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

8/27/2010

Diane Heron
Scribner Kidney Center
2150 North 107th St. Ste. 105
Seattle, WA 98133

Dear Ms. Heron;

The Department of Health survey team has reviewed your progress report dated 8/26/2010, for deficiencies noted during the survey completed on 6/15/2010. The progress report has been accepted.

Please be advised that you will not be receiving documentation from this office regarding your certification status. Your certification status remains in effect unless you are notified in writing of a change in status.

Should you have any questions please feel free to contact me at (360) 371-7899.

Your cooperation in this matter has been and is appreciated.

Sincerely,

S. Mickschl

Stephen Mickschl, RN, MS
Department of Health
Facilities & Services Licensing

NORTHWEST
KIDNEY CENTERS

Scribner Kidney Center

August 26, 2010

Stephen B. Mickschl, RN, MS
Department of Health
PO Box 1870
Blaine WA 98231-1870

Dear Mr. Mickschl,

Enclosed is the progress report from the Medicare Re-Certification inspection of June 14-15, 2010 at Scribner Kidney Center.

Please contact me with any questions you may have about the progress report.

I can be reached at 206-720-8528.

Please note that I will be away from the office September 4-19.

Sincerely,

Diane Heron, RN
Clinical Director
Scribner Kidney Center

Since 1962,
a nonprofit,
community-based
health care provider

14 dialysis facilities
located in:

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Bellevue
First Hill
Kent
Lake City
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Port Angeles
Renton
SeaTac
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Dialysis services
also provided in:

200 Homes
11 Hospitals

2150 N 107th

Suite #160

Seattle, WA 98133

Ph: 206.363.5090

Fx: 206.363.6146

www.nwkidney.org

Progress Report for Scribner Kidney Center

V 122 494.30(a)(4)(ii) Procedure for Infection Control

The facility must demonstrate that it follows standard infection control practices.

The manager is conducting weekly audits by observing that staff are demonstrating the correct procedure for setting up a machine while a patient in the chair is awaiting their fistula/graft to clot. Results of the audits show that initially the staff needed a reminder on how far they need to turn the machine away from the patient in the chair. For the last month the audits show that staff are correctly setting up the machine away from the patient in the chair.

This was corrected by July 31, 2010.

V 236 494.40(a)ANSI/AAMI RD 52:2004 As Adopted by Reference

5.4.5 Additives: Labeling spiked jugs/labeling if for specific patient.

Weekly audits are being done to ensure that acid jugs that contain additives are labeled with the patients name, the final concentration of the added electrolytes , the date the prescribed electrolyte was added and the person who mixed the additive. In addition a permanent record is being kept with the above mentioned information. Weekly audits are done to ensure that the permanent record is being kept. Weekly monitoring shows that the acid jugs are being labeled correctly and that permanent records with this information are being maintained.

V 407 494.60(c)(4) Patient Care Environment

Patients must be in view of staff during hemodialysis to ensure patients safety.

Staff have instructed patients that their accesses must be visible at all times. Staff have been educated to notify the manager if a patient refuses to uncover their access. To date there have been no incidents of uncovered accesses reported to the manager.

The correction was completed July 6, 2010.

V 503 494.80(a)(2) Assessment Criteria

The patients comprehensive assessment must include but is not limited to the evaluation of the appropriateness of the dialysis prescription.

Patient rounds are conducted within thirty minutes after treatment has begun to ensure that the dialysis prescription is being followed per physician orders. Staff have been educated at weekly staff meetings that the physician orders must be followed as written. A trending tool was developed and used each week to document any errors in physicians orders. Findings show that no dialysis prescription errors have occurred to this point.

The correction was completed July 15, 2010.

