were	V 552		

pdc

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V 552	Continued From page 6 received. No changes to the care plan were noted after the 12/22/2009 date. 3. Per record review, Patient #5 had evidence of a completed KDQOL survey dated 2/17/2010. The patient scored "below average" on the Physical component Summary (PCS), Symptoms and Problems, and Burden of Kidney Disease sections. The record did not contain evidence that an "assessment" of the patient regarding any of the scores had been accomplished. The social work section of the patient's care plan had been completed on 2/3/2010 (14) days before the scores were received. 4. Per record review, Patient #1 had evidence of a completed KDQOL survey dated 4/7/2010. The patient scored "below average" on the PCS, Symptoms and Problems, and Effects of Kidney Disease on Daily Life sections. The record did not contain evidence that an "assessment" of the patient regarding any of the scores had been accomplished. The social work section of the patient's care plan had been completed on 4/8/2010. 5. Per record review, Patient #6 had evidence of a completed KDQOL survey dated 12/2/2009. The patient scored "below average" on Symptoms and Problems section. The record did not contain evidence that an "assessment" of the patient regarding this score had been accomplished. The social work section of the patient's care plan had been completed on 12/4/2009, but no additions to the care plan were noted regarding the KDQOL scores. 6. Per record review, Patient #4 had evidence of a completed KDQOL survey dated 12/3/2009. The patient scored "below average" on the	V 552		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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V 552	Continued From page 7 Burden of Kidney Disease section. The record did not contain evidence that an "assessment" of the patient regarding this score had been done. The social work section of the patient's care plan had been completed on 12/1/2009 (2) days before the scores were received. 7. Per record review, Patient #2 had evidence of a completed KDQOL survey dated 3/11/2010. The patient scored "below average" on the PCS and Symptoms and Problems sections. The record did not contain evidence that an "assessment" of the patient regarding these scores had been done. The social work section of the patient's care plan had been completed on 3/10/2010 (1) day before the scores were received.	V 552		

DRC

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V 000	INITIAL COMMENTS Surveyor: 00210 MEDICARE RE-CERTIFICATION SURVEY FOR END STAGE RENAL DISEASE This survey for Medicare End State Renal Disease facility re-certification was conducted June 1 through June 3, 2010 by Lee Malmberg RS and Stephen Mickschl, RN, MS. 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 the Elliott Bay Kidney Center in substantial compliance with all the Conditions except as listed below: Shell #6B2B11	V 000	An acceptable Plan of Correction (due date 6/27/2010) must include the following: · HOW the deficiency will be or was corrected, · WHO is responsible for the correction, · WHAT monitors will be put in place to assure continuing compliance · WHEN each deficiency will be corrected. Insert anticipated date of correction in far right column under "Complete Date". Correction cannot take longer than 60 days from the date of the survey (due date 8/3/2010). A Progress Report with a summary of corrective actions is due no later than 90 days after the survey was completed (due date 9/3/2010). The administrator or representative's signature and signing date are required on the first (original) page and initials in the lower right hand corner on all other pages. Please return the original survey report to: Lee Malmberg, RS Department of Health PMB #337 6947 Coal Creek Parkway SE Newcastle, WA. 98059-3159	
V 408	494.60(d) EMERGENCY PREPAREDNESS The dialysis facility must implement processes	V 408		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deborah Kuhlman	Clinical Director	6/24/2010

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.

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

Facilities and Services Licensing
Investigations and Inspection Office

To: **Deborah Kuhkman Clinical Director** **Elliott Bay Kidney Center** Date: June 16, 2010

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: June 27, 2010
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 3, 2010
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: September 3, 2010.
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

plc

V408 494.60(d) Emergency Preparedness

The dialysis center will implement processes to manage and monitor emergency medical kits to prevent containing outdated medical supplies.

HOW: FSS to monitor the emergency box inventory on a monthly basis

WHO: Katherine Prince, Facility Services Manager

WHAT: The FSS to create a check list of emergency box contents noting expiration dates. The FSS to review this check list monthly

WHEN: The new check list for the emergency box has been created and is in use (June 3, 2010).

V417 494.60(e)(1) Fire Safety

The dialysis center staff will conduct quarterly fire drills on each shift following NKCs/ Safety – Emergency and Disaster Preparedness policy. This practice follows the Life Safety Code of the National Fire Protection Association.

