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

April 1, 2013

Tosha Teske, Clinical Director
Snoqualmie Ridge Kidney Center
35131 SE Douglas Street, Suite 113
Snoqualmie, Washington 98065

Dear Ms. Teske:

Surveyors from the Washington State Department of Health conducted a CMS ESRD recertification survey at Snoqualmie Ridge Kidney Center on March 5 - 6, 2013. Snoqualmie Ridge Kidney Center developed a plan of correction to correct deficiencies cited during this survey. This plan of correction was approved on April 1, 2013..

The Department of Health accepts Snoqualmie Ridge Kidney Center's attestation to be in compliance with the regulations at 42 CFR 494, End Stage Renal Dialysis Facilities. The survey team sincerely appreciates your cooperation and hard work during the survey process and looks forward to working with you again in the future.

Sincerely,

Marieta L. Smith, RN, MN
Survey Team Leader

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
	502540	A. BUILDING _____ B. WING _____	03/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NKC - SNOQUALMIE RIDGE KIDNEY CT	35131 SE DOUGLAS STREET SNOQUALMIE, WA 98065

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V 000	INITIAL COMMENTS CMS END STAGE RENAL DISEASE FACILITY RECERTIFICATION SURVEY This Medicare ESRD recertification survey was conducted March 5, 2013 through March 6, 2013 Marieta Smith RN, MN; and Paul Throne, MSW/MPH, PHA. Lisa Sassi, RN, MN participated in the survey as an orientee. The Department of Health staff reviewed all Medicare Conditions of Participation set forth in 42 CFR 494. The department staff found NKC Snoqualmie Ridge Kidney Center in substantial compliance with all the Conditions, except those standard level deficiencies listed below. Shell #L73811	V 000	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. 5. Return the original report with the required signatures.	
V 111	494.30 IC-SANITARY ENVIRONMENT The dialysis facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents within and between the unit and any adjacent hospital or other public areas. This Standard is not met as evidenced by: Based on observation, the dialysis facility failed to ensure that all critical surfaces were maintained in a cleanable condition. Failure to maintain cleanable surfaces risks contamination of patient care equipment through	V 111		

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 111	Continued From page 1 ineffectual cleaning. Findings include: During a tour of the dialysis facility on 03/05/2013, it was observed that 8 of 10 dialysis machines inspected had torn and rough remnants of paper labels attached to the sides of the upper (control) area of the dialysis machines. These labels were used to document machine maintenance. The paper labels were not cleanable.	V 111		
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: Based on observation and review of facility policies and procedures, the dialysis facility failed to ensure that hand hygiene was performed according to facility policy and CDC guidelines when caring for patients during dialysis procedures, as demonstrated by 1 staff member observed (RN #1) Failure to utilize proper infection control precaution during dialysis risks transmission of communicable diseases between patients and staff. Reference: Centers for Disease Control and Prevention (MMWR April 27, 2001; Vol 50, No. RR-5)	V 113		

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V 113	Continued From page 2 Findings: 1. The facility's policy and procedure entitled "Infection Control Practices in the Clinical Units - Principles and Applications" (Revised 7/11/2012) stated in part that hand hygiene was to be performed after removing gloves and after touching a computer keyboard. 2. On 3/5/2013 at 8:50 AM, Surveyor #1 observed RN #1 touch a computer keyboard, then did not perform hand hygiene prior to putting on clean gloves. At 9:08 AM, Surveyor #1 observed RN #1 remove his/her contaminated gloves, then did not perform hand hygiene prior to putting on clean gloves.	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: Based on observation, interview, and review of facility policies and procedures, the dialysis facility failed to ensure that patient care providers utilized personal protective equipment during medication administration according facility policy and CDC guidelines, as demonstrated by 1 staff member observed (RN #2).	V 115		