V 541 494.90 Patient Plan of Care

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

In July 2010 a pilot program with four nephrologists began where the interdisciplinary team (IDT) members (patients nephrologist, nurse, social worker and dietitian) met via conference call to discuss the patients plan of care. The patient was invited to attend the IDT meeting. Following the conference call a progress note was written in the electronic medical record (EMR) noting the date and time of the meeting and issues discussed.
In August 2010 twelve more nephrologists were added to the above list and those IDT members met to discuss the patients plan of care. Documentation of the meeting was made into the EMR.
By September 2010 all Northwest Kidney Centers nephrologists will have participated in the monthly IDT meetings and will continue to attend monthly IDT meetings to discuss patients plan of care.

The manager is doing monthly audits of the comprehensive assessments, plans of care and progress notes to ensure that all patients plans of care have been entered into the EMR. Results of the audits show that all patients reviewed in July and August have had IDT meetings and completions of plans of care and that those have been entered into the EMR.

The pilot process was completed by July 30, 2010.

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

The interdisciplinary team must provide the necessary monitoring and social work interventions. These include counseling services and referrals for other social services to assist the patients 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.

The Social Services manager is doing monthly audits of the KDQOL surveys to ensure that any below average results are discussed at the IDT meeting with a plan of care written that reflects the proposed interventions of all members of the team.
Nineteen KDQOL surveys have been completed by patients at Scribner Kidney Center over the last two months. Results show that no below average scores have occurred to this point.

This correction was completed August 10, 2010.

V 638 494.110(b) Monitoring Program Improvement

The dialysis facility must continuously monitor its performance and take action that results in performance improvements and track performance to ensure that improvements are sustained over time.

Monthly audits are being done to ensure that actions plans have been developed for quality identifiers not meeting goals.
Results of the audits show that quality identifiers not meeting goals are being addressed at the quality meetings with action plans developed by the quality team members. The results of the audits are being included in the minutes of the quality assessment meetings

This correction was completed August 15, 2010.

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

July 7, 2010

Diane Heron
Scribner Kidney Center
2150 North 107th St. Ste. 105
Seattle, WA 98133

Dear Ms. Heron;

The Department of Health inspection team has reviewed and accepted your addended plan of correction for deficiencies found during your facility's Medicare Re-Certification inspection of June 14-15, 2010.

A Progress Report is due on or before September 16, 2010, 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,

S. Mickschl

Stephen B. Mickschl, RN, MS

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

June 23, 2010

Diane Heron
Scribner Kidney Center
2150 North 107th St. Ste. 105
Seattle, WA 98133

Dear Ms. Heron;

This letter contains information regarding the recent survey of Scribner Kidney Center by the Washington State Department of Health. Your Medicare Re-Certification survey was completed on June 15, 2010.

During the survey, deficient practice was found in the areas listed on the attached Statement(s) 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 business 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 that is missing vital information, as incomplete and unacceptable.

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 (360) 371-7899.

Sincerely,

Stephen Mickschl, MS, RN

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

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

Office of Investigation & Inspections
Clinical Care Facilities

To: DIANE HERON **Date: JUNE 23, 2010**

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

PLAN OF CORRECTION

REQUIREMENTS:

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

   Your PLAN OF CORRECTION should be returned approximately by **JULY 7, 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 16, 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 25, 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: 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.

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

Printed: 06/23/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	502507	A. BUILDING _____ B. WING _____	06/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 000	INITIAL COMMENTS Surveyor: 08982 MEDICARE RECERTIFICATION SURVEY FOR END-STAGE RENAL DISEASE This survey for Medicare End State Renal Disease facility recertification was conducted June 14-15, 2010 by Stephen Mickschl, MS, RN and Lee Malmberg, RS. During this on-site survey, Department of Health (DOH) staff reviewed all the Medicare Conditions for Coverage set forth in 42 CFR 494, End Stage Renal Disease Facilities. The Department staff found Scribner Kidney Center in substantial compliance with all the Conditions except as listed below: Shell # 8FR711	V 000		
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: 08982 Based on observations, the facility failed to ensure that staff had procedures to prevent contamination of cleaned and disinfected machines and supplies during the change-over time between patients using the same machine	V 122		

