Printed: 08/24/2012
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
	502508	A. BUILDING ______ B. WING ______	08/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NKC - RENTON KIDNEY CENTER	**602 OAKESDALE AVE SW RENTON, WA 98057**

(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 RE-CERTIFICATION SURVEY FOR END-STAGE RENAL DISEASE This survey for Medicare End State Renal Disease facility re-certification was conducted August 20-22, 2012 by Larry Anderson, RS, and Stephen Mickschl, MS, RN. During this on-site survey, Department of Health (DOH) staff reviewed all the Medicare Conditions for Coverage set forth in 42 CFR 494, End Stage Renal Disease Facilities. The Department staff found NKC-Renton Kidney Center in substantial compliance with all the Conditions except as listed below: Shell # N5V911	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, the facility failed to ensure that clinical 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.	V 113		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jane Davis BSN RN Clinical Director		9/10/12

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.

JD

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 502508	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 08/22/2012

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V 113	Continued From page 1 Findings: 1. Observations of Staff #2 on 8/20/2012 at 10:30 AM showed the staff member touching the dialysis machine at Station #7 with un-gloved hands. Staff #2 was seen to adjust the clean dialysis tubing and the computer screen with un-gloved hands while waiting for the new patient to arrive. Thus, the clean machine was being contaminated by the staff member's un-gloved hands.	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 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. Findings: 1. Observations of patient care on 8/21/2012 at	V 115		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	502508	A. BUILDING ______ B. WING ______	08/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NKC - RENTON KIDNEY CENTER	**602 OAKESDALE AVE SW RENTON, WA 98057**

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V 115	Continued From page 2 10:15 AM at Station #7 showed a patient family member was applying pressure to the fistula puncture holes while the access was in the process of clotting off. The family member was observed to be wearing a mask, gloves and gown through the process. However, the gown only covered down to the family members knees and the family member was wearing short pants. Thus, the family member was not proerly protected from any potential blood contamination during the process. The technician working with the patient and family member was Staff #3. The staff member was observed to come to the station, at two different times, to check on the patient and never made any attempts to ensure that the family member had adequately covered his/her knees from potential blood contamination. This observation was verified by Staff #1 who talked to Staff #3 after this situation was brought to the facility's attention.	V 115		
V 558	494.90(b)(2) POC-IMPLEMENT UPDATE-15 DAYS P PT ASSESS Implementation of monthly or annual updates of the plan of care must be performed within 15 days of the completion of the additional patient assessments specified in §494.80(d). This Standard is not met as evidenced by: Surveyor #1 Based on record review, the facility failed to ensure that a patient's plan of care was implemented within 15 days of completion of the comprehensive patient assessment for 4 of 11 records reviewed for assessments (Patient #'s 1-4). Failure to complete a comprehensive assessment	V 558		

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V 558	Continued From page 3 of a dialysis patient's needs impairs the facility's ability to develop an effective plan for care. Findings: 1. Per review of Patient #3's record, the dietary assessment was completed on 1/23/2012; the nurse and physician assessments were completed on 1/24/2012; and the social work assessment was completed on 12/14/2011. The date of the IDT meeting was recorded on 1/25/2012. Thus, the meeting was at least 27 days late. 2. Per review of Patient #2's record, the nurse assessment was completed on 6/26/2012; the physician assessment was completed on 6/12/2012; the dietary assessment was completed on 6/11/2012; and the social work assessment was completed on 5/21/2012. The date of the IDT meeting was recorded on 6/28/2012. Thus, the meeting was at least 16 days late. 3. Per review of Patient #4's record, the social work assessment was completed on 5/1/2012; the physician and dietary assessments were completed on 4/12/2012; and the social work assessment was completed on 5/1/2012. The date of the IDT meeting was recorded on 5/8/2012. Thus, the meeting was at least 13 days late. 4. Per review of Patient #1's record, the nurse assessment was completed on 2/13/2012; the physician assessment completed on 2/4/2012; the social work assessment was completed on 1/26/2012; and the dietary assessment was completed on 1/24/2012. The date of the Interdisciplinary Team (IDT) meeting was	V 558		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 558	Continued From page 4 recorded on 2/14/2012. Thus, the meeting was at least 6 days late.	V 558		
V 630	494.110(a)(2)(ii) QAPI-INDICATOR-NUTRITIONAL STATUS The program must include, but not be limited to, the following: (ii) Nutritional status. This Standard is not met as evidenced by: Surveyor #1 Based on review of facility provided documentation, the facility Quality Assessment Process Improvement (QAPI) system failed to document assessments of collected information and develop action plans to improve patient serum albumin levels that remained below identified goals. Failure assess and apply corrective action action to identified issues that were not meeting established Federal goals places all patients at risk of harm related to the lack of QAPI action. Findings: Per review of facility provided documents, the QAPI identifier for nutrition that triggered a review by the QAPI process was identified as a BCG "less than 3.5". The QAPI identifier, as listed in the Measures Assessment Tool (MAT), was identified as ensuring patients maintain a level of "4.0". Thus, the QAPI review was not monitoring the nutrition progress of patients to ensure overall goal for patient serum albumin laboratory values was to maintain patients at 4.0 (BCG).	V 630		

JD.

