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

April 25, 2013

Administrator
NKC-Lake City Kidney Center
14524 Bothell Way NE
Forest Park, WA 98155

Dear Ms. Heron:

The Department of Health inspection team has reviewed and accepted your plan of correction for deficiencies found during your facility's Medicare Re-certification inspection of March 12-14, 2013.

A Progress Report is due on or before June 14, 2013, when all deficiencies have been corrected. **The Progress Report must address all items listed in the plan of correction, including the prefix tags or CFR reference numbers and letters, the actual correction completion dates, and the results of the monitoring process to verify the corrections are effective.**

Please call me with any questions at (360) 371-7899 and mail the Progress Report to the address listed in the header.

Sincerely,

Stephen B. Mickschl, MS, RN

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

FORM APPROVED
OMB NO. 0938-0360

END STAGE RENAL DISEASE APPLICATION AND SURVEY AND CERTIFICATION REPORT - Version 2

PART I - APPLICATION - TO BE COMPLETED BY FACILITY

1. Type of Application/Notification: (check all that apply; If "Other", specify in "Remarks" section [Item 33]): (V1)

☐ 1. Initial | ☑ 2. Recertification | ☐ 3. Relocation | ☐ 4. Expansion/change of services | ☐ 5. Change of ownership

☐ 6. Other, specify:

2. Name of Facility: Lake City Kidney Center		3. CCN: 502536
4. Street Address: 14524 Bothell Way NE		5. NPI: 1972696581
6. City: Lake Forest Park	7. County: KING	8. Fiscal Year End Date: 6-30-13
9. State: Washington	10. ZIP Code: 98155	11. Administrator's Email Address: Diane.Heron@nwkidney.org
12 Telephone No.: 206-365-0775	13. Facsimile No.: 206-365-5542	14. Medicare Enrollment (CMS 855A) completed? ☑ Yes ☐ No ☐ NA

15. Facility Administrator Name: Diane Heron
Address: 14524 Bothell Way NE
City: Lake Forest Park State: Washington Zip Code: 98155 Telephone No: 206-720-8528

16. Ownership (V2) ☐ 1. For Profit ☑ 2. Not For Profit ☐ 3. Public

17. Is this facility owned and managed by a hospital and on the hospital campus (i.e., hospital-based)? (V3) ☐ 1. Yes ☑ 2. No

Is this facility owned and managed by a hospital and located off the hospital campus (i.e., satellite)? (V4) ☐ 1. Yes ☑ 2. No

Is this facility not owned or managed by a hospital (i.e., independent)? (V5) ☐ 1. Yes ☑ 2. No

If owned and managed by a hospital, hospital name: (V6) CCN: (V7)

18. Is this facility located in a SNF/NF (check one): (V8) ☐ 1. Yes ☑ 2. No

If Yes, SNF/NF name: (V9) CCN: (V10)

19. Is facility owned and/or managed by a multi-facility organization? (V11) ☐ 1. No 2. ☑ Yes, Owned ☐ 3. Yes, Managed

If Yes, name of multi-facility organization: (V12) Northwest Kidney Centers

Multi-facility organization's address: 700 Broadway Seattle WA 98122

20. Current Services (check all that apply): (V13)

☑ 1. In-center Hemodialysis (HD) ☐ 2. In-center Peritoneal Dialysis (PD) ☐ 3. In-center Nocturnal HD ☐ 4. Reuse

☐ 5. Home HD Training & Support ☑ 6. Home PD Training & Support ☐ 7. Home Training & Support only (HD & PD)

21. New services being requested (check all that apply-home training & support only must provide both home PD & home HD): (V14)

☑ 1. N/A ☐ 2. In-center HD ☐ 3. In-center PD ☐ 4. In-center Nocturnal HD ☐ 5. Reuse

☐ 6. Home HD Training & Support ☐ 7. Home PD Training & Support ☐ 8. Home Training & Support only (HD & PD)

22. Does the facility have any home dialysis (PD/HD) patents receiving dialysis in long-term care (LTC) facilities?

(V15) ☐ 1. Yes ☑ 2. No

LTC (SNF/NF) facility name: (V16) ____ CCN: (V17) ____

Staffing for home dialysis in LTC provided by: (V18) ☐ 1. This dialysis facility ☐ 2. LTC staff ☐ 3. Other, specify

Type of home dialysis provided in this LTC facility: (V19) ☐ 1. HD ☐ 2. PD

For additional LTC facilities, record this information and attach to the "Remarks" (item 33) section.