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V 115	Continued From page 3 Failure to utilize proper infection control precaution during dialysis risks transmission of communicable diseases between patients and staff Reference: Centers for Disease Control and Prevention (MMWR April 27, 2001; Vol 50, No. RR-5) Findings: 1. The facility's policy and procedure entitled "Personal Protective Equipment [PPE]" (Effective 9/26/2012) stated in part that patient care providers would wear PPE for face and eye protection, such as a face shield or a mask with goggles with side shields, when splashes, sprays, splatter, or any droplets of blood or other potentially infectious materials posed a hazard to the eyes, nose, or mouth. This included administration of medications through the extracorporeal dialysis circuit or by subcutaneous injection. 2. On 3/5/2013 at 12:30 PM, Surveyor #1 observed RN #2 administer medications to Patient #7 at Station #3. RN #1 injected medication into the patient's extracorporeal dialysis circuit, then administered medication subcutaneously into the patient's arm. RN #1 did not wear a face shield, mask, or goggles when administering the medications. 3. During an interview at the time of the observation, RN #2 stated s/he did not wear a face shield, mask, or goggles when administering medications to patients ..	V 115		
V 116	494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT	V 116		

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V 116	Continued From page 4 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. -- Nondisposable items that cannot be cleaned and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) should be dedicated for use only on a single patient. -- Unused medications (including multiple dose vials containing diluents) or supplies (syringes, alcohol swabs, etc.) taken to the patient's station should be used only for that patient and should not be returned to a common clean area or used on other patients. This Standard is not met as evidenced by: Based on observation and review of facility policies and procedures, the dialysis facility failed to ensure that items used for patient care were transported to a disinfection area in a manner that did not risk cross-contamination. Failure to utilize proper infection control precaution during dialysis risks transmission of communicable diseases between patients and staff. Findings: 1. The facility's policy and procedure entitled "Infection Control Practices in the Clinical Units - Principles and Applications" (Revised 7/11/2012) stated in part that any item taken to the patient's dialysis station would be considered contaminated and would be either disposed of, dedicated for use on a single patient, or cleaned and disinfected before being returned to a	V 116		

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V 116	Continued From page 5 common area or used for other patients. Staff members were not to keep dialysis supplies in the pockets of their personal protective equipment (PPE) gowns. 2. On 3/5/2013 at 9:05 AM, Surveyor #1 observed RN #2 place a tourniquet on the arm of Patient #8 at Station #13. RN #2 then removed the tourniquet, placed the tourniquet in the pocket of his/her PPE gown, and transported the tourniquet to a disinfection area.	V 116		
V 117	494.30(a)(1)(i) IC-CLEAN/DIRTY;MED PREP AREA;NO COMMON CARTS Clean areas should be clearly designated for the preparation, handling and storage of medications and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled. Do not handle and store medications or clean supplies in the same or an adjacent area to that where used equipment or blood samples are handled. When multiple dose medication vials are used (including vials containing diluents), prepare individual patient doses in a clean (centralized) area away from dialysis stations and deliver separately to each patient. Do not carry multiple dose medication vials from station to station. Do not use common medication carts to deliver medications to patients. If trays are used to deliver medications to individual patients, they must be cleaned between patients. This Standard is not met as evidenced by: Based on observation, the dialysis facility failed to ensure that clean paper towels were not subject	V 117		

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V 117	Continued From page 6 to contamination from unclean trash containers. Contaminated paper towels risks transmission of communicable diseases to patients and staff. Findings: On 3/5/2013 at 8:45 AM, Surveyor #1 observed that the tops of the trash containers at two handwashing sinks in the dialysis clinic area were within 3 inches of the bottoms of the paper towel dispensers. Towels removed from the dispensers were at risk for contamination from touching the trash containers. Staff were at risk for recontaminating their hands by touching the trash containers when obtaining paper towels.	V 117		
V 124	494.30(a)(1)(i) IC: HBV: TEST ALL,REV RESULTS/STATUS B4 ADMIT Routine Testing for Hepatitis B The HBV serological status (i.e. HBsAg, total anti-HBc and anti-HBs) of all patients should be known before admission to the hemodialysis unit. Routinely test all patients [as required by the referenced schedule for routine testing for Hepatitis B Virus]. Promptly review results, and ensure that patients are managed appropriately based on their testing results. This Standard is not met as evidenced by: Based on interview, record review, and review of facility policies, the facility failed to re-vaccinate and test 1 of 8 patients reviewed who was susceptible to the hepatitis B Virus (HBV) according to CDC guidelines. (Patient #2). Failure to immunize susceptible patients against	V 124		