HOW: FSS will complete quarterly fire drills. Two sign in sheets will be completed each quarter one for the day staff and one for the evening staff

WHO: Emiliah Kambrami-Sithole, Quality Improvement and Regulations Manager

WHAT: Each quarter the FSS will arrange with the unit manager a fire drill for each shift of staff

WHEN: June 30,2010 the staff will participate in a mock drill. Each shift of staff will sign the attendance roster..

V 541 494.90 Patient Plan of Care

The interdisciplinary team will meet to develop an interdisciplinary plan of care.

HOW: Arrangements will be made for the entire IDT (RN, MSW, RD, attending nephrologist) to meet at the same time to discuss the patient's CA/POC. The meeting to include the patient as the patient prefers. Documentation of the meeting will be done in the EMR.

WHO: Donald Williams, RN, Manager, and Unit case-manager

WHAT: A pilot process for the plan of care review by all IDT member is starting. Each NKC MD will be given a telephone conference number, and a routine block of time for

their patient review. The IDT will call the conference number and discuss the patient with the MD. This will be done on a routine monthly basis.

WHEN: August 3, 2010 The Manager will audit CA/POC, EMR, and patient progress notes for completion of documentation

V 552 494.90 (a) (6) Development of Patient Plan of Care – Psychosocial Status.

The interdisciplinary team must provide the necessary monitoring and social work interventions. These include counseling services and referrals for other social services, to assist the patient in achieving and sustaining an appropriate psychosocial status as measured by a standardized mental and physical assessment tool chosen by the social worker, at regular intervals, or more frequently on an as-needed basis.

HOW: Using the KDQOL measurement tool, the social worker will provide counseling and referral services to patients that score "below average".

WHO: Bill Bowden, MSW Manager, Social Services Department

WHAT: The KDQOL will be administered a month before the annual Comprehensive Assessment is due to allow enough time to include in the patient's plan of care. Members of the interdisciplinary team will discuss the below average KDQOL results at the interdisciplinary team meeting and the team will develop a plan of care that reflects the proposed interventions of all members of the team.

WHEN: August 3, 2010. Social Services Manager will audit the plans of care developed by the social worker in the month of July to assure the patients with "below average" scores have updated plans of care that incorporate the appropriate social work interventions.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
6947 Coal Creek Parkway SE #337, Newcastle, WA 98059-3159

July 21, 2010

Deborah Kuhlman, RN, Clinical Director
NKC Elliott Bay Kidney Center
700 Broadway
Seattle, WA. 98122

Dear Ms. Kuhlman:

The Department of Health has reviewed your plan of correction for deficiencies found during your Medicare survey on June 3, 2010. We recommend to Medicare your re-certification based on your plan of correction and the attached documentation.

A progress report is due on September 3, 2010, when all deficiencies have been corrected. The progress report must address all items listed in the plan of correction, including the prefix tags and CFR reference numbers and letters, the actual correction completion dates, and the results of the monitoring process to ensure the corrections are effective.

Please mail to Lee Malmberg, Department of Health, 6947Coal Creek Parkway SE #337, Newcastle, WA 98059-3159

Thank you

Sincerely,

Lee Malmberg

Lee Malmberg, RS
Public Health Advisor

NORTHWEST
KIDNEY CENTERS

September 1, 2010

Lee Malmberg, RS
Department of Health, PMB 337
6947 Coal Creek Parkway SE
Newcastle, WA 98059

RE: Provider number: 50-2511
Elliott Bay Kidney Center
600 Broadway
Seattle, Washington 98122

Inspection Date – June 03, 2010
Progress Report – September 3, 2010

Dear Mr. Malmberg,

Enclosed you will find the Progress Report in follow-up of the Elliott Bay Kidney Center survey. I have included discussions regarding action plans with a summary of progress for each tag number. I hope this is to your satisfaction.

Please feel free to call me if you have any question regarding this report. I can be reached at (206) 720-3956 or Connie Anderson, Vice President of Clinical Services, can be reached at (206) 720-8506.

Sincerely,

Deborah Kuhlman

Deborah Kuhlman, RN, BS, CNN
Clinical Director

PROGRESS SUMMARY

V408 494.60(d) Emergency Preparedness

The dialysis center implemented a changed process to manage and monitor emergency medical kits to prevent containing outdated medical supplies. The unit Facility Services Specialist (FSS) created a check list for the emergency box contents, June 3, 2010. This Check List notes content expiration dates. The Check List is reviewed monthly by the FSS. SEE
Completed June 3, 2010
Copies of the July and August reviewed check lists are included.