23. Number of dialysis patients currently on census:

In-center HD: (V20) 62 In-center Nocturnal HD: (V21) 0 In-center PD: (V22) 0

Home PD: (V23) 24 Home HD <= 3x/week: (V24) 0 Home HD > 3x/week: (V25) 0

24. Number of approved in-center dialysis stations: (V26) 13 Onsite home training room(s) provided? (V27) ☑ 1. Yes ☐ 2. No

25. Additional stations being requested: (V28) ☑ None In-center HD: (V29) ____ In-center Nocturnal HD: (V30) ____

In-center PD: (V31) ____

26. How is isolation provided? (V32)

☑ 1. Room ☐ 2. Area (established facilities only) ☐ 3. CMS Waiver/Agreement (Attach copy)

27. If applicable, number of hemodialysis stations designated for isolation: (V33) 0

28. Days & time for in-center patient shifts (check all days that apply and complete time field in military time): (V34)

1st shift starts:	M ✓0545	T ✓0545	W ✓0545	Th ✓0545	F ✓0545	Sat closed	Sun ✓0545
Last shift ends:	M ✓2230	T ✓2230	W ✓2230	Th ✓2230	F ✓2230	Sat closed	Sun ✓2230

29. Dialyzer reprocessing system: (V35) ☐ 1. Onsite ☐ 2.Centralized/Offsite ☑ 3. N/A

30. Staff (List full-time equivalents):

Registered Nurse: (V36)	5.35	Certified Patient Care Technician: (V37)	6.6
LPN/LVN: (V38)	0.6	Technical Staff (water, machine): (V39)	0.5
Registered Dietitian: (V40)	0.5	Masters Social Worker: (V41)	0.6
Others: (V42)			

31. State license number (if applicable): (V43)

32. Certificate of Need required? (V44) ☑ 1. Yes ☐ 2. No ☐ 3. NA

33. Remarks (copy if more and attach additional pages if needed):

34. The information contained in this Application Survey and Certification Report (Part I) is true and correct to the best of my knowledge. 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. 494.1 and 488.604 respectively.

I have reviewed this form and it is accurate:

Signature of Administrator/Medical Director	Title	Date
[signature]	Clinical Director	3-12-13

PART II TO BE COMPLETED BY STATE AGENCY

35. Medicare Enrollment (CMS 855A approved by MAC/FI)? (V45) ☐ 1. Yes ☐ 2. No

(Note: approved CMS 855A required prior to certification)

36. Type of Survey (V46) ☐ 1. Initial ☐ 2. Recertification ☐ 3. Relocation ☐ 4. Expansion/change of services ☐ 5. Change of ownership ☐ 6. Complaint ☐ 7. Revisit ☐ 8. Other, specify

37. State Region (V47) 37. State County Code (V48)

39. Network Number (V49)

My signature below indicates that I have reviewed this form and it is complete:

40. Surveyor Team Leader (sign)	41.Name/Number (Print)	42. Professional Discipline *(Print)*	43. Survey Exit Date

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

PO Box 1870 • Blaine, Washington 98231-1870

Office of Investigation & Inspections
Clinical Care Facilities

To: ADMINISTRATOR **Date: MARCH 26, 2013**

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

PLAN OF CORRECTION

REQUIREMENTS:

1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies.
2. EACH plan of correction statement **must include** the following:
   - The regulation number and/or the tag number;
   - **HOW** the deficiency will be corrected;
   - **WHO** is responsible for making the correction;
   - **WHAT** will be done to prevent reoccurrence and how you will monitor for continued compliance; and
   - **WHEN** the correction will be completed.
3. Your PLAN OF CORRECTION must be returned within 10 **calendar** days from the date you receive the Statement of Deficiencies.