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V 124	Continued From page 7 hepatitis B risks serious harm and morbidity through infection with the hepatitis B virus. Failure to test patients susceptible to HBV risks non-detection of newly acquired hepatitis B infections and risks transmission of HBV to patients and staff. Reference: Centers for Disease Control "Recommendations for Preventing Transmission of Infections Among Chronic Hemodialysis Patients" (MMWR, Vol. 50/No. RR-5, 2001) Findings: 1. The facility's policy and procedure entitled "Hepatitis Surveillance and Vaccination" (Reviewed 10/6/2011) stated in part that dialysis patients who had previously demonstrated immunity to HBV (an antibody Index Value of 1.00 or greater), then tested for HBV with an Index Value of less than 1.00 during their yearly HBV antibody test would be offered re-vaccination. The patient would be tested for HBV antigen monthly until immunity was regained. 2. On 3/5/2013 at 3:05 PM, review of the HBV vaccination and testing records for Patient #2 revealed that the patient's annual test for anti-HBV was 0.98 on 1/9/2013. The patient had previously tested as being immune to HBV. There was no documentation in the patient's record of a plan for re-vaccination for HBV. The patient had not been tested monthly for HBV as directed by facility policy. 3. An interview with the facility's nurse manager at the time of the record review confirmed that the re-vaccination and testing had not been done according to facility policy.	V 124		
V 543	494.90(a)(1) POC-MANAGE VOLUME STATUS	V 543		

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V 543	Continued From page 8 The plan of care must address, but not be limited to, the following: (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: Based on record review, interview, and review of facility policies and procedures, the dialysis facility failed to ensure that the patient's fluid volume status as measured by the patient's blood pressure was assessed during hemodialysis according to facility policy and procedure in 1 of 5 patient care records reviewed (Patients #1). Failure to monitor the patient's fluid volume status risks adverse patient outcomes related to hypovolemia. Findings: 1. The facility's policy entitled "Hemodialysis Monitoring" (Effective 2/24/2012) stated in part that the patient's blood pressure would be assessed every 30 minutes during dialysis and more frequently as needed. 2. Review of the 10 most recent hemodialysis treatment records dated 2/9/2013 to 3/2/2013 for Patient #1 revealed the following: a. On 2/12/2013 at 1:43 PM, the patient's blood pressure had been documented as 87/38. The patient's blood pressure was not re-checked until 2:13 PM. b. On 2/14/2013 at 11:44 AM, the patient's blood pressure had been documented as 82/28. The patient's blood pressure was not re-checked until	V 543		

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V 543	Continued From page 9 12:14 pm. At 2:14 PM, the patient's blood pressure had been documented as 84/21. The patient's blood pressure was not re-checked until 2:45 PM. c On 2/16/2013 at 2:05 PM, the patient's blood pressure had been documented as 83/36. The patient's blood pressure was not re-checked until 2:35 PM. d. On 2/21/2013 at 2:00 PM, the patient's blood pressure had been documented as 105/38 and at 2:31 PM as 110/28. The patient's blood pressure was not re-checked until 3:00 PM. 2. An interview with the facility's nurse manager on 3/6/2013 at 11:20 AM confirmed that the fluid volume status of this patient had not been assessed as directed by facility policy. ..	V 543		
V 544	494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE 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: 1. Based on record review and interview, the dialysis facility failed to ensure that staff members followed the physician's plan for achieving adequate dialysis by following the dialysis prescription for blood flow rate in 5 of 6 patient care records reviewed (Patients #1, #2, #4, #5. #6). Failure to follow the physician's prescription for	V 544		

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V 544	Continued From page 10 blood flow rate when performing dialysis risks inadequate dialysis treatment and patient harm. Failure to document the reason for inability to achieve the prescribed flow rate limits timely change to the patient's care plan for maintenance of an effective dialysis access. Findings: a. On 3/5/3013 at 12:02 PM, Patient #6 was observed during dialysis treatment. The patient's blood flow rate in the machine had been set at 400 ml/min. Review of the patient's dialysis prescription revealed that the patient's physician had ordered the patient to be dialyzed at no more than 350 ml./min. At interview with the dialysis facility's nurse manager at the tine of the observation confirmed that the patient was not being dialyzed according to the dialysis prescription. b. Review of the 10 most recent hemodialysis treatment records dated 2/9/2013 to 3/2/2013 for Patient #1 revealed that the patient had not been dialyzed with the prescribed blood flow rate during 3 of 10 treatments. There was no notation on the patient's treatment records regarding why the blood flow rate had varied from the dialysis prescription. Review of the 10 most recent hemodialysis treatment records dated 2/11/2013 to 3/4/2013 for Patient #2 revealed that the patient had not been dialyzed with the prescribed blood flow rate during 6 of 10 treatments. There was no notation on the patient's treatment records regarding why the blood flow rate had varied from the dialysis prescription.	V 544		