V417 494.60(e)(1) Fire Safety

The dialysis center conducted it's second quarter fire drills on June 25, 2010 one for each shift following NKCs/ Safety – Emergency and Disaster Preparedness policy. This practice follows the Life Safety Code of the National Fire Protection Association.
Completed June 30, 2010
Enclosed are copies of the two fire drill evaluation forms are included. There are separate forms for each shift with individual attendance rosters.

V 541 494.90 Patient Plan of Care

NKC began its' pilot process to have routine meetings for the entire interdisciplinary team (IDT) – RN, MSW, RD, and attending nephrologists to meet simultaneously to discuss the patients' CA/POC. The patients were also asked to participate with this IDT meeting, if they preferred. Documentation of the meeting is included in the EMR. The pilot process started in July with four physicians. In August the number of physicians was increased to twelve physicians. Beginning in September all physicians will be included in these monthly calls.
Completed September 1, 2010
Enclosed find copies of audited charts with Plans of Care.

V 552 494.90 (a) (6) Development of Patient Plan of Care – Psychosocial Status

There have been 33 patients (actually 34 but one was transplanted) who have completed the KDQOL survey since 6/1/10. 20 of the 33 patients had KDQOL scores that were either average or above average in all five sections. 13 patients scored below average on one or more sections. All 13 of these patients have below average KDQOL plans of care in EMR.
Completed September 1, 2010
Enclosed find copies of audited charts with Plans of Care regarding below average KDQOL scores.

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

Facilities and Services Licensing
Investigations and Inspection Office

To: **Deborah Kuhkman Clinical Director** **Elliott Bay Kidney Center** Date: June 16, 2010

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   Your PLAN OF CORRECTION should be returned approximately by: June 27, 2010
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5. Return the original report with the required signatures.

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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 3, 2010
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: September 3, 2010.
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

plc

Printed: 06/16/2010
FORM APPROVED
OMB NO. 0938-0391

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
	502511	A. BUILDING _____ B. WING _____	06/03/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELLIOTT BAY KIDNEY CENTER	600 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 408	Continued From page 1 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: 00210 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: On 6/2/2010 during a review of the dialysis center's two emergency kits the surveyor found expired glucometer control solutions and test strips. The expiration date on the Accu-Chek control solution bottle was marked, "use by 8/2009" and the expiration date on the test strip bottle was 7/31/2009. This was confirmed by the administrator during an interview by the surveyor on 6/3/2010.	V 408		
V 417	494.60(e)(1) FIRE SAFETY Except as provided in paragraph (e)(2) of this section, by February 9, 2009. The dialysis facility must comply with applicable provisions of the	V 417		

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V 417	Continued From page 2 2000 edition of the Life Safety Code of the National Fire Protection Association (which is incorporated by reference at §403.744(a)(1)(i) of this chapter). This Standard is not met as evidenced by: Surveyor: 00210 Based on record review and interview of administrative staff, the dialysis center failed to comply with the provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association related to quarterly fire drills. 20.7.1.2 Failure by the dialysis center staff to conduct quarterly fire drills on each shift reduces the ability of the staff to respond to an immediate emergency and places the patients at risk for possible injury in the case of a fire. On 6/3/2010 during a review of the fire drill logs the surveyor found that the facility staff did not participate in quarterly fire drills for the second quarter of 2009. This was confirmed by the administrator and the nurse manager during an interview by the surveyor on 6/3/2010.	V 417		
V 541	494.90 PATIENT PLAN OF CARE The interdisciplinary team as defined at §494.80 must develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the patient's needs, as identified by the comprehensive assessment and changes in the patient's condition, and must include measurable	V 541		

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V 541	Continued From page 3 and expected outcomes and estimated timetables to achieve these outcomes. The outcomes specified in the patient plan of care must be consistent with current evidence-based professionally-accepted clinical practice standards. This Standard is not met as evidenced by: Surveyor: 08982 Based on record review, review of facility policies and procedures, and interview, the facility failed to develop a process for development of an interdisciplinary patient plan of care that included a review of all care plan items for all patients. Failure to discuss all aspects of the patient's comprehensive assessment and to include the patient's nephrologist as part of this process limits the opportunity for team coordination and development of an effective, individualized plan of care for the patient. Findings: 1. During an interview with Staff member #1 on 6/1/2010 at 12:50 PM, the staff member stated that he/she did not attend meetings with the Inter-Disciplinary Team (IDT) to discuss individual patient's comprehensive assessment results and develop an interdisciplinary plan of care. Per review of patient care plans for Patient #s P1, P2, P6 and P7, no evidence was found that the IDT had met and/or discussed the total care plan prior to the patient signing the plan as being completed. This observation was confirmed by the administrator. Per interview with the facility administrator on 6/2/2010, the facility had changed its process of	V 541		