   Your PLAN OF CORRECTION should be returned approximately by **APRIL 9, 2013**.
4. **The Administrator or Representative's signature is required on the first page of the original. Each subsequent page must be INITIALED IN THE LOWER RIGHT HAND CORNER.**
5. Return the original report with the required signatures.

HELPFUL HINTS:

1. An incomplete and or incorrectly completed PLAN OF CORRECTION cannot be accepted and may be returned to the facility.
2. The regulation number immediately precedes the text of the statement of deficiency. The "Tag" number is found in the margin to the far left of the statement of deficiency. Your plan of correction cannot be processed without the reference numbers.

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

   The Required Date of Correction must be no later than: **MAY 14, 2013**.
3. Keep a copy of the Statement of Deficiencies and your Plan of Correction for your records.
4. The first page of the original report must be signed, and each subsequent page **must** be initialed to avoid being returned.

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: **JUNE 14, 2013.**
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: Stephen B. Mickschl, MS, RN P.O. Box 1870, Blaine, WA. 98231-1870
If you have any questions, please call me at (360) 371-7899.

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

March 26, 2013

Administrator
NKC-Lake City Kidney Center
14524 Bothell Way NE
Forest Park, WA 98155

Dear Ms. Heron:

This letter contains information regarding the recent survey of NKC-Lake City Kidney Center by the Washington State Department of Health. Your Medicare survey was completed on March 14, 2013.

During the survey, deficient practice was found in the areas listed on the attached Statement of Deficiencies. Enclosed are directions and due dates for completing the Plan of Correction to address those deficient practices. The Plan of Correction must be completed and returned to the address above within ten (10) calendar days of receipt of this letter.

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

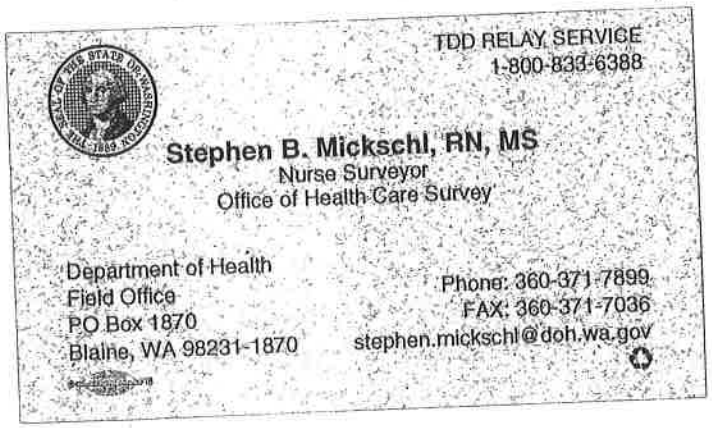
Please feel free to contact me, if there are questions regarding the survey process, deficiencies cited, or completion of the Plan of Correction, at (360) 371-7899.

Sincerely,

S. Mickschl

Stephen Mickschl, MS, RN

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



TDD RELAY SERVICE
1-800-833-6388

Stephen B. Mickschl, RN, MS
Nurse Surveyor
Office of Health Care Survey

Department of Health
Field Office
PO Box 1870
Blaine, WA 98231-1870

Phone: 360-371-7899
FAX: 360-371-7036
stephen.mickschl@doh.wa.gov

Diane Heron

From: Mary J. McHugh
Sent: Thursday, March 28, 2013 4:24 PM
To: Bill Bowden; Lara Severn; Connie Anderson; Diane Heron
Subject: KDQOL policy

8 of KDQOL policy has been updated to read.....uploaded to Policy Manager today.

