STATE OF WASHINGTON
DEPARTMENT OF HEALTH
PO Box 47852 • Olympia, Washington 98504-7852
P.O. Box 281
Rosalia, WA 99170

June 11, 2010

Ms. Gerry Morrison, Clinical Manager
NKC Lake Washington Kidney Center
1474 112th Avenue NE
Bellevue, WA 98004

Dear Ms. Morrison,

This packet contains information regarding the recent survey of NKC Lake Washington Kidney Center by the Washington Department of Health. Your survey was completed June 24, 2010.

Enclosed are directions and due dates for completing the Plan of Correction to address the deficient practice for each report. The Plan of Correction must be completed and returned to the address below, within ten days of your receipt of this letter.

Please carefully complete each Plan of Correction. Be sure that each correction you write includes all four necessary elements as described in the instructions and on the right hand side of each report. Plans of Correction missing vital information may be returned as incomplete and unacceptable. Also enclosed is a patient record and staff identifier list. This item is for your information only, and no response is required.

Please feel free to have staff contact me if there are questions regarding the survey process, deficiencies cited, or completion of the Plan of Correction. I may be reached at (509)569-3109 or by e-mail Barbara.Skyles@DOH.WA.GOV.

Sincerely,

Barbara Skyles, REHS/RS, MA
Survey Team Leader

Enclosures: Plan of Correction Instructions
Survey Report

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

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Facilities and Services Licensing
Hospital & Ambulatory Care Survey

To: NKC Lake Washington Kidney Center

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 19, 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 24, 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 24, 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: Barbara Skyles, REHS/RS MA, P.O. Box 281, Rosalia, WA 99170
If you have any questions, please call me at (509) 569-3109.

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
	502505	A. BUILDING _____ B. WING _____	06/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE WASHINGTON KIDNEY CENTER	1474 112TH AVENUE NE BELLEVUE, WA 98004

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V 000	INITIAL COMMENTS Surveyor: 14867 MEDICARE ESRD RECERTIFICATION SURVEY This Medicare ESRD recertification survey was conducted at NKC Lake Washington Kidney Center June 22, 2010 through June 24, 20101 by Marieta Smith, RN, MN, and Barbara Skyles REHS/RS MPA. The Department of Health staff reviewed all Medicare Conditions of Participation set forth in 42 CFR 494. The department staff found NKC Lake Washington Kidney Center in substantial compliance with all the Conditions, except those standard level deficiencies listed below. This facility is recommended for Medicare recertification based on an approved Plan of Correction. Shell #6LGT11.	V 000	An acceptable Plan of Correction must include the following: HOW Explain how the deficiency will be or was corrected. WHO Identify who is responsible for the completing the correction. WHEN The date each deficiency will be corrected must be recorded in the "complete date" column on the far right of the report. Correction cannot take longer than 60 days from the date of the survey without the surveyor's approval. WHAT Explain what will be done to prevent reoccurrence, and how you will monitor for continued compliance. Please explain your monitoring goals and progress toward your goals. It is not necessary to supply copies of performance improvement documents, policies, or training records with your response. The administrator or representative's signature and date are required on the first page and initials in the lower right hand corner on the remaining pages of this report.	
V 112	494.30(a) PROCEDURES FOR INFECTION CONTROL	V 112		

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 112	Continued From page 1 The facility must demonstrate that it follows standard infection control precautions by implementing- (1)(i) The recommendations (with the exception of screening for hepatitis C), found in "Recommendations for Preventing Transmission of Infections Among Chronic Hemodialysis Patients," developed by the Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, volume 50, number RR05, April 27, 2001, pages 18 to 28. The Director of the Federal Register approves this incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. This publication is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Central Building, Baltimore, MD or at the National Archives and Records Administration (NARA). Copies may be obtained at the CMS Information Resource Center. For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_regulations/ibr_locations.html. The recommendation found under section header "HBV-Infected Patients", found on pages 27 and 28 of RR05 ("Recommendations for Preventing Transmission of Infections Among Chronic Hemodialysis Patients"), concerning isolation rooms, must be complied with by February 9, 2009. This Standard is not met as evidenced by: Surveyor: 13692 Based on observation and interview, the facility failed to ensure that patients with AV fistulas and	V 112		