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V 544	Continued From page 11 Similar findings were found in the records of Patients #4 and #5. An interview with the facility's nurse manager on 3/6/2013 at 11:20 AM confirmed that dialysis care providers were expected to document the reason why a patient could not be dialyzed at the prescribed blood floor rate. 2. Based on record review and interview, the dialysis facility failed to ensure that staff members followed the physician's plan for achieving adequate dialysis by following the dialysis prescription for length of time on dialysis in 2 of 5 patient care records reviewed (Patients #4, #5). Failure to follow the physician's prescription for length of time on dialysis risks inadequate dialysis treatment and patient harm. Findings: a. Review of the 10 most recent hemodialysis treatment records dated 2/11/2013 to 3/4/2013 for Patient #4 revealed that the patient had not been dialyzed for the prescribed length of time on 3/2/2014. The patient's dialysis prescription was for the patient to dialyze 4.25 hours. On that date, the patient dialyzed for 3.5 hours. There was no notation on the patient's treatment records regarding why the patient's length of treatment had varied from the dialysis prescription. b. Review of the 8 most recent hemodialysis treatment records dated 2/1/2013 to 2/26/2013 for Patient #5 revealed that the patient had not been dialyzed for the prescribed length of time on 2/19/2013, 2/21/2013, 2/23/2013, and 2/26/2013.	V 544		

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V 544	Continued From page 12 The patient's dialysis prescription was for the patient to dialyze 4.0 hours. On 2/19/2013, the patient dialyzed for 3.5 hours. On 2/21/2013, the patient dialyzed for 2.75 hours. On 2/23/2013, the patient dialyzed for 2.13 hours. On 2/26/2013, the patient dialyzed for 3.3 hours. c. An interview with the facility's nurse manager on 3/6/2013 at 11:20 AM confirmed that dialysis care providers were expected to document the reason why a patient could not be dialyzed for the prescribed length of time.	V 544		
V 550	494.90(a)(5) POC-VASCULAR ACCESS-MONITOR/REFERRALS The interdisciplinary team must provide vascular access monitoring and appropriate, timely referrals to achieve and sustain vascular access. The hemodialysis patient must be evaluated for the appropriate vascular access type, taking into consideration co-morbid conditions, other risk factors, and whether the patient is a potential candidate for arteriovenous fistula placement. This Standard is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure that the patient's hemodialysis catheter was assessed and dressing changes performed and documented according to facility policy for 1 of 2 patients with dialysis catheters reviewed (Patients #2). Failure to assess, perform, and document the condition of the patient's hemodialysis catheter	V 550		

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(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 550	Continued From page 13 and catheter dressing changes risks infection of the catheter and adverse patient outcomes related to septicemia. Findings: 1. Review of the 10 most recent hemodialysis treatment records dated 2/11/2013 to 3/4/2013 for Patient #2 revealed the records lacked evidence that the patient's dialysis catheter dressing had been changed and that the catheter insertion site had been assessed on 2/11/2013 and 2/20/2013. 2. An interview with the facility's nurse manager on 3/6/2013 at 11:20 AM revealed that dialysis care providers were expected to change the patient's dialysis catheter dressing and assess the catheter insertion site during every dialysis treatment. This information was to be documented on the patient's treatment record.	V 550		
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: 1. Based on record review and review of facility policies and procedures, the dialysis facility failed to ensure that a patient's plan of care was completed within 15 days of completion of the comprehensive patient reassessment of the patient's condition for 3 of 5 patients reviewed (Patients #1, #4, #5).	V 558		

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	502540	A. BUILDING _____ B. WING _____	03/06/2013