> If the patient score is below average on any of the five sections of the KDQOL-36, a below average KDQOL plan of care is developed by the interdisciplinary team to address the conditions responsible for the below average score. If the patient score has declined ≥ 10 points on any of the five sections, a KDQOL plan of care is developed. All KDQOL plans of care are discussed by the interdisciplinary team during the patient's plan of care conference call. The nephrologist will take the lead responsibility for addressing below average Physical Component and Problem and Symptoms scores. The social worker will take the lead responsibility for addressing below average Mental Component, Burden and Effects scores.

Mary J. McHugh, FACHE
Vice President, Administrative Operations and External Relationships
Northwest Kidney Centers
700 Broadway
Seattle, WA 98122
Phone: (206) 720-8507
Fax: (206) 860-5821
Email: Mary.McHugh@nwkidney.org

Mary J. McHugh, FACHE
Vice President, Administrative Operations and External Relations
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700 Broadway, Seattle, WA 98122 | Tel: 206-720-8507 | Fax: 206-860-5821
Mary.McHugh@nwkidney.org

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NORTHWEST
Kidney Centers

April 4, 2013

Stephen B. Mickschl, MS, RN
P.O. Box 1870
Blaine, WA 98231-1870

Dear Mr. Mickschl,

Enclosed is the Plan of Correction for the deficiencies found at the recent Medicare survey at Lake City Kidney Center.

If you have any questions please contact me at 206-720-8528.

Thank you.

Diane Heron, RN

Diane Heron, RN
Clinical Director
Lake City Kidney Center
206-720-8528

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
	502536	A. BUILDING _____ B. WING _____	03/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NKC- LAKE CITY KIDNEY CENTER	14524 BOTHELL WAY NE FOREST PARK, WA 98155

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 000	INITIAL COMMENTS MEDICARE END-STAGE RENAL DISEASE (ESRD) SURVEY CERTIFICATION This Medicare ESRD Re-certificationl Survey was conducted at NWK-Lake City Kidney Center by Larry Anderson, RS and Stephen Mickschl, MS, RN. The State Agency recommends Medicare Re-Certification, based on the attached documentation. Shell #KMUY11	V 000		
V 113	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station. This Standard is not met as evidenced by: Surveyor #1 Based on observations and administrative staff interview, the facility failed to ensure that patient care staff wore gloves when touching patient equipment. Failure to ensure that proper infection control procedures are consistently implemented places all patients at risk of harm related to the possibility of infection transmission. Reference: Centers for Disease Control and Prevention (MMWR April 27, 2001; Vol 50, No.RR-5)	V 113		

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

Diane L Henson | Clinical Director | 4-4-13

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 113	Continued From page 1 Findings: 1. During observations of Patient #9, on 3/12/13 starting at 9:00 AM, the patient's machine alarms kept going off and facility Patient Care Technician's (PCT) were noted to return to the room repeatedly to investigate the reason. While the PCT's were engaged with other patients, the machine starting alarming again and Staff #1 was seen to enter the room and attempt to fix the problem. He/she put a glove on the right hand that covered the fingers to the palm but was not pulled all the way over the hand. Staff #1 proceeded to touch the machine to silence the alarm with the gloved hand and then placed a glove over the left hand, using the contaminated glove already on the right hand. Staff #1 then removed the gloves and re-gloved without disinfecting the hands. He/she then manipulated the dialysis tubing that was inserted into the patient's arm.	V 113		
V 115	494.30(a)(1)(i) IC-GOWNS, SHIELDS/MASKS-NO STAFF EAT/DRINK Staff members should wear gowns, face shields, eye wear, or masks to protect themselves and prevent soiling of clothing when performing procedures during which spurting or spattering of blood might occur (e.g., during initiation and termination of dialysis, cleaning of dialyzers, and centrifugation of blood). Staff members should not eat, drink, or smoke in the dialysis treatment area or in the laboratory. This Standard is not met as evidenced by: Surveyor #1 Based on observations and administrative staff interview, the facility failed to ensure that patient	V 115		