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 122	Continued From page 1 and chair. Failure to ensure that machines and supplies remain free of possible contamination between patients places all patients at risk of harm related to potentially acquiring an infection from another patient. Findings: During observational rounds on 6/14/2010, staff were observed to remove dirty tubing from machines, clean, disinfect the machine and then put new tubing on the machine intended for the next patient. The practice occurred while the previous patient was still sitting at the station awaiting fistula/graft punctures to clot. When staff removed the pressure clamps and dressings to finally secure the puncture sites, this was also done while the patient was sitting in close proximity to the cleaned and disinfected machine and supplies.	V 122		
V 236	494.40(a) ANSI/AAMI RD52:2004 AS ADOPTED BY REFERENCE 5.4.5 Additives: labeling spiked jugs/labeling if for specific pt (5.4.4.1 Concentrate jugs): If a chemical spike is added to an individual container to increase the concentration of an electrolyte, the label should show the added electrolyte, the date and time added, and the name of the person making the addition. Containers should be labeled to indicate the final concentration of the added electrolyte .... This information should also be recorded in a permanent record. Labels should be affixed to the containers when the mixing process begins.	V 236		

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V 236	Continued From page 2 6.4.2 Additives When additives are prescribed for a specific patient, the container holding the prescribed acid concentrate should be labeled with the name of the patient, the final concentration of the added electrolyte, the date on which the prescribed concentrate was made, and the name of the person who mixed the additive. This Standard is not met as evidenced by: Surveyor: 00210 Item #1 Based on observation and review of facility records ans policy and procedures, the dialysis center failed to label the spiked acid jug with the patient's name when chemical additives were prescribed for a specific patient. Failure to include the patient name on spiked acid jugs increases the risk for a patient to receive chemical additives not prescribed for a specific patient. Findings: On 6/14/2010 at 9:00 am the surveyor observed a patient receiving hemodialysis at patient station #18 and the patient's name was not written on the spiked (2 K, 3.5 Ca) acid jug that was prescribed for the specific patient. Also, the facility's written policy for "Mixing Concentrates"and dated 12/16/09 did not have instructions in the policy to include placing the patient's name on the label. Item #2 Based on observation, review of facility records	V 236		

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V 236	Continued From page 3 and interview of administrative staff, the dialysis center failed to ensure that the information on the label affixed to the spiked acid container was also recorded in a permanent record. Failure to record information from the label on the spiked acid jug into a permanent record log places the patient at risk for possible injury by not allowing for monitoring during the mixing of the concentrates. Findings: On 6/14/2010 the surveyor observed that a log was not available to record the information from the spiked acid jug label into a permanent record. These findings were confirmed by Staff #3 during an interview by the surveyor on 6/14/2010.	V 236		
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: 08982 Based on observations and clinical staff interviews, the facility failed to ensure that staff maintained view of patient access areas. Failure to maintain view of patient dialysis access areas places them at risk of harm should a needle dislodge and the patient bleed while not being seen by staff to immediately intervene.	V 407		

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V 407	Continued From page 4 Findings: 1. During observational rounds on 6/14/2010, the following patients had their access sites covered so they could not be seen without removing the cover: Station 21 at 8:48 AM. 2. During observational rounds on 6/15/2010, the following patients had their access sites covered so they could not be seen without removing the cover: Station #4 and #6 at 9:55 AM. The observations were verified by patient care staff present at the time.	V 407		
V 503	494.80(a)(2) ASSESSMENT CRITIERIA [The patient's comprehensive assessment must include, but is not limited to, the following:] (2) Evaluation of the appropriateness of the dialysis prescription, This Standard is not met as evidenced by: Surveyor: 08982 Based on medical record review and staff interview, the facility failed to ensure that physician orders were followed or obtained when staff did not have the blood flow rate (BFR) set as ordered by the physician for 1 of 3 records reviewed for blood flow rates (P1). Failure to set the appropriate BFR places patients at risk of not moving enough blood through the dialyzer to clean toxins from the blood. Findings:	V 503		