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V 541	Continued From page 4 care planning to that of having a interdisciplinary "Care Team Meetings" on a monthly basis. The facility's medical director, a registered nurse, the social worker, and the dietician discussed individual patients that were not meeting facility target outcomes during these meetings. Any action plans developed during this meeting, to improve patient outcomes, were only recorded in Quality Assessment Process Improvement (QAPI) meeting minutes. Any outcomes or potential changes to patient's care plans were not recorded in the patient's medical record. Review of the facility's policy and procedure entitled "Plan of Care" (last reviewed 4/9/2009), it did not identify how the IDT was to work in an interdisciplinary manner to develop the patient's plan of care.	V 541		
V 552	494.90(a)(6) DEVELOPMENT OF PATIENT PLAN OF CARE The interdisciplinary team must provide the necessary monitoring and social work interventions. These include counseling services and referrals for other social services, to assist the patient in achieving and sustaining an appropriate psychosocial status as measured by a standardized mental and physical assessment tool chosen by the social worker, at regular intervals, or more frequently on an as-needed basis. This Standard is not met as evidenced by: Surveyor: 08982 Based on review of facility documents and administrative staff interview, the facility's Inter-Disciplinary Team (IDT) failed to ensure that the tool selected by the National Quality Forum	V 552		

pac

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 552	Continued From page 5 and Centers for Medicare and Medicaid Services for adult patients (the KDQOL-36 assessment survey) was completed, any issues assessed and incorporated into the plan of care for 7 of 8 records reviewed (P1, P2, P4-P8). Failure to incorporate the information into the care planning process places patients at risk of not having any identified issues incorporated in the care plan. Findings: 1. Per record review, Patient #8 had evidence of a completed KDQOL survey dated 3/3/2010. The patient scored "below average" on the "Mental Component Summary" (MCS). The record did not contain evidence that an "assessment" of the patient regarding the score had been accomplished. The social work section of the patient's care plan had been completed on 2/25/2010 (6) days before the MCS score was received. No changes to the care plan were noted after the 2/25/2010 date. Per interview with facility Social Worker on 6/1/2010 at 1250, the staff person stated that he/she could not provide evidence that a specific assessment had been completed regarding the MCS score, after it had been received. 2. Per record review, Patient #7 had evidence of a completed KDQOL survey dated 1/7/2010. The patient scored "below average" on the MCS, Symptoms and Problems, and Effects of Kidney Disease on Daily Life sections. The record did not contain evidence that an "assessment" of the patient regarding any of the scores had been accomplished. The social work section of the patient's care plan had been completed on 12/22/2009 (16) days before the scores were	V 552		

pec

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	502511	A. BUILDING _____ B. WING _____	06/03/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 552	Continued From page 6 received. No changes to the care plan were noted after the 12/22/2009 date. 3. Per record review, Patient #5 had evidence of a completed KDQOL survey dated 2/17/2010. The patient scored "below average" on the Physical component Summary (PCS), Symptoms and Problems, and Burden of Kidney Disease sections. The record did not contain evidence that an "assessment" of the patient regarding any of the scores had been accomplished. The social work section of the patient's care plan had been completed on 2/3/2010 (14) days before the scores were received. 4. Per record review, Patient #1 had evidence of a completed KDQOL survey dated 4/7/2010. The patient scored "below average" on the PCS, Symptoms and Problems, and Effects of Kidney Disease on Daily Life sections. The record did not contain evidence that an "assessment" of the patient regarding any of the scores had been accomplished. The social work section of the patient's care plan had been completed on 4/8/2010. 5. Per record review, Patient #6 had evidence of a completed KDQOL survey dated 12/2/2009. The patient scored "below average" on Symptoms and Problems section. The record did not contain evidence that an "assessment" of the patient regarding this score had been accomplished. The social work section of the patient's care plan had been completed on 12/4/2009, but no additions to the care plan were noted regarding the KDQOL scores. 6. Per record review, Patient #4 had evidence of a completed KDQOL survey dated 12/3/2009. The patient scored "below average" on the	V 552		