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V 115	Continued From page 2 care staff used appropriate personal protective equipment (PPE) when providing care to patients. Failure to ensure that staff follow requirements for use of PPE places patients at risk of contacting infectious diseases from staff that were not using appropriate PPE. Reference: Per review of facility policy and procedure titled "Personal Protective Equipment", IC-P6015 it states on page 1, "Staff will wear personal protective equipment (PPE) appropriate to the anticipated potential exposure. Examples: ...manipulation of access needles or catheters...". Findings: 1. During observations of Patient #9, on 3/12/13 starting at 9:00 AM, the patient's machine alarms kept going off and Patient Care Technician's (PCT) were noted to return to the room repeatedly to investigate the reason. While the PCT's were engaged with other patients, the machine starting alarming again and Staff #1 was seen to enter the room and attempt to fix the problem. He/she was seen to stand next to the patient's dialysis machine, tubing and chair to manipulate the tubing and needle insertion sites. Staff #1 was engaged with this patient off and on for about 11 minutes before successfully adjusting the dialysis needles so the machine would stop alarming. Staff #1 was noted to leave the patient's station and return on two additional times to silence the machine and manipulate the dialysis insertion lines and needles. Staff #1 eventually re-taped the insertion needles which stopped the machine from alarming. During this whole observation time period, Staff #1 never put a cover garment on over	V 115		

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V 115	Continued From page 3 his/her street clothing for protection, even when the insertion site needles were being manipulated and re-taped. No facility staff were noted to remind Staff #1 that he/she needed to have a covering garment on when accomplishing these tasks. In fact, Staff #1 was the only person, on the floor providing patient care, that did not have a covering garment over their clothing.	V 115		
V 117	494.30(a)(1)(i) IC-CLEAN/DIRTY;MED PREP AREA;NO COMMON CARTS Clean areas should be clearly designated for the preparation, handling and storage of medications and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled. Do not handle and store medications or clean supplies in the same or an adjacent area to that where used equipment or blood samples are handled. When multiple dose medication vials are used (including vials containing diluents), prepare individual patient doses in a clean (centralized) area away from dialysis stations and deliver separately to each patient. Do not carry multiple dose medication vials from station to station. Do not use common medication carts to deliver medications to patients. If trays are used to deliver medications to individual patients, they must be cleaned between patients. This Standard is not met as evidenced by: Based on observation the facility failed to store clean patient care items in a location that would prevent them from being contaminated. Failure on the part of the facility to properly store patient care items puts patients at risk of	V 117		

DH

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

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V 117	Continued From page 4 infection. Findings include: 1. On 3/12/2013, Surveyor #2 noted that several packs of patient care items (wrapped in blue barrier material) were being stored under a sink in the patient treatment area. This observation was again made on 3/13/2013, and acknowledged by staff # L1.	V 117		
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. This Standard is not met as evidenced by: Based on observations staff responsible for water quality checks (chlorine) failed to demonstrate adherence to manufacturers directions for testing.	V 260		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 260	Continued From page 5 Failure on the part of staff to follow testing directions puts patients at risk of receiving chlorine and/or chloramines via dialysate product water. Findings include: 1. On 3/12/2013, Surveyor #2 observed staff #L1 perform a chlorine test at the primary carbon tank sampling port using a test strip. The manufacture's directions call for the test strip to be held under the water stream for a period of 30 seconds before shaking off residual water and noting the test result by comparing the strip color with the color blocks on the product label. The staff person failed to time the amount of time that the strip was held under the water stream. 2. On 3/12/2013, Surveyor #2 observed staff #L1 perform a chlorine test using a HACH DPD colorimeter test kit. At the time of the test staff #L1 failed to rinse the bottle caps, did not orient the test tubes in the colorimeter per directions and mixed the tubes and the reagents used. 3. On 3/12/2013, Surveyor #2 observed staff #L2 perform a chlorine test at the primary carbon tank sampling port using a test strip. The surveyor noted that the staff person failed to compare the test strip with the color blocks on the product label. 4. On 3/12/2013, Surveyor #2 asked staff #L2 to perform a chlorine test using a HACH DPD colorimeter test kit. At that time that staff person indicated that he/she would need to follow the testing directions provided as he/she was not familiar enough with the colorimeter testing procedures.	V 260		