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V 503	Continued From page 5 1. Per record review, Patient #1 dialyzed on 6/14/2010. The record showed the BFR was set at 350. Per review of the physician orders, the patient's BFR was to be "300". There was no evidence that the physician had changed the order. This was verified by Staff #1 who provided electronic chart access.	V 503		
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. This Standard is not met as evidenced by: Surveyor: 08982 Based on record review, review of facility policies and procedures, and staff interviews, 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:	V 541		

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V 541	Continued From page 6 1. An interview with Staff #3, on 6/14/2010 at 10:15 AM, revealed that the Inter-Disciplinary Team (IDT) did not meet to discuss individual patient's 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. During interviews with Staff #1 and Staff #2,on 6/14/2010 at 11:55 AM and 12:05 PM respectively, both Staff #1 and Staff #2 stated that the care planning process did not contain a "group meeting" of the IDT, but rather a series of mini-conferences held monthly. The information was then placed in progress notes, not the patient's care plan. Instead of an IDT 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 not always attend the QAPI meetings. 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 552	494.90(a)(6) DEVELOPMENT OF PATIENT PLAN OF CARE	V 552		

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V 552	Continued From page 7 The interdisciplinary team must provide the necessary monitoring and social work interventions. These include counseling services and referrals for other social services, to assist the patient in achieving and sustaining an appropriate psychosocial status as measured by a standardized mental and physical assessment tool chosen by the social worker, at regular intervals, or more frequently on an as-needed basis. This Standard is not met as evidenced by: Surveyor: 08982 Based on review of facility documents and administrative staff interview, the facility's Inter-Disciplinary Team (IDT) failed to ensure that the tool selected by the National Quality Forum 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 5 of 8 records reviewed for KDQOL scores(P3-P7). Failure to incorporate the information into the care planning process places patients at risk of not having any identified issues incorporated in the care plan. Findings: 1. Per record review, Patient #3 had evidence of a completed KDQOL survey dated 3/26/2010. The patient scored "below average" on the "Physical Component Summary" (PCS) and "Symptoms and Problems". The record did not contain evidence that an "assessment" of the patient regarding these scores had been	V 552		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCRIBNER KIDNEY CENTER	2150 NORTH 107TH SEATTLE, WA 98133

(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 552	Continued From page 8 accomplished by the IDT, nor that any assessed issues were added to the care plan. 2. Per record review, Patient #4 had evidence of a completed KDQOL survey dated 10/20/2009. The patient scored "below average" on the "Symptoms and Problems", "Mental Component Summary "(MCS), and "Burden of Kidney Disease" sections. The record did not contain evidence that an "assessment" of the patient regarding these scores had been accomplished by the IDT, nor that any assessed issues were added to the care plan. 3. Per record review, Patient #5 had evidence of a completed KDQOL survey dated 11/30/2009. The patient scored "below average" on the PCS and "Effects of Kidney Disease" sections. The record did not contain evidence that an "assessment" of the patient regarding these scores had been accomplished by the IDT, nor that any assessed issues were added to the care plan. 4. Per record review, Patient #6 had evidence of a completed KDQOL survey dated 1/6/2010. The patient scored "below average" on the "Burden of Kidney Disease" and "Effects of Kidney Disease" sections. The record did not contain evidence that an "assessment" of the patient regarding these scores had been accomplished by the IDT, nor that any assessed issues were added to the care plan. 5. Per record review, Patient #7 had evidence of a completed KDQOL survey dated 5/11/2010. The patient scored "below average" on the MCS, "Burden of Kidney Disease" and "Effects of Kidney Disease" sections. The record did not contain evidence that an "assessment" of the	V 552		

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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
	502507	A. BUILDING _____ B. WING _____	06/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCRIBNER KIDNEY CENTER	2150 NORTH 107TH SEATTLE, WA 98133