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V 112	Continued From page 2 grafts washed their dialysis access sites prior to initiation of dialysis. Washing the access site with soap and water prior to the skin prep and cannulation reduces the amount of bacteria on the patient's skin, and reduces the chance for infection of the AV fistula or graft. Findings: 1. The CDC publication "Recommendations for Preventing Transmission of Infections Among Chronic Hemodialysis Patients" (MMWR, Vol, 50, #RR05, April 27, 2001) states that training and education of patients (or family members for patients unable to be responsible for their own care) regarding infection control practices should be given on admission to dialysis and at least annually thereafter and should address personal hygiene, hand washing technique, and the patient's responsibility for proper care of the access and recognition of signs of infection. 2. On 6/22/2010, Surveyor #13692 observed that the facility had a dedicated handwashing sink for patients to wash their AV fistula or graft access sites prior to initiation of dialysis. 3. During an interview on 6/23/2010 at 9:50 AM, the patient educator (Staff Member #3) stated that patients were given instructions regarding washing their access sites when admitted to the dialysis unit, or when their AV fistula or graft had been surgically created and was ready for cannulation. These instructions were entitled "Access Care for your Fistula or Graft" and "Fistula Self-Punctures" During an interview on 6/23/2010 at 9:50 AM, a	V 112		

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V 112	Continued From page 3 patient care technician (Staff Member #4) stated s/he did not ask the patient whether they had washed their access when they arrived at the dialysis unit prior to initiation of dialysis. During interviews on 6/22/2010 and 6/23/2010, 4 of 4 patients interviewed that had AV fistulas (Patients #1, #2, #3, #4) stated that they had not been instructed to wash their accesses prior to initiation of dialysis.	V 112		
V 114	494.30(a)(1)(i) CDC RR-5 AS ADOPTED BY REFERENCE A sufficient number of sinks with warm water and soap should be available to facilitate hand washing. This Standard is not met as evidenced by: Surveyor: 13692 Based on observation, the facility failed to ensure that clean supplies and medications were not subject to splash from the sink next to the medication preparation area. Subjecting clean supplies and medication to splash from the handwashing sink risked contamination of these items and transmission of communicable diseases. Findings: On 6/22/2010, Surveyor #13692 observed that one of the primary handwashing sinks for the dialysis unit was located within 6 inches of the medication preparation area. There was no barrier or other device present to prevent	V 114		

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V 114	Continued From page 4 contamination of clean supplies and medication.	V 114		
V 122	494.30(a)(4)(ii) PROCEDURES FOR INFECTION CONTROL [The facility must demonstrate that it follows standard infection control precautions by implementing- (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment. This Standard is not met as evidenced by: Surveyor: 14867 Based on review of facility policy, observation of patient care staff, interview with facility staff, and review of disinfection product directions for use (DFU), patient care staff failed to ITEM 1: clean and disinfect contaminated surfaces, medical devices and equipment between patients according to facility policy and procedures (Staff Members #1, #8, #9), and ITEM 2: follow disinfection product directions for use (DFU) (Staff Members #9, #10) . Failure to clean and disinfect contaminated surfaces, devices and equipment between patients and follow DFU for disinfection product increases the risk of infection transmission for all 91 patients on census. Findings: ITEM 1 1. The facility ' s policy and procedure entitled " Non-disposable Medical Items/Supplies Used at	V 122		

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V 122	Continued From page 5 the Dialysis Station " (Policy #IC-N6031) read as follows: " Items taken into the dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before being taken to a common clean area or used on another patient. " 2. On 6/22/2010 at 9:10 AM, Surveyor #13692 observed patient care Staff Member #1 perform an assessment of a patient at Station #15. Staff Member #1 assessed the patient ' s lungs and listened to the bruit in the patient ' s fistula using a stethoscope. The staff member then placed the stethoscope around his/her neck. The staff member did not disinfect the stethoscope after performing the assessment. 3. On 6/23/2010 at 8:15 AM, Surveyor #13692 observed patient care Staff Member #2 perform an assessment of a patient at Station #12. Staff Member #2 listened to the bruit in the patient ' s fistula using a stethoscope. The staff member then placed the stethoscope around his/her neck. The staff member did not disinfect the stethoscope after performing the assessment. 4. On 6/23/10 at 10:30 AM, Surveyor #14867 observed patient care Staff Member #8 used a stethoscope for assessing a patient at use a 70% alcohol wipe to clean/disinfect the stethoscope diaphragm and place it around his/her neck without disinfecting the entire devise. ITEM 2 1. Facility Policy "Infection Control Practices in the Clinical Units (HDP-119305, revised 10/23/09 ML) states "If blood is not present on any surface, the surface can be wiped off using NKC surface disinfection solution."	V 122		