DH

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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V 552	Continued From page 6	V 552		
V 552	494.90(a)(6) POC-P/S COUNSELING/REFERRALS/HRQOL TOOL 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 #1 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 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 4 of 6 records reviewed for KDQOL scores (Patient #'s 10, 11, 12 and 13). Failure to assess and 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 #10 had evidence of a completed KDQOL survey dated 9/25/12. The patient scored "below average" on the "Physical	V 552		

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	502536	A. BUILDING _____ B. WING _____	03/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NKC- LAKE CITY KIDNEY CENTER	14524 BOTHELL WAY NE FOREST PARK, WA 98155

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V 552	Continued From page 7 Component Summary", Symptoms and Problems" and "Effects of Kidney Disease on Daily Life" sections. The record did not contain evidence that an "assessment", by the Inter-Disciplinary Team (IDT), regarding the below average scores had been accomplished, nor that any assessed issues were added to the care plan. An additional survey was found dated 3/29/12. This survey identified below average scores for the "Physical Component Summary". The record did not contain evidence that an "assessment", by the IDT, regarding the below average scores had been accomplished, nor that any assessed issues were added to the care plan. 2. Per record review, Patient #11 had evidence of a completed KDQOL survey dated 7/18/12. The patient scored "below average" on the "Mental Component Summary" section. The record did not contain evidence that an "assessment", by the IDT, regarding the below average scores had been accomplished, nor that any assessed issues were added to the care plan. 3. Per record review, Patient #13 had evidence of a completed KDQOL survey documented dated 6/18/12. The patient scored "below average" on the "Mental Component Summary" section. The record did not contain evidence that an "assessment", by the IDT, regarding the below average scores had been accomplished, nor that any assessed issues were added to the care plan. 4. Per record review, Patient #12 had evidence of a completed KDQOL survey documented dated 8/13/12. The patient scored "below average" on the "Mental Component Summary" and "Burden of Kidney Disease" sections. The record did not	V 552		

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V 552	Continued From page 8 contain evidence that an "assessment", by the IDT, regarding the below average scores had been accomplished, nor that any assessed issues were added to the care plan. 5. Per interview with Staff #S3 on 3/13/13, no evidence could be provided to show that a system was in place to have the IDT assess the reasons why a patient's survey score declined ten (10) points or more, for any area, from the last completed survey.	V 552		
V 628	494.110(a)(2) QAPI-MEASURE/ANALYZE/TRACK QUAL INDICATORS The dialysis facility must measure, analyze, and track quality indicators or other aspects of performance that the facility adopts or develops that reflect processes of care and facility operations. These performance components must influence or relate to the desired outcomes or be the outcomes themselves. This Standard is not met as evidenced by: Surveyor #1 Based on review of Dialysis Facility Reports (DFR), facility QAPI documents and administrative staff interview, the facility failed to have documentation that received DFR data had been reviewed, analyzed, and interventions developed to improve outcomes, where needed. Failure to review DFR data within the QAPI program places patients at risk of harm because the facility did not identify potential problem areas and put corrective action in place. Findings:	V 628		

DH

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V 628	Continued From page 9 Per review of the 2012 DFR, based on data from the Centers for Medicare & Medicaid Services (CMS), the facility was noted as having a higher rate of hospitalized patients with septicemia than the State, Network and National average for 2008. Per review of the QAPI program documents, no evidence was found that the above identified issue had been assessed by the program. Per interview with Staff #S2 on 3/13/13, no evidence of investigation, analysis or corrective action could be produced to show that the data from the DFR had been incorporated into the QAPI program.	V 628		
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 record review and interview, the dialysis facility failed to develop a process for documenting the administration of heparin prior to initiation of dialysis that included the time of administration and the caregiver who administered the medication, as found in 4 of 4 patient care records reviewed (Patients #1, #2, #3, #4) Failure to develop a process for documenting administration of heparin prior to initiation of	V 726		