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	502511	A. BUILDING _____ B. WING _____	06/03/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 552	Continued From page 7 Burden of Kidney Disease section. The record did not contain evidence that an "assessment" of the patient regarding this score had been done. The social work section of the patient's care plan had been completed on 12/1/2009 (2) days before the scores were received. 7. Per record review, Patient #2 had evidence of a completed KDQOL survey dated 3/11/2010. The patient scored "below average" on the PCS and Symptoms and Problems sections. The record did not contain evidence that an "assessment" of the patient regarding these scores had been done. The social work section of the patient's care plan had been completed on 3/10/2010 (1) day before the scores were received.	V 552		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	502511	A. BUILDING _____ B. WING _____	06/03/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELLIOTT BAY KIDNEY CENTER	600 BROADWAY SEATTLE, WA 98122

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V 000	INITIAL COMMENTS Surveyor: 00210 MEDICARE RE-CERTIFICATION SURVEY FOR END STAGE RENAL DISEASE This survey for Medicare End State Renal Disease facility re-certification was conducted June 1 through June 3, 2010 by Lee Malmberg RS and Stephen Mickschl, RN, MS. 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 the Elliott Bay Kidney Center in substantial compliance with all the Conditions except as listed below: Shell #6B2B11	V 000	An acceptable Plan of Correction (due date 6/27/2010) must include the following: · HOW the deficiency will be or was corrected, · WHO is responsible for the correction, · WHAT monitors will be put in place to assure continuing compliance · WHEN each deficiency will be corrected. Insert anticipated date of correction in far right column under "Complete Date". Correction cannot take longer than 60 days from the date of the survey (due date 8/3/2010). A Progress Report with a summary of corrective actions is due no later than 90 days after the survey was completed (due date 9/3/2010). The administrator or representative's signature and signing date are required on the first (original) page and initials in the lower right hand corner on all other pages. Please return the original survey report to: Lee Malmberg, RS Department of Health PMB #337 6947 Coal Creek Parkway SE Newcastle, WA. 98059-3159	
V 408	494.60(d) EMERGENCY PREPAREDNESS The dialysis facility must implement processes	V 408		

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

Deborah Kuhlman — Clinical Director — 6/24/2010

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.

V408 494.60(d) Emergency Preparedness

The dialysis center will implement processes to manage and monitor emergency medical kits to prevent containing outdated medical supplies.

HOW: FSS to monitor the emergency box inventory on a monthly basis

WHO: Katherine Prince, Facility Services Manager

WHAT: The FSS to create a check list of emergency box contents noting expiration dates. The FSS to review this check list monthly

WHEN: The new check list for the emergency box has been created and is in use (June 3, 2010).

V417 494.60(e)(1) Fire Safety

The dialysis center staff will conduct quarterly fire drills on each shift following NKCs/ Safety – Emergency and Disaster Preparedness policy. This practice follows the Life Safety Code of the National Fire Protection Association.

HOW: FSS will complete quarterly fire drills. Two sign in sheets will be completed each quarter one for the day staff and one for the evening staff

WHO: Emiliah Kambrami-Sithole, Quality Improvement and Regulations Manager

WHAT: Each quarter the FSS will arrange with the unit manager a fire drill for each shift of staff

WHEN: June 30,2010 the staff will participate in a mock drill. Each shift of staff will sign the attendance roster..

V 541 494.90 Patient Plan of Care

The interdisciplinary team will meet to develop an interdisciplinary plan of care.

HOW: Arrangements will be made for the entire IDT (RN, MSW, RD, attending nephrologist) to meet at the same time to discuss the patient's CA/POC. The meeting to include the patient as the patient prefers. Documentation of the meeting will be done in the EMR.

WHO: Donald Williams, RN, Manager, and Unit case-manager

WHAT: A pilot process for the plan of care review by all IDT member is starting. Each NKC MD will be given a telephone conference number, and a routine block of time for

their patient review. The IDT will call the conference number and discuss the patient with the MD. This will be done on a routine monthly basis.

WHEN: August 3, 2010 The Manager will audit CA/POC, EMR, and patient progress notes for completion of documentation

V 552 494.90 (a) (6) Development of Patient Plan of Care – Psychosocial Status.