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V 558	Continued From page 14 Failure to revise and implement a plan of care based on reassessment of the patient's condition risks poor patient outcomes due to inadequate and inappropriate treatment Findings: a. Review of records of 5 dialysis patients on 3/5/2013 revealed the following: 1) The annual comprehensive patient assessment for Patient #1 performed by the registered dietician was dated 2/14/2012. The patient's annual interdisciplinary care conference was dated 3/22/2012. 2) The annual comprehensive patient assessment for Patient #4 performed by the registered dietician was dated 9/7/2012. The patient's annual interdisciplinary care conference was dated 10/16/2012. 3) The initial comprehensive patient assessment for Patient #5 performed by the social worker was dated 2/14/2013. The patient's annual interdisciplinary care conference was dated 2/12/2013. 4) The facility's policy and procedure entitled "Plan of Care" (Effective 10/30/2012) did not state that the annual updates of the patient's plan of care must be performed within 15 days of the completion of the annual patient assessments. Review of the Operations Committee meeting minutes dated 11/2/2012 revealed that the facility had authorized patients assessments to be performed up to 30 days prior to the annual update of the patient's plan of care.	V 558		

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V 558	Continued From page 15 2. Based on record review and review of facility policies and procedures, the dialysis facility failed to ensure that an unstable patient's plan of care was revised by an interdisciplinary team (IDT) based on a monthly reassessment of the patient's condition for 2 of 2 unstable patient reviewed (Patient #10, #11) Failure to revise and implement a plan of care based on reassessment of the patient's condition risks poor patient outcomes due to inadequate and inappropriate treatment Findings: a. The facility's policy and procedure entitled "Unstable Patient Care Plans" (Effective 10/2/2012) stated in part that a comprehensive patient reassessment would be performed monthly by the IDT when a patient was determined to be unstable. The patient's plan of care would be revised based on the assessment findings. b. Review of the records of Patient #10 revealed that on 12/28/2012 the patient was determined to be unstable due to the concurrent conditions of low dialysis adequacy, low hemoglobin and hematocrit, and low albumin.. After the patient was released from the hospital, a revised plan of care was developed by the IDT on 1/23/2013. There was no evidence that the patient's care plan was reviewed by the IDT in February 2013. c. .Review of records of Patient #11 revealed that on 12/28/2012 the patient was determined to be unstable due to recent hospitalization and placement in a long term care facility. A revised	V 558		

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V 558	Continued From page 16 plan of care was developed by the IDT on 1/4/2013. There was no evidence that the patient's care plan was reviewed by the IDT February 2013.	V 558		
V 628	494.110(a)(2) QAPI-MEASURE/ANALYZE/TRACK QUAL INDICATORS The dialysis facility must measure, analyze, and track quality indicators or other aspects of performance that the facility adopts or develops that reflect processes of care and facility operations. These performance components must influence or relate to the desired outcomes or be the outcomes themselves. This Standard is not met as evidenced by: Based on interview and review of QAPI data and plans, the dialysis facility failed to effectively measure and analyze two key quality indicators (mortality and hospitalization) in a manner that would allow effective consideration of these measures and development of improvement plans. Failure to measure and analyze key quality indicators leaves the dialysis facility unable to determine whether its performance meets its expectations and plan for improvement as necessary. Findings include: During review of QAPI data and plans on 03/06/2013, it was found that data for mortality and hospitalization were available to the quality	V 628		

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V 628	Continued From page 17 committee in the form of 3-month retrospective totals. There was no longer period of time over which data was reported for aggregation and analysis. The dialysis facility manager confirmed that data for these two indicators was presented in 3-month intervals, which did not include numbers large enough to analyze these indicators for preventable outcomes or important trends.	V 628		
V 726	494.170 MR-COMPLETE, ACCURATE, ACCESSIBLE The dialysis facility must maintain complete, accurate, and accessible records on all patients, including home patients who elect to receive dialysis supplies and equipment from a supplier that is not a provider of ESRD services and all other home dialysis patients whose care is under the supervision of the facility. This Standard is not met as evidenced by: Based on record review and interview, the dialysis facility failed to develop a process for documenting the administration of heparin prior to initiation of dialysis that included the time of administration and the caregiver who administered the medication, as found in 5 of 5 patient care records reviewed (Patients #1, #2, #3, #4, #5) Failure to develop a process for documenting administration of heparin prior to initiation of dialysis risks medication administration errors due to omission of the medication or administration of the medication by multiple caregivers. Findings: 1. Review of dialysis treatment records for Patient #1 revealed the following:	V 726		