NORTHWEST
Kidney Centers

50
years
first in the world

September 10th

Stephen B. Mickschl, MS, RN
PO Box 1870
Blaine Wa 98231-1870

From: NKC – Renton Kidney Center -502508
602 Oakesdale Ave SW
Renton Wa 98057

Plan of corrections:

V113 494.30 (a)(1)IC- Wear Gloves/Hand Hygiene
How: The staff member involved was re-educated on appropriate PPE wear (gloves) when touching supplies at a clean dialysis station including the machine, dialysis tubing, the computer screen, patient chair to prevent contamination.
Who: John Vandermay, Renton Kidney Center Manager, is responsible for making the correction.
What: The unit manager will be doing monthly infection control audit to assure compliance with infection control procedures.
When: The member was re-educated on 8/20/12 when manager was made aware of the problem. An Infection control audit of the staff was done during the week of 8/24/12 and monthly thereafter.

V115 494.30(a)(1)(i) IC –Gowns,Shields/Masks- No Staff Eat /Drink
How: Staff member and family member involved were re-educated on appropriate PPE.
Who: John Vandermay Renton Manager is the responsible party for making the correction.
What: The unit manager will do audit wk of August 27th 2012 and monthly thereafter.
When: The first audit was completed on August 28th. Family member will be wearing pants to cover legs when holding wife's puctures.

V558 494.90 (b)(2) POC- Implement update-15 days P PT Assess
How: Review with nutritionist timeline to ensure a ptatient's plan of care will be implemented within 15 days of completion of the comprehensive assessment to develop an effective plan of care.

Continuation **V558 494.90 (b) (2)POC – Implement update 15 days P Pt Assess**
Who: Katy Wilkens Nortwest Kidney Center Nutrition Manager, is the responsible party for making correction.
What: The Nutritionist Manager will re-educate the dieticians to the 15 day timeline week of 9/3/12.
When: Nutrition Manager had a staff meeting 9/6/12 reviewed the NKC Comprehensive Assessment Procedure.

V 630 494.110(a) (2)(ii) QAPI-Indicator-Nutritional Status
How: Change the Quality Indicator Value from Albumin < 3.5 to Albumine <4.0 on the QAPI review tool.
Who: The Director of Quality Infection Control, Employee Health and Diabetes has rewritten the organizational template for the monthly QAPI reviews to include a section for evaluation of patient outliers with a Albumin <4.0.
What: Monthly QAPI meetings will now include a review and evaluation of patient nutritional status for outliers with an Albumin <4.0.
When: Template changed to Albumin <4.0 8/27/12

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

FORM APPROVED
OMB NO. 0938-0360

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

PART I - APPLICATION - TO BE COMPLETED BY FACILITY

1. Name of Facility: Northwest Kidney Centers dba Renton Kidney Center
2. CCN: 502508
3. Street Address: 700 Broadway
4. NPI: 1922193564
5. City: Seattle
6. County: King
7. Fiscal Year End Date: 6/30/2013
8. State: Washington
9. ZIP Code: 98122
10. Administrator's Email Address: Jane.Davis@nwkidney.org
11. Telephone No.: 425-251-0647
12. Facsimile No.: 425-251-0713
13. Medicare Enrollment (CMS 855A) completed? [X] Yes [ ] No [ ] NA

14. Facility Administrator Name: Jane Davis
Address: 700 Broadway
City: Seattle State: Wa Zip Code: 98122 Telephone No: 425-251-0647

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

[ ] 1. Initial [X] 2. Recertification [ ] 3. Relocation
[ ] 4. Expansion [ ] 5. Change of Ownership [ ] 6. Change of services
[ ] 7. Other (specify)

16. Ownership (V2) [ ] 1. For Profit [X] 2. Not For Profit [ ] 3. Public

17. Is this Facility Hospital-Owned? (V3) [ ] 1. Yes [X] 2. No If Yes, hospital CCN (V4):
If yes, is this Facility on the main hospital-campus? (V5) [ ] 1. Yes 2. No
(V6) Hospital name:

18. Is this Facility SNF-Owned? (V7) [ ] 1. Yes [X] 2. No If Yes, SNF CCN (V8):

19. Is facility owned and/or managed by a multi-facility organization? (V9) [ ] 1. No [X] 2. Yes
[X] Owned [ ] Managed
(V10) If Yes, name of parent or managing organization: Northwest Kidney Centers
(V11) Address: 700 Broadway Seattle, Wa. 98122

20. Current Services: (check all that apply)
(V12) X 1. In-center Hemodialysis (HD) [X] 2. In-center Peritoneal Dialysis (PD)(CAPD/CCPD)
X 3. Home HD Training & Support X 4. Home PD (CAPD/CCPD) Training & Support