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V 122	Continued From page 6 2. PDI Sani-Cloth Plus germicidal Disposable Cloth (EPA Reg#9480-9) DFU state "Use a wipe to remove heavy soil. Unfold a clean wipe and thoroughly wet the surface. Treated surface must remain visibly wet for a full five (5) minutes. Use additional wipe(s) if needed to assure continuous five (5) minutes wet contact time." 3. On 6/22/10 at 3:05 PM, Surveyor #14867 observed patient care Staff Member #9 use a Sani-Cloth Plus germicidal Disposable Cloth (EPA Reg#9480-9) to wipe the dialysis machine at Station #1 after patient use. The machine was not visible wet after 1 minute. Staff member #9 returned to Station #1 after assisting the patient to wipe the chair with the germicidal wipe at 3:15 PM. The chair was not visibly wet after 1 minute. Staff Member #9 stated during an interview on 6/22/10 at 3:30 PM that s/he always uses one wipe for the machine and one wipe for the chair between patient use. 4. On 6/24/10 at 7:40 AM, Staff Member #10 was observed cleaning a machine with Sani-Cloth Plus germicidal Disposable Cloth (EPA Reg#9480-9) to clean a machine. The machine was visibly wet for 2.75 - 3 minutes.	V 122		
V 407	494.60(c)(4) PATIENT CARE ENVIRONMENT Patients must be in view of staff during hemodialysis treatment to ensure patient safety (video surveillance will not meet this requirement). This Standard is not met as evidenced by: Surveyor: 13692	V 407		

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V 407	Continued From page 7 Based on observation, interview, and record review, the facility failed to ensure that the dialysis access sites of all patients were visible to facility staff at all times during treatment for 3 of 18 patients observed (Patients #5, #6, #7). Failure to ensure that a patient's dialysis access is visible at all times to hemodialysis staff members risks patient exsanguination from a leaking or disconnected dialysis access, which can result in patient death. Findings: 1. The facility's policy and procedure entitled "Visibility of Vascular Access" (Policy #CD-V1129) stated that each patient's vascular access site and bloodline connections must be seen by a staff member throughout the dialysis treatment. An interview on 6/23/2010 at 12:00 PM with the clinical director (Staff Member #6) and clinical manager (Staff Member #7) revealed that staff members were to document visualization of the patient's dialysis access every 30 minutes on the patient's electronic hemodialysis treatment record. 2. On 6/22/2010 at 8:15 AM, Surveyor #13692 observed that Patient #5, who was blind, was bipolar, and had a history of restlessness and agitation, was being dialyzed in the isolation station (Station #18). An interview with the charge nurse at 8:20 AM (Staff Member #8) revealed that Patient #5 was routinely dialyzed in the isolation station away from other patients to decrease stimulation. Review of Patient #5's hemodialysis treatment	V 407		

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V 407	Continued From page 8 records on 6/23/2010 revealed the records lacked documentation that the patient's access was visualized by staff on 5/29/2010 from 7:42 AM to 9:10 AM (1.5 hrs); on 6/3/2010 from 9:53 AM to 10:52 AM (1 hr.); on 6/8/2010 from 10:06 AM to 11:00 AM (54 minutes); on 6/10/2010 from 8:58 AM to 9:51 AM (53 minutes); on 6/12/2010 from 7:55 AM to 8:49 AM (54 minutes) and from 8:53 AM to 9:55 AM (62 minutes); and on 6/152010 from 7:57 AM to 9:46 AM (109 minutes) and from 9:46 AM to 10:42 AM (54 minutes). 3. On 6/22/2010 at 8:15 AM, Surveyor #13692 observed that the left arm access site of the patient in Station #16 (Patient #6) was located at her side below the level of the arm of the dialysis chair and partially covered with a waterproof barrier. At 8:16 AM, Staff Member #4 walked past the station but did not observe that the patient's access site was not clearly visible. On 6/23/2010 at 7:50 AM, Surveyor #13692 again observed that the left arm access site of the patient in Station #16 (Patient #6) was located at her side below the level of the arm of the dialysis chair and partially covered with a waterproof barrier. Review of Patient #6's hemodialysis treatment records on 6/23/2010 revealed that the records lacked documentation that the patient's access was visualized by staff on 5/29/2010 from 5:55 AM and 6:55 AM (1 hr) and from 6:55 AM to 7:37 AM (42 minutes); on 6/1/2010 from 5:53 AM to 5:50 AM (53 minutes) and from 8:32 AM to 9:18 AM (46 minutes) and from 9:18 AM to 10:36 AM (78 minutes); and on 6/3/2010 from 5:54 AM to 6:41 AM (46 minutes) and from 6:54 AM to 7:40 AM (46 minutes).	V 407		