The interdisciplinary team must provide the necessary monitoring and social work interventions. These include counseling services and referrals for other social services, to assist the patient in achieving and sustaining an appropriate psychosocial status as measured by a standardized mental and physical assessment tool chosen by the social worker, at regular intervals, or more frequently on an as-needed basis.

HOW: Using the KDQOL measurement tool, the social worker will provide counseling and referral services to patients that score "below average".

WHO: Bill Bowden, MSW Manager, Social Services Department

WHAT: The KDQOL will be administered a month before the annual Comprehensive Assessment is due to allow enough time to include in the patient's plan of care. Members of the interdisciplinary team will discuss the below average KDQOL results at the interdisciplinary team meeting and the team will develop a plan of care that reflects the proposed interventions of all members of the team.

WHEN: August 3, 2010. Social Services Manager will audit the plans of care developed by the social worker in the month of July to assure the patients with "below average" scores have updated plans of care that incorporate the appropriate social work interventions.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB 0938-0360

END STAGE RENAL DISEASE APPLICATION/NOTIFICATION AND SURVEY AND CERTIFICATION REPORT

PART I - APPLICATION - TO BE COMPLETED BY FACILITY

1. Name of Facility: Northwest Kidney Centers dba Elliott Bay K.C.
2. Provider Number: 5 0 2 5 1 7
3. Street Address: 700 Broadway
4. City: Seattle
5. County: King
6. State: Washington
7. ZIP Code: 98122
8. Telephone No.: 206-292-2515
9. Facsimile No.: 206-292-2138
10. Fiscal Year Ending Date: 6/30/2016
11. Name/Address/Telephone Number of Authorized Official
Name: Deborah Kuhlman
Address: 700 Broadway Seattle Wa 98122
Telephone No. 206-720-3951
12. Type of Application/Notification: (V1) *(check all that apply and specify in Remarks section* [see item 27])
☐ 1. Initial ☐ 2. Expansion to new location ☐ 3. Change of ownership
☐ 4. Change of location ☐ 5. Expansion in current location ☐ 6. Change of services/operations
☒ 7. Other *(specify)* Recertification
13. Ownership (V2) ☐ For Profit ☒ Not for Profit ☐ Public
14. Is this Facility Hospital-Based *(check one)* (V3) ☐ Yes ☒ No *If Yes, hospital provider number* (V4) ☐☐☐☐☐☐
15. Is this Facility SNF-Based *(check one)* (V5) ☐ Yes ☒ No *If Yes, SNF provider number* (V6) ☐☐☐☐☐☐
16. Is this facility owned and/or managed by a multi-facility organization? (V7) ☒ Yes ☐ No *If Yes, name and address of parent organization*
Name: Northwest Kidney Centers Address: 700 Broadway Seattle, Wa. 98122 (V8)
17. Services Provided: (V9) *(check all that apply and specify in Remarks section* [see item 27])
☒ 1. Hemodialysis ☐ 2. Peritoneal Dialysis ☐ 3. Transplantation ☐ 4. Home Training: __ Hemodialysis __ Peritoneal Dialysis ☐ 5. Home Support: __ Hemodialysis __ Peritoneal Dialysis
18. Is Reuse Practiced? (V10) ☐ Yes ☒ No
19. Reuse System (V11) *(check all that apply)* ☐ 1. Manual ☐ 2. Semi-Automated ☐ 3. Automated
20. Germicide (V12) *(check all that apply)* ☐ 1. Formalin ☐ 2. Heat ☐ 3. Gluteraldehyde ☐ 4. Peracetic Acid Mixture ☐ 5. Other *(specify)* _____
21. Number of Dialysis Patients
(V13) 94 Total Patients = (V14) 94 Hemodialysis + (V15) 0 Peritoneal Dialysis
22. Number of Stations *(check all that apply and include isolation stations under Total Stations)*
(V16) 18 Total Stations = (V17) 18 Hemodialysis + (V18) 0 Hemodialysis Training
23. Does the facility have isolation stations? (V19) ☐ Yes ☒ No
24. Total Number of Patients *(enter number of dialysis facility patients treated on each shift for full week prior to submission of this form)*

A. SUNDAY 5/30				B. MONDAY 5/31				C. TUESDAY 5/25				D. WEDNESDAY 5/26			
1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
13	14	15	X	18	18	15	X	14	12	13	X	17	15	16	X
E. THURSDAY 5/27				**F. FRIDAY 5/28**				**G. SATURDAY**							
1	2	3	4	1	2	3	4	1	2	3	4				
15	12	13	X	18	17	16	X	X	X	X	X				