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V 726	Continued From page 18 Patient #1's dialysis prescription stated that the patient was to be given 4000 units of heparin intravenously prior to the initiation of treatment. Patient #1's 10 most recent hemodialysis treatment records dated 2/9/2013 to 3/2/2013 included the amount of heparin in the heparin syringe at the beginning of treatment, the amount of heparin in the heparin syringe at the end of treatment, and the total amount of heparin infused during treatment. There was no documentation in the patients' records that the patient had been given the prescribed amount of heparin prior to initiation of treatment, the time the heparin had been given, and the name of the caregiver who administered the heparin. Similar findings were found in the records of Patients #2, #3, #4, and #5. 2. An interview with the facility's nurse manager on 3/5/3013 at 11:30 AM revealed that the total amount of heparin infused during treatment was automatically entered on the patient's dialysis record by the facility's computer software program. There was no process for dialysis caregivers to actively document heparin given to patients prior to initiation of treatment.	V 726		
V 751	494.180 GOV-ID GOV BODY W/FULL AUTHORITY/RESPONS The ESRD facility is under the control of an identifiable governing body, or designated person(s) with full legal authority and responsibility for the governance and operation of the facility. The governing body adopts and	V 751		

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V 751	Continued From page 19 enforces rules and regulations relative to its own governance and to the health care and safety of patients, to the protection of the patients ' personal and property rights, and to the general operation of the facility. This Standard is not met as evidenced by: Based on observation, record review and interview, the dialysis facility's governing body failed to maintain the number of dialysis stations authorized by the Washington State Department of Health Certificate of Need Program. Findings: On 3/5/2013 at 8:30 AM, a tour of the dialysis unit revealed that the unit had eleven stations available for dialysis. At Surveyor #1's request, the Acting Facility Director (Staff Member #1) presented a copy of DOH Certificate of Need #1230 (dated 8/2/2001), which authorized Snoqualmie Ridge Kidney Center to maintain nine dialysis stations. The dialysis facility had two more dialysis stations than had been authorized by the Washington State Department of Health Certificate of Need Program. This deficiency was corrected during the survey. Two stations were taken off-line on 3/5/2013.	V 751		

NORTHWEST Kidney Centers

March 20, 2013

Plan of Correction- Snoqualmie Ridge Kidney Center 2013 Survey

V111- 494.30 IC-SANITARY ENVIRONMENT

How: Paper labels on the sides of all of the machines have been removed.
Who: FSS has physically removed all of the labels and any residue. Template to be created by IT.
What: NKC will develop a template that is placed as an icon on the COW (Computer on Wheels) that the staff use daily. They will be able to put the Conductivity and Weekly Citric Thermal on this template and designate machine and station. They can use this as a reference and a place to document.
When: This template will tentatively be available to use by April 30th. The staff will use a paper copy of this template for documentation until the template is completed and available for use on the COW.

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

How: A Mandatory Staff In-Service to be given by the Infection Control Nurse at NKC. Focusing on Hand Hygiene, Sanitary Environment and general Infection Control Practices within dialysis.
Who- Emiliah Sithole Kambarami and/or Joyce Morimoto. Documentation of participation to be completed by Unit Manager, Cathy Carlson.
What: Unit Manager will audit weekly for 8 weeks and then monthly for proper technique and compliance. . If staff is non-adherent, we will identify areas of concern and provide additional education. Additional weekly audits will be performed until evidence of 100% compliance is reached. If applicable, will provide one-on-one specific education if needed.
When: This Mandatory In-Service will be completed by April 5th 2013. Audits will begin the week of April 8th and continue weekly through May 31st and then monthly thereafter. The weekly audits will include one observation of all staff that is scheduled to work a shift during that week.