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V 407	Continued From page 9 4. On 6/23/2010 at 7:45 AM, Surveyor #13692 observed that the left arm access site of the patient in Station #17 (Patient #7) was below the level of the arm of the dialysis chair and partially covered with a waterproof barrier. At that time, Staff Member #5 was working at a counter across from the dialysis station but did not observe that the patient's access site was not clearly visible. On 6/23/2010, review of Patient #7's hemodialysis treatment record for 6/22/2010 revealed that the record lacked documentation that the patient's access was visualized by staff from 7:09 AM to 8:27 AM (78 minutes), and from 8:27 AM to 9:39 AM (72 minutes). 5. An interview on 6/23/2010 at 12:00 PM with the clinical director (Staff Member #6) and clinical manager (Staff Member #7) confirmed that visibility of the patient's accesses had not been monitored according to facility policy.	V 407		
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 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.	V 541		

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V 541	Continued From page 10 This Standard is not met as evidenced by: Surveyor: 13692 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. 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. An interview with the clinical director (Staff Member #6) on 6/22/2010 at 9:00 AM revealed that interdisciplinary team (IDT) did not meet to discuss individual patients' comprehensive assessment results and develop an interdisciplinary plans of care. The nephrologist, a registered nurse, the social worker, and the dietician developed patient plans of care for their particular discipline without team input. The IDT did not meet for a care planning conference unless specifically requested by the patient. Instead of an interdisciplinary care planning conference, 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 Quality Assessment and Performance Improvement (QAPI) meetings. Action plans were developed during this meeting to improve patient outcomes and recorded in QAPI meeting minutes but were not recorded in the patient's medical record. The patient's nephrologist did	V 541		

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	502505	A. BUILDING _____ B. WING _____	06/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE WASHINGTON KIDNEY CENTER	1474 112TH AVENUE NE BELLEVUE, WA 98004

(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 541	Continued From page 11 not attend the QAPI meetings. 2. Review of the facility's policy and procedure entitled "Plan of Care" (#CD-P1111; Reviewed 4/9/2009) did not identify how the IDT was to work in an interdisciplinary manner to develop the patient's plan of care.	V 541		
V 543	494.90(a)(1) DEVELOPMENT OF PATIENT PLAN OF CARE (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status; This Standard is not met as evidenced by: Surveyor: 13692 Based on record review, interview, and review of facility staff education materials, the facility failed to ensure that dialysis staff members followed established procedures for calculating and removing fluid from patients during dialysis for 7 of 9 patients reviewed. (Patients # 5; #6, #7,) Failure to follow policies and procedures for fluid removal during dialysis risks fluid overload, which could result in hypertension and congestive heart failure, or excess fluid removal from patients, which could result in hypotension and hypovolemic shock. Findings: 1. The facility's education services learning packet entitled "An Introduction to Fluid	V 543		

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V 543	Continued From page 12 Management During Dialysis" (12/28/2005) stated that staff were to calculate how much fluid was to be removed from the patient during dialysis according to the following formula: The patient's current weight minus the patient's "dry weight" or target weight plus the amount of fluid used to rinse the tubing at the end of the procedure (400 ml) plus the amount of fluid administered or ingested by the patient during dialysis. This method for calculating fluid removal was confirmed by the facility's staff educator (Staff Member #3) during at interview on 6/24/2010 at 9:00 AM. 2. Review of the records of 9 hemodialysis patients revealed the following: a. The calculation for fluid removal from Patient #5 on 5/29/2010 did not include include the 400 ml. for rinsing the tubing at the end of the procedure. The calculation indicated that only 1100 ml of fluid should have been removed during dialysis on that date. The patient's record indicated that 2450 ml of fluid were removed. The calculation for fluid removal from Patient #5 on 6/12/2010 indicated that since he started his treatment under his target weight, no fluid should have been removed that treatment. The patient's record indicated that 1490 ml of fluid were removed. Similar findings were found for the patient's treatment on 6/5/2010, 6/8/2010, 6/10/2010, 6/12/2010, 6/15/2010, 6/17/2010, and 6/19/2010. There was no documentation in the patient's record why the procedure for calculating and removing fluid during dialysis had not been followed during those treatments.	V 543		