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V 726	Continued From page 10 dialysis risks medication administration errors due to omission of the medication or administration of the medication by multiple caregivers. Findings: 1. Review of the computerized dialysis treatment record, on 3/12/13 at 10:38 AM, for Patient #1 revealed the following: the dialysis prescription stated that the patient should be given 2000 units of heparin intravenously prior to the initiation of treatment. A review of dialysis machine settings, accomplished by a Patient Care Technician (PCT), showed a "Hemodialysis Charting" screen indicating the amount of heparin in the heparin syringe at the beginning of treatment, the amount of heparin in the heparin syringe at the end of treatment, and the total amount of heparin infused during treatment. Another charting screen showed an area that was completed by the person starting the settings for the continuous administration of heparin during dialysis. This area also showed what the "heparin bolus (in units) was to be administered. The PCT stated that the "heparin bolus" area on the screen was automatically populated by the computer software from the physician's order. Thus, this number was not an indication of how much heparin was administered to the patient. Further record review did not provide evidence that the heparin bolus had actually been given prior to initiation of treatment, the time the heparin had been given, and the name of the caregiver who administered the heparin. 2. Similar findings were found in the records of Patients #2, #3, and #4.	V 726		

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V 726	Continued From page 11 3. During an interview with Staff # S4, the only licensed nurse on duty at this time, the nurse stated that he/she had not been documenting the "heparin bolus" any other place in the medical record. 4. It was further determined that the total amount of heparin infused during treatment was automatically entered on the patient's dialysis record by the facility's computer software program. There was no process for dialysis caregivers to actively document heparin given to patients prior to initiation of treatment.	V 726		
V 727	494.170(a) MR-PROTECT PT RECORDS FM LOSS/CONFIDENTIAL The dialysis facility must- (1)Safeguard patient records against loss, destruction, or unauthorized use; and (2) Keep confidential all information contained in the patient's record, except when release is authorized pursuant to one of the following: (i) The transfer of the patient to another facility. (ii) Certain exceptions provided for in the law. (iii) Provisions allowed under third party payment contracts. (iv) Approval by the patient. (v) Inspection by authorized agents of the Secretary, as required for the administration of the dialysis program. This Standard is not met as evidenced by: Surveyor #1 Based on observations, the facility failed to implement precautions to prevent unauthorized access to patient records. Failure to implement appropriate precautions	V 727		

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

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V 727	Continued From page 12 places patients at risk of harm related to the loss of medical record integrity, security and un-controlled accessibility to records. Findings: During general facility observations in the nurse's station area on 3/12/13, a drawer was opened and it contained file folders with people's names on the folders. Staff #2 stated that these files belonged to dialysis patients that would intermittently come in for dialysis, but were not the facility's regular patients. This drawer did not have any mechanism to prevent unauthorized access, nor did the facility have a written plan for their protection. Staff #2 stated that the facility was regularly cleaned by a contractor that came into the facility after staff had left for the day. Thus, these cleaning people would have unauthorized access to these records. Note: the facility had removed the records to a secure area prior to the completion of the survey.	V 727		

DH

NORTHWEST Kidney Centers

April 2, 2013

Plan of Correction-Lake City Kidney Center 2013 Survey

V113-494.30(a)(1) IC-Wear Gloves/Hand Hygiene

How: A Mandatory Staff In-Service to be given by the Infection Control Nurse at NKC. In-service will be given to all staff on Hand Hygiene, Sanitary Environment and general Infection Control Practices within dialysis.
Who- NKC Infection Control staff (Emiliah Sithole and/or Joyce Morimoto). Documentation of staff participation at the inservice will be completed by Unit Manager, Lara Severn-Schadee.
What: Unit Manager will perform infection control audits of staff weekly for 8 weeks and then monthly to insure proper technique and compliance.
When: This Mandatory In-Service will be completed by April 19th 2013. Audits will begin the week of April 22nd 2013 and continue weekly through June 10th 2013, and then monthly thereafter.