V115- 494.30 (a)(1)(i) IC-Gowns, Shield/Masks- No Staff eat/Drink

How: A Mandatory Staff In-Service to be given by the Infection Control Nurse at NKC. Focusing on proper PPE wear and general Infection Control Practices within dialysis.
Who- Emiliah Sithole Kambarami and/or Joyce Morimoto. Documentation of participation to be completed by Unit Manager, Cathy Carlson.
What: Unit Manager will audit weekly for 8 weeks and then quarterly for proper technique and compliance. . If staff is non-adherent, we will identify areas of concern and provide additional education. Additional weekly audits will be performed until evidence of 100% compliance is reached. If applicable, will provide one-on-one specific education if needed.
When: This Mandatory In-Service will be completed by April 5th 2013. Audits will begin the week of April 8th and continue weekly through May 31st and then quarterly thereafter. The weekly audits will include one observation of all staff that is scheduled to work a shift during that week.

V116 494.30 (a)(1)(i) IC- If to station=Disp/Dedicate or Disinfect

How: A Mandatory Staff In-Service to be given by the Infection Control Nurse at NKC. Focusing Clean/Dirty patient areas and equipment, and on General Infection Control Practices within dialysis
Who- Emiliah Sithole Kambarami and/or Joyce Morimoto. Documentation of participation to be completed by Unit Manager, Cathy Carlson.
What: : Unit Manager will audit weekly for 8 weeks and then quarterly for proper technique and compliance. If staff is non-adherent, we will identify areas of concern and provide additional education. Additional weekly audits will be performed until evidence of 100% compliance is reached. If applicable, will provide one-on-one specific education if needed.
When: This Mandatory In-Service will be completed by April 5th 2013. Audits will begin the week of April 8th and continue weekly through May 31st and then quarterly thereafter. The weekly audits will include one observation of all staff that is scheduled to work a shift during that week.

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

How: All trash cans have been removed from under the paper towel dispenser. Labels will be placed on the paper towel dispenser reminding staff/janitor not to place garbage cans next to dispenser.
Who: Cathy Carlson (Unit Manager) has already removed the trash cans. Tammy Heck (FSS) is having labels made for the dispenser that clearly state that garbage receptacles cannot be placed near or around paper towel dispenser.
What: Weekly audit for 8 weeks to ensure compliance. And then quarterly thereafter. If evidence that this plan is not working, SKRC will remove the medium sized trash cans from the unit and only have the large cans on rollers and the small cans that are kept at patient chair-side.
When: The correction of removing the trash cans in completed and the placement of the labels will be completed by April 5th. Audits will begin the week of April 8th and continue weekly through May 31st and then quarterly thereafter. Audits will be performed at random 2x/wk.

V124 494.30(a)(1)(i) HBV: Test All, Rev Results/Status

How: Educate the Case Manager to run the Hepatitis report after monthly labs. If a patient has results <1.0 then administer booster or series per protocol and recheck per protocol.
Who: Case Manager/Nurse Educator- Cathy Carlson.
What: To be discussed at Monthly QAPI meeting when discussing Immunization Status. Any patient listed on the Hepatitis report who has a value of < 1.0 will be discussed. Any communication related to the Hep B vaccine status that is outside of protocol will be documented in CyberRen.
When: Correction and plan made 3/21/13. Monthly audit of all SRKC patients that are below 1.0 and discuss status for immunization at QAPI.

V543 494.90(a)(1) POC Manage Volume Status

How: Mandatory In-Service to be given by Manager and Director related to frequency of checking and re-checking BP's, frequency of monitoring when unstable and documentation. Educate Charge Nurse to audit floor staff for compliance. This to be completed by April 12th 2013.
Who: Cathy Carlson, Tosha Teske and Charge Nurses.
What: Educate all staff on proper blood pressure management and documentation. Educate Charge nurses to do on-going daily audits of all patient charts before closing them out for evidence of proper monitoring and documentation. If weekly audits show failed compliance, additional education and audits will be performed until 100% compliance is achieved.
When: Mandatory In-Service to be completed by April 5th 2013. Includes educating Charge Nurses on auditing the charts before closing out. Cathy will perform weekly audits of all patient charts for 8 weeks starting April 8th and end May 31st.