21. Requested Services: (check all that apply)
(V13) [X] 1. In-center HD [X] 2. In-center PD(CAPD/CCPD)
[X] 3. Home HD Training & Support [X] 4. Home PD (CAPD/CCPD) Training & Support

22. Do Facility staff provide and/or support dialysis in nursing home(s)?
(V14) [ ] 1. Yes [X] 2.No If yes, list all nursing homes under "Remarks" *(Item 33)* and answer the next question on Staffing(V15)
(V15) Staffing for dialysis provided by: [ ] 1. DME [ ] 2. Nursing home staff 3. This facility
(V16) Dialysis type: [ ] 1. HD [ ] 2. PD

23. Number of dialysis patients: (1) HD TRAINING (1) PD TRAINING
(V17) 144 In-center HD (V18) 0 In-center Nocturnal HD (V19) 0 In-center PD
(V20) 0 Home PD (V21) 0 Daily Home HD (V22) 0 Conventional Home HD

24. Number of dialysis stations including isolation stations (complete all sections that apply):
(V23) 28 Total Stations (V24) 26 In-center Hemodialysis (V25) 2 Home Training Station(s)/Room(s)

25. How is isolation provided? (V26) ☒ 1. Room ☐ 2. Area ☐ 3. Agreement (Attach copy)

26. If applicable, number of hemodialysis stations designated for isolation: (V27) 1

27. Days of Operation (check all that apply) (V28): ☒ MWF ☒ TTS

Opening Times: (V29) MWF Staff: 5:00am (V30) MWF Patients 6:00am (V31) TTS Staff 5:00am (V32) TTS Patients 6:00am

28. Is reuse practiced? (V33) ☐ 1. Yes ☒ 2. No

29. Reuse System (V34) ☐ 1. Manual ☐ 2. Semi-Automated ☐ 3. Automated ☐ 4.Centralized/Offsite

30. Staff (List full-time equivalents)
(V35) Registered Nurse 12.64
(V36) LPN/LVN 4.0
(V37) Masters Social Worker 1.6
(V38) Registered Dietitian 1.2
(V39) Patient Care Technician 11.75
(V40) Others 1.6

31. State license number (if applicable) (V41):

32. Certificate of Need required? (V42) ☒ Yes ☐ No ☐ NA

33. Remarks (attach additional pages if needed):

V35 RN total includes 2.0 FTE's for PD + .5 RN for PD.
V40 1.0 FTE for Receptionist
0.5 FTE for FSS

Nursing list:

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 and 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
Jane Davis RN	Clinical Director	8/20/12

PART II - TO BE COMPLETED BY STATE AGENCY

35. Medicare Enrollment (CMS 855A approved by MAC)? (V43) ☐ Yes ☐ No

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

36. Type of Survey (V44) ☐ 1. Initial ☒ 2. Recertification ☐ 3. Complaint ☐ 4. Other

37. State Region (V45)

38. Network Number (V46) 16

I have reviewed this form and it is complete: 39. Surveyor Team Leader Name/Number *(Print)*	Professional Discipline *(Print)*	40. Survey Exit Date
STEPHEN MECKSCHL/08982	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 North West Kidney Centers Renton Kidney Center	3. CCN 502508
4. Street Address 700 Broadway	5. NPI 1922193564
6. City Seattle / 7. County King	8. Fiscal Year End Date 6/30/2013
9. State Washington / 10. ZIP Code 98122	11. Administrator's Email Address Jane.DavisC nwKidney.org
12 Telephone No. 425-251-0647 / 13. Facsimile No. 425-251-0713	14. Medicare Enrollment (CMS 855A) completed? ☒ Yes ☐ No ☐ NA

15. Facility Administrator Name: Jane Davis
Address: 700 Broadway
City: Seattle State: WA Zip Code: 98122 Telephone No: 425-251-0

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: (1) HD Training (1) PD Training
In-center HD: (V20) 144 In-center Nocturnal HD: (V21) 0 In-center PD: (V22) 0
Home PD: (V23) 6 Home HD <= 3x/week: (V24) 0 Home HD > 3x/week: (V25) 0

24. Number of approved in-center dialysis stations: (V26) 28 Onsite home training room(s) provided? (V27) 2 ☐ 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) 1

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

	M	T	W	Th	F	Sat	Sun
1st shift starts:	0600	0600	0600	0600	0600	0600	____
Last shift ends:	2245	2245	2245	2245	2245	2245	____

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

30. Staff (List full-time equivalents):

Registered Nurse: (V36)	12.64	Certified Patient Care Technician: (V37)	11.78
LPN/LVN: (V38)	4.0	Technical Staff (water, machine): (V39)	.5
Registered Dietitian: (V40)	1.2	Masters Social Worker: (V41)	1.6
Others: (V42)	1.6		

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):

V35 RN Totals includes 2.0 FTE's for PD & .5 for PD.
V40 1.0 FTE for Receptionist.

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
Jane Davis RN	Clinical Director	8/20/12.

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