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V 552	Continued From page 9 patient regarding these scores had been accomplished by the IDT, nor that any assessed issues were added to the care plan. The above observations were confirmed by Staff #2 on 6/14/2010 at 12:05 PM.	V 552		
V 638	494.110(b) MONITORING PROGRAM IMPROVEMENT The dialysis facility must continuously monitor its performance, take actions that result in performance improvements, and track performance to ensure that improvements are sustained over time. This Standard is not met as evidenced by: Surveyor: 08982 Based on review of quality assessment documents and administrative staff inteview, the facility failed to ensure that quality identifiers that consistently did not meet goals would be assessed and actions plans written. Failure to assess and create action plans for issues that do not meet goals places patients at risk of not having identified problem areas corrected in an appropriate time interval. Findings: 1. Per review of facility provided quality assessment documents, monthly goals for anemia (below goal for past 3 months; and PTH-I (below goal for past 3 months) were identified as not meeting the established goals. Per interview with Staff #3 on 6/15/2010, the committee is supposed to assess and create an action plan for issues not meeting their goals. Per review of quality minutes, no evidence was found that an action plan had been developed for those issues	V 638		

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V 638	Continued From page 10 consistently below their established goal.	V 638		

Plan of Correction for Scribner Kidney Center

V 122 494.30(a)(4)(ii) Procedure for Infection Control

The facility must demonstrate that it follows standard infection control practices.

HOW: During the changeover time between patients the staff have been educated to turn the front of the machine away from the patient sitting in the chair prior to disinfecting the machine and placing new tubing on for the next patient. The back of the machine will be facing the patients awaiting the fistula/graft punctures to clot.

WHO: The manager is responsible for making the correction.

WHAT: The manager will do weekly audits by observing that staff are demonstrating the correct procedure for setting up a machine while a patient is sitting the chair awaiting the fistula/graft to clot during the changeover period.

WHEN: The correction was completed June 18, 2010.

V 236 494.40(a)ANSI/AAMI RD52:2004 As Adopted by Reference

5.4.5 **Additives** : labeling spiked jugs/labeling if for specific patient.

HOW: Acid jugs that contain additives will be labeled with the patients name, the final concentration of the added electrolytes, the date the prescribed concentrate was added and the person who mixed the additive. A permanent record is being kept with the information of the label affixed to the spiked acid container.

WHO: The Facility System Specialist (FSS) has made the correction.

WHAT: The manager will be notified of all patients needing additives and communicate that to the FSS. The manager will monitor on a weekly basis that the spiked acid jugs are labeled correctly and that a permanent record is being kept with this information.

WHEN: The correction was completed June 16, 2010.

V 407 494.60 (c)(4) Patient Care Environment

Patients must be in view of staff during hemodialysis treatment to ensure patients safety.

HOW: Patients will be educated that their accesses must remain visible at all times . Patients will be monitored every thirty minutes or more often as needed to ensure accesses are visible.

WHO: The manager is responsible for this correction.

WHAT: Staff will notify the manager if the patient refuses to keep the access visible. Per Northwest Kidney Center policy –any patients that do not comply with keeping their access visible will have their dialysis treatment discontinued after two warnings by staff to uncover their access.

WHEN: This correction was completed on June 16, 2010.

V 503 494.80(a)(2) Assessment Criteria

The patient's comprehensive assessment must include but is not limited to the evaluation of the appropriateness of the dialysis prescription.

HOW: Staff will be educated to follow physicians orders as written.

WHO: The manager.

WHAT: The charge nurse will notify the manager of errors related to the dialysis prescription during the patients rounds. Any errors will be documented with a quality improvement report. The manager will counsel those staff involved in the dialysis prescription errors.

WHEN: The correction will be completed by July 15, 2010.

V 541 494.90 Patient Plan of Care

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

HOW: Arrangements will be made for the entire interdisciplinary team (RN, MSW, RD and attending nephrologist) to meet at the same time to discuss the patients Comprehensive assessment/plan of care.(CA/POC) The meeting is to include the patient as the patient prefers. Documentation of the meeting will be done in the electronic medical record.(EMR).

WHO: The manager and case manager.

WHAT: A pilot process for the plan of care review by all IDT members is starting. Each Northwest Kidney Center physician will be given a telephone conference number and routine block of time for their patients review. The IDT will call the conference number and discuss the patients with the physician. This will be done on a routine monthly basis.
The manager will audit the CA/POC , EMR and patient progress notes for completion of documentation.