V544 494.90 (a)(1) POC- Achieve Adequate Clearance

How: Mandatory In-service to be given by Manager and Director related to documentation of variances to the prescribed MD order as it relates to blood flow and time. Educate on the importance of adhering to prescription.
Who: Cathy Carlson and Tosha Teske and Charge Nurses.
What: Unit Manager will do weekly audits of all patient charts for 8 weeks to ensure compliance to MD orders and to documentation of variances. If compliance not met, will do additional education and additional weekly audits. Will continue this pattern until evidenced by 100% compliance with adherence to MD orders and/or documentation as to reason for variance.
When: Mandatory In-service to be completed by April 5th 2013. Weekly audits to start April 8th and end on May 31st 2013 to confirm adherence.

V550 494.90(a)(5) POC- Vascular Access

How: Mandatory In-Service to review the Policy as it relates to catheter care and documentation.
Who: Cathy Carlson and Tosha Teske
What: Unit Manager will do weekly audits on all catheter patients for 8 weeks to ensure compliance in both catheter care and documentation. If compliance not met, will do additional education and additional weekly audits. Will continue this pattern until evidenced by 100% compliance.
When: Mandatory In-service to be completed by April 5th 2013. Weekly audits to start April 8th and end on May 31st 2013 to confirm adherence.

V558 494.90(b)(2) POC Implement Update-15 days Pt Assess

How: 1.) All Disciplines have 15 days from the date they do their Comprehensive Assessment to complete the POC for that patient. If the Comprehensive Assessment has been developed and it is outside of the 15 day date range from the POC; r/t hospitalizations, change of POC call etc.. a progress note by all disciplines needs to be recorded in the EMR. 2.) Per Policy Unstable Care Plans need to be reviewed and updated monthly. Educate Case Manager to run the unstable care plan report on the first day of the month and have all disciplines complete by the 15th of the month per policy.
Who: 1.) The Operations Committee enforcing the CMS regulation that the POC to be completed no longer than 15 days after the Comprehensive Assessment. Mary McHugh is responsible for making sure SW and Dietary are in compliance. 2.) Cathy Carlson will run her unstable report first day of the month and follow policy. All disciplines will be reminded to complete their POC within the timeline.
What: 1.) Mary McHugh will perform monthly audits x 3 months on all SRKC patients who have CA/POC due in that time frame to ensure that SW and Dietary are in compliance. In addition, any discipline that has not completed their portion in a timely manner will be reported to the Clinical Director>Medical Director>CMO as needed. 2.) Cathy will discuss unstable patients weekly at the team huddles and monthly at the QAPI.
When: Mary will begin audits in the month of April and will continue through the month of June. Discussion of unstable patients at QAPI started on March 25th and will continue thereafter. SW and Dietary are aware of timeline and have already initiated the change.

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

How: Trending for Hospitalization and Mortality will be tracked for 6 consecutive months and reviewed at QAPI.
Who: Suhail Ahmad and IT.
What: This tracking report will be available on our Quality Indicator reports in the KNET and used at the monthly QAPI meeting. Data and trending will be reviewed at this time.
When: This reporting will be available for the April QAPI meetings.

V726 494.170 MR-Complete, Accurate, Accessible

How: The Heparin bolus amount will be charted in the Intra screen in CyberRen. This will record it as a Medication administered, time it was given and who it was administered by.
Who: Cathy Carlson will educate all clinical staff on how to document properly.
What: Staff will chart Heparin bolus in the same place and in the same manner. This data will be added to the monthly heparin audit report to ensure accurate data has been charted on 100% of patients and for every treatment on-going. The addition to the report will be ready by April 19th. Heparin audits are already done on a weekly basis, this change in documentation will be added to the audit report and monitored weekly along with the standard monitoring. Education to staff as needed if audits show discrepancies.
When: Staff will be educated by March 31st 2013. The addition to the Heparin report will be available by April 19th. Until then, audits will be done manually by Cathy Carlson.

V751 494.180 Gov Body w/Full Authority/Response

How: Machines that are used for rinsing will be labeled as "Rinse Stations". Only 9 machines are allowed to be on the floor at any given time per C of N unless labeled and being used as rinsing stations. This was addressed and corrected during the survey.
Who: Cathy Carlson, Unit Manager immediately corrected the deficiency.
What: All staff aware of the policy and Unit Manager has addressed the issue. Any station that is used for rinsing the machines needs to be labeled as a "Rinsing Station" as designated as such.

When: Corrected during the survey.