25. Total Number of patients followed at home (V20) 6

26. Staffing					
(list full-time equivalents)	(V21) ☒ Registered Nurse	9.35	(V22) ☒ Licensed Practical Nurse	1.00
	(V23) ☒ Social Worker	.30	(V24) ☒ Dietitian	.60
	(V25) ☒ Technicians	10.00	(V26) ☒ Others	1.50

27. Remarks: *(Use this space for explanatory statements for Items 1–26)*

V26 .5 Facility System Specialist
1.0 Medical Receptionist

28. The information contained in this Application Survey and Certification Report (Part I) is true and correct to the best of my belief. I understand that incorrect or erroneous statements may cause the Request for Approval to be denied, or facility approval to be rescinded, under 42 C.F.R. 405.2100 and 405.2180, respectively.

Signature of Authorized Official	Title	Date
[signature]	Clinical Director	6-1-2010

PART II TO BE COMPLETED BY STATE AGENCY

29. ESRD Provider Number *(If the facility has a provider number)* ☐☐☐☐☐☐

30. Network Number (V27) ☐☐

31. State Region (V28)	32. State County Code (V29)

33. Type of Survey (V30) *(check all that apply)* ☐ Initial ☐ Complaint ☐ Recertification ☐ Other

34. Survey Protocol (V31) *(check all that apply)* ☐ Basic ☐ Initial ☐ Supplemental ☐ Combination

35. Surveyor Name/Number *(print)*	Professional Discipline *(print)*

36. Date of Survey

INSTRUCTIONS FOR FORM CMS-3427

PART I - DOCUMENTATION NEEDED TO PROCESS FACILITY APPLICATION/NOTIFICATION

A completed request for approval as a supplier of End Stage Renal Disease (ESRD) services in the Medicare program *(Part I - Form CMS-3427)* must include:

- A copy of the Certificate of Need approval, if such approval is required by the State, and
- A narrative statement describing the need for the service(s) to be provided.

IDENTIFYING INFORMATION (ITEMS 1–11, 13–15)

Enter the name and address *(actual physical location)* of the ESRD facility or unit where the services are performed. If the mailing address is different, show the mailing address in the Remarks block (*Item 27*). If the facility is owned or managed by an organization, indicate the name and address of the parent organization *(Item 16)*. Show the name of an authorized person who is responsible for the management of the facility (*Item 11*). Check the applicable block to indicate whether the facility is hospital or SNF based *(Box 14 or 15)* and enter the provider number of the hospital or SNF.

TYPE OF APPLICATION (ITEM 12)

Check appropriate category. If this is an in-unit expansion request, show the location of the additional stations. A "change of service/ operations" would indicate any change in items 17 or 18. *(Separate building locations require separate approvals.)*

TYPE OF SERVICE AND DIALYSIS STATIONS (ITEMS 17–23)

Check each service for which you are requesting approval *(Item 17)*. Enter the number of stations for which you are asking approval *(Item 22)*. If this is an expansion request, show the total number of stations (including those previously approved) for which you are asking approval.

REMARKS (ITEM 27)

You may use this block for explanatory statements related to items 1–26.

COPY OF CERTIFICATE OF NEED APPROVAL

If State law requires Certificate of Need approval, you must submit a copy of the approval.

Forward a copy of completed form CMS-3427 (Part I) to the State agency.

PART II - SURVEY AND CERTIFICATION REPORT - TO BE COMPLETED BY THE STATE AGENCY

Record deficiencies identified on an Initial, Recertification, Complaint or Other survey as follows: (Steps A–E are optional if you are using ASPEN or any other computer generated report.)

A. In the first column, identify the data tag number from the Interpretive Guidelines for End Stage Renal Disease Facilities.

B. In the second column, write the regulatory citation. If it is a Condition for Coverage, enter "CfC" below the regulatory citation.

C. In the third column, describe the findings and evidence under "Comments."

D. Draw horizontal lines to separate identified tag numbers.

E. If more space is needed, photocopy the "Deficiencies and Comments" page and continue the recording.

F. If available, in lieu of A–E , attach a computer-generated list.

Upon completion of the survey data, enter the CMS-3427 and forward to the Centers for Medicare & Medicaid Services regional office, if requested.