WHEN: This correction will be completed by August 10, 2010.

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

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

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

WHO: Bill Bowden MSW, Manager Social Services Department.

WHAT: The KDQOL will be administered a month before the annual Comprehensive Assessment is due to allow enough time to include in the patients plan of care. Members of the interdisciplinary team will discuss the below average KDQOL results at the IDT meeting and the team will develop a plan of care that reflects the proposed interventions of all the members of the team.
Social Services Manager will audit the plans of care developed by the social worker in the month of July to assure the patients with "below average" scores have updated plans of care that incorporate social work interventions.

WHEN: The correction will be completed by August 10, 2010.

V 638 494.110(b) Monitoring Program Improvement

The dialysis facility must continuously monitor its performance and take action that results in performance improvements and track performance to ensure that improvements are sustained over time.

HOW: Action plans will be developed for quality identifiers that do not consistently meet goals.

WHO: The manager.

WHAT: Monthly audits will be done by the Clinical Director to ensure that action plans have been developed for quality identifiers not meeting goals.

WHEN: The correction will be completed by August 1, 2010.

SKC

Changes to the Plan of Correction for Scribner Kidney Center—July 6, 2010

V 407 494.60(c)(4) Patient Care Environment

Patients must be in view of staff during hemodialysis to ensure patients safety.

HOW: Patients must have their access visible at all times. Staff will instruct patients as to the reasons why the access must be visible at all times.

WHO: The manager will responsible for this correction.

WHAT: Per Northwest Kidney Centers policy—any patient that does not comply with keeping their access visible at all times during a treatment will have their dialysis treatment discontinued after two warnings by staff to uncover their access. The nephrologist will be notified of the discontinued treatment, a progress note documenting the warnings and non compliance entered in the EMR and a quality improvement (QIR) reported completed. The QIRs will be reviewed at the units QAPI meeting. Individual patient trends will be monitored and a behavioral care plan initiated after three warnings in a month.

WHEN: The correction was completed on July 6, 2010.

V 503 494.80(a)(2) Assessment Criteria

The patients comprehensive assessment must include but is not limited to the evaluation of the appropriateness of the dialysis prescription.

HOW: Staff will be educated to follow physicians orders as written.

WHO: The manager.

WHAT: Patient rounds are conducted within thirty minutes after treatment has begun to assure that the correct dialysis prescription is in effect. Any errors will be communicated to the manager and documented in a quality improvement report. The manager will develop a trending tool to monitor dialysis prescription errors and counsel staff involved. These findings will be reported at the monthly quality meetings.

WHEN: The correction will be completed by July 15, 2010.

V 541 494.90 Patient Plan of Care

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

HOW: Arrangements will be made for the entire team (RN, MSW, RD and attending nephrologist) to meet at the same time to discuss the patients comprehensive assessment/plan of care. (CA/POC). The meeting is to include the patient as the patient prefers. Documentation of the meeting will be done in the electronic medical record(EMR).

WHO: The manager and case manager.

WHAT: A pilot process for the plan of care review by all the IDT members is starting. Each Northwest Kidney Center physician will be given a telephone conference number and routine block of time to review their patients CA/POC due that month. This will be done on a routine monthly basis.
The case manager will document in the EMR of each patient that the IDT met and discussed the CA/POC via conference call. On a monthly basis the manager will audit the CA/POC, EMR and patient progress notes for completion of documentation.

WHEN: This correction will be completed by August 10, 2010.

V 638 494.110(b) Monitoring Program Improvement

The dialysis facility must continuously monitor its performance and take action that results in performance improvements and track performance to ensure that improvements are sustained over time.

HOW: Actions plans will be developed for quality identifiers that do not consistently meet goals.

WHO: The manager.

WHAT: Monthly audits will be done by the Clinical Director to ensure that action plans have been developed for quality identifiers not meeting goals. The results of the audits will be included in the minutes of the quality assessment meetings.

WHEN: This correction will be completed by August 1, 2010.