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V 543	Continued From page 13 b. The calculation for fluid removal from Patient #6 on 5/31/2010 did not include the 400 ml for rinsing the tubing at the end of the procedure. The calculation indicated that only 3900 ml of fluid were to be removed during dialysis on that date instead of 4300 ml. The patient's record indicated that 3700 ml of fluid were removed. Similar findings were found for the patient's treatment on 6/1/2010 and 6/2/2010 The calculation for fluid removal from Patient #6 on 6/9/2010 did not include the 400 ml for rinsing the tubing at the end of the procedure. The calculation indicated that only 2000 ml of fluid were to be removed during dialysis on that date instead of 2400 ml. The patient's record indicated that 1350 ml of fluid were removed. There was no explanation in the patient's record why the calculated amount of fluid had not been removed. c. The calculation for fluid removal from Patient #8 on 5/29/2010 indicated that a total of 2500 ml of fluid were to be removed during dialysis on that date. The patient's record indicated that 3330 ml of fluid were removed. There was no explanation in the patient's record why that amount of fluid had been removed nor a physician's order authorizing this removal. Similar findings were found for the patient's treatment on 6/5/2010, 6/12/2010, 6/15/2010, and 6/19/2010 The calculation for fluid removal from Patient #8 on 6/17/2010 indicated that 4200 ml of fluid were to be removed during dialysis on that date. The patient's record indicated that 3470 ml of fluid	V 543		

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V 543	Continued From page 14 were removed. There was no explanation in the patient's record why the calculated amount of fluid had not been removed. d. Similar findings were found for Patients #9, #10, #11, and #14. 3. An interview on 6/23/2010 at 4:00 PM with the clinical director (Staff Member #6) and clinical manager (Staff Member #7) confirmed that the records lacked documentation that fluid had been removed during dialysis according to facility policy and procedure.	V 543		
V 544	494.90(a)(1) DEVELOPMENT OF PATIENT PLAN OF CARE [The plan of care must address, but not be limited to, the following:] Achieve and sustain the prescribed dose of dialysis to meet a hemodialysis Kt/V of at least 1.2 and a peritoneal dialysis weekly Kt/V of at least 1.7 or meet an alternative equivalent professionally-accepted clinical practice standard for adequacy of dialysis. This Standard is not met as evidenced by: Surveyor: 13692 Based on record review, interview, and review of facility policies and procedures, the facility failed to ensure that staff members followed the physician's plan for care by following the dialysis prescription for anticoagulation for 8 of 9 patients reviewed (Patients #5, #6, #8, #9, #10, #11, #13,	V 544		

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V 544	Continued From page 15 #14). Failure to follow the physician's prescription for anticoagulation when performing dialysis risks inadequate dialysis treatment and patient harm. Findings: 1. The facility's policy and procedure entitled "Hemodialysis Monitoring" (#CD-H1024; Reviewed 2/24/2010) stated that patients would be monitored every half hour or more often as medically indicated. Monitoring would include assessment of the hemodialysis delivery system for anticoagulant delivery. 2. Patient #5's dialysis prescription specified that the patient's dialyzer was to be primed with 3000 units of heparin prior to initiating dialysis. The patient was to receive a bolus of 3000 units of heparin at the start of dialysis and 1000 units of heparin per hour during 2.5 hrs of his dialysis treatment (Total: 8500 units). The patient's treatment records indicated that he received a total of 8000 units of heparin on 5/29/2010, 9000 units of heparin on 6/5/2010, 9500 units of heparin on 6/8/2010, 8000 units of heparin on 6/10/2010, 9500 units of heparin on 6/12/2010, and 8000 units of heparin on 6/15/2010 and 6/19/2010. 4. Patient #6's dialysis prescription specified that the patient's dialyzer was to be primed with 3000 units of heparin prior to initiating dialysis. The patient was to receive a bolus of 1000 units of heparin at the start of dialysis and 500 units of heparin during 4 hours and 30 minutes of his dialysis treatment (Total: 6250 units). The patient's treatment records indicated that she received a total of 7000 units of heparin on	V 544		

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V 544	Continued From page 16 6/2/2010, 6/5/2010, and 6/7/2010; and 4000 units of heparin on 6/9/2010. 5. Patient #8 dialysis prescription specified that the patient's dialyzer was to be primed with 3000 units of heparin prior to initiating dialysis. The patient was to receive a bolus of 8000 units of heparin at the start of dialysis and 2500 units of heparin during 4 hours of his dialysis treatment (Total: 21,000 units). The patient's treatment records indicated that he received a total of 16,000 units of heparin on 5/29/2010; 9300 units on 6/1/2010; 18,000 units of heparin on 6/3/2010, 6/8/2010 and 6/19/2010; and 18,500 units of heparin on 6/5/2010, 6/10/2010, 6/15/2010, and 6/17/2010. 6. Similar findings were found in the records of Patients #9, #10, #11, #13, and #14 7. An interview on 6/23/2010 at 12:00 PM with the clinical director (Staff Member #6) and clinical manager (Staff Member #7)	V 544		