V115- 494.30 (a)(1)(i) IC-Gowns, Shields/Masks- No Staff EAT/DRINK

How: A Mandatory Staff In-Service to be given by the Infection Control Nurse at NKC. In-service will focus on proper PPE wear and general Infection Control Practices within dialysis.
Who-NKC Infection Control staff (Emiliah Sithole and/or Joyce Morimoto). Documentation of participation at the inservice will be completed by Unit Manager, Lara Severn-Schadee.
What: Unit Manager will perform weekly staff audits for eight weeks to ensure proper use of PPE and hand hygiene. The audits will then be done quarterly to monitor proper technique and compliance.
When: This Mandatory In-Service will be completed by April 19th 2013. Audits will begin the week of April 22nd 2013 and continue weekly through June 10th 2013, and then monthly thereafter.

V117 494.30(a)(1)(i) IC-Clean/Dirty;Med Prep Area; No Common Carts

How: All packs of patient care items have been removed from under the sink.
Who: Lara Severn-Schadee (Unit Manager) has already removed patient care packs and checked regularly to confirm they are not being stored there.
What: Weekly audit for 8 weeks to ensure compliance. And then quarterly thereafter.
When: The correction of removing the patient care packs is completed. Audits will begin the week of April 1st 2013 and continue weekly through May 20th and then quarterly thereafter.

V260 494.40(a) Personnel-Training Program/Periodic Audits

How: Facility Systems Specialist (FSS) will provide inservices to staff regarding proper procedure for use of chlorine and chloramine test strips. Staff will do a return demonstration to ensure that staff are performing the procedure correctly.

Who: FSS (Dan Harris) to complete teaching and Unit Manager (Lara Severn-Schadee) to follow up and confirm completion.

What: Demonstration to staff of the procedure for testing chlorine and chloramine with staff performing a return demonstration of procedure.

When: In-service to be completed by April 19th 2013, with yearly competencies per protocol thereafter.

V552 494.90(a)(6) POC-P/S Counseling/Referrals/HRQOL Tool

How: A care plan will be developed for patients with below average scores on the KDQOL survey. The care plan will be reviewed with the Interdisciplinary Team at the monthly QAPI meeting.
The KDQOL policy has been updated and states that a plan of care will be developed for patients whose scores have dropped > or equal to 10 points on any of the five sections of the KDQOL survey.

Who: The nephrologist is responsible for addressing the below average scores on the Physical Component and Problem and Symptom sections. The social worker will be responsible for addressing the Mental Component, Burden and Effects score.

What: Audits by the Social Services Manager will be done quarterly to assure that KDQOL survey scores below average and scores that declined > or equal to 10 points have been incorporated into the plan of care.

When: This correction will be completed by May 1, 2013.

V628 494.110(a)(2) QAPI-Measures/Analyze/Track Qual Ind.

How: Dialysis Facility Report (DFR) results with relation to higher rate of hospitalizations with septicemia will be investigated and analyzed at the QAPI meetings.

Who: Lara Severn-Schadee, IDT team

What: Ongoing results from the DFR will be reviewed monthly during the QAPI meeting.

When: Starting with the next QAPI meeting in April, 2013

V726 494.170 MR-Complete, Accurate, Accessible

How: The Heparin bolus amount administered prior to dialysis will be charted in the Intra screen in the electronic medical record (EMR). This will record it as a Medication administered, time it was given and who it was administered by.
Who: Lara Severn-Schadee will educate all clinical staff on how to document properly.
What: Staff will chart Heparin bolus in the same place and in the same manner. This data will be added to the monthly heparin audit report to ensure accurate data has been charted. The addition to the report will be ready by April 19th.
When: Staff will be educated by April 15th 2013. The Heparin audit report will be available by April 19th.

V727 494.170(a)MR-Protect PT Records FM Loss/Confidential

How: All private patient information has been removed from unsecured areas and will be locked in a designated area decided by Unit Manager (Lara Severn-Schadee).
Who: Lara Severn-Schadee (Unit Manager) and Plant Operations Department

What: Slide bolt lock to be placed on cupboard at nurses' station by April 19, 2013.

When: Slide bolt lock was installed on the cupboard on April 2, 2013.