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

August 2, 2013

Administrator
NKC-West Seattle Kidney Center
4045 DELRIDGE WAY SW
Seattle, WA 98106

Dear Ms. Bennett;

The Department of Health inspection team has reviewed and accepted your plan of correction for deficiencies found during your facility's Medicare re-certification inspection of June 25-26, 2013.

No further reporting is due at this time.

Sincerely,

Stephen B. Mickschl, MS, RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	502523	A. BUILDING _____ B. WING _____	06/26/2013

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V 000	INITIAL COMMENTS MEDICARE RE-CERTIFICATION SURVEY FOR END STAGE RENAL DISEASE This survey for Medicare End State Renal Disease facility recertification was conducted on June 25-26, 2013 by Stephen Mickschl, RN, MS; Larry Anderson, RS, and Lisa Mahoney, MPH. During this on-site survey, Department of Health staff reviewed all the Medicare Conditions for Coverage set forth in 42 CFR 494, End Stage Renal Disease Facilities. Shell # I8MD11	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 observation, facility staff failed to ensure that hand hygiene was performed according to CDC guidelines when caring for patients during dialysis procedures. Failure to utilize proper infection control precaution during dialysis risks transmission of communicable diseases between patients and staff. Ref: Centers for Disease Control and Prevention. Guideline for Hand Hygiene in Health-Care	V 113		

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 113	Continued From page 1 Settings: Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. MMWR 2002;51(No. RR-16): page 32. Findings: 1. During 6/25/13 environmental observations, Staff #5 was observed providing patient care. The staff member brought a plastic container of dialysate fluid to Station #7 at 12:48 PM. Staff #5 then proceeded to place the container on the foot of the dialysis machine without wearing gloves. Then Staff #5 grabbed the machine hose, that goes into the container and placed the hose into the container and secured the cap. All these actions were accomplished while Staff #5 was not wearing any gloves. During rounds at 2:02 PM, Staff #5 was observed cleaning the machine and other equipment at Station #8. Staff #5 left and went to the computer-on-wheels near the station and touched the keyboard several times with the same "dirty gloves" he/she was wearing at Station #8, thus contaminated a previously "clean" piece of equipment. Staff #5 was then seen going to the machine at Station #9 which was alarming. He/she proceeded to touch the machine's computer screen to silence the alarm and re-set the machine's computer. All these actions were performed wearing the same pair of "dirty gloves" worn at Station #8 (gloves not changed between patient stations). Staff #5 was also observed at 2:05 PM silencing an alarm and re-setting the machine's computer at Station #8. He/she was observed to place a single glove over the "tips of his/her fingers" to touch the machine, rather than pulling	V 113		

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V 113	Continued From page 2 the glove completely onto the hand for full protection. 2. During 6/25/13 environmental observations, Staff #4 was observed providing patient care at 12:49 PM. The staff member went to Station #3 to clear an alarm and re-set the machine. Staff #4 accomplished this with a gloved right hand. However, before leaving the station he/she moved dialysis tubing that was draped over the patient's mid-section and left leg with an "un-gloved" left hand.	V 113		
V 413	494.60(d)(3) PE-ER EQUIP ON PREMISES-02, AED, SUCTION Emergency equipment, including, but not limited to, oxygen, airways, suction, defibrillator or automated external defibrillator, artificial resuscitator, and emergency drugs, must be on the premises at all times and immediately available. This Standard is not met as evidenced by: Based on observations, the facility failed to secure oxygen bottles in a manner to prevent them from falling over and potentially becoming missile hazards. Failure on the part of the facility to properly secure oxygen bottles puts patients, staff and visitors of the facility at risk of injury or death. Findings include: 1. On 6/26/13, Surveyor #2 noted that 3 of 5 oxygen bottles located adjacent to the Nurse's Station were not properly secured in storage racks/stands to prevent them from falling or tipping over.	V 413		
V 417	494.60(e)(1) PE-FIRE SAFETY-LIFE SAFETY	V 417		

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V 417	Continued From page 3 CODE 2000 (1) Except as provided in paragraph (e)(2) of this section, by February 9, 2009. The dialysis facility must comply with applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association (which is incorporated by reference at §403.744 (a)(1)(i) of this chapter). This Standard is not met as evidenced by: Based on observations, record review and interview, the facility failed to inspected portable fire extinguishers monthly as is required. Failure on the part of the facility to inspect its fire extinguishers as required puts patients, staff and visitors of the facility at risk of injury from smoke and fire should the extinguishers being needed to suppress a fire. Findings include: 1. On 6/25/13, Surveyor #2 noted that the monthly reinspection record tag located on two of the facility's portable fire extinguishers (back hall and at patient waiting area) had last been initialed on 4/13. This finding was acknowledged by the facility water technician. 2. On 6/26/13, Surveyor #2 asked a patient care technician (PCT) who was working in the isolation room if the monthly reinspection record tag on the portable fire extinguisher in the isolation room had been initialed for the current month. It was indicated by the PCT that the last entry on the tag was made 4/13.	V 417		
V 544	494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE	V 544		

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V 544	Continued From page 4 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: I. Based on record review and interview, the dialysis facility failed to ensure that staff members followed the physician's dialysis prescription for anticoagulation for 8 of 10 patient records reviewed for treatment parameters (Patients #1, #2, #3, #4, #6, #7, #8, #9). Failure to follow the physician's prescription for anticoagulation when performing dialysis risks inadequate dialysis treatment and poor patient outcomes. Findings: 1. Per record review, Patient #6's dialysis prescription specified that the patient was to receive 1000 units of heparin per hour during the first 240 minutes of dialysis treatment, for a total of 4000 units. No heparin was to be given to the patient during the last 30 minutes of treatment. The "Hemodialysis Session" paperwork showed that the heparin was started at 7:12 AM on 5/14/13 and should have ended at 11:12 AM. The dialysis treatment was ended at 11:30 AM. Thus, the heparin was not stopped "30 minutes before the end of treatment, as ordered by the physician. Additional examples of the above was also noted on 5/30, 6/6, 6/13, and 6/20/13. 2. Per record review, on Patient #7's dialysis	V 544		

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V 544	Continued From page 5 prescription specified that the patient was to receive 1500 units of heparin per hour during the first 270 minutes of dialysis treatment, for a total of 6750 units. No heparin was to be given to the patient during the last 30 minutes of treatment. The "Hemodialysis Session" paperwork records that the heparin was started at 6:07 AM on 6/6/13 and should have ended at 10:37 AM. However, the paperwork showed that the computer-controlled heparin actually ended at 11:12 AM. The dialysis treatment was ended at 11:08 AM. Thus, the heparin was not stopped "30 minutes before the end of treatment, as ordered by the physician. In addition, the "Total Heparin Infused" section of the record showed that the patient received 7500 units, yet the machine computer should have stopped the flow at 10:48 AM with "0 units" remaining. But the machine still had "1500 units" to deliver at 10:11 AM, so the "Total Heparin Infused" that was recorded was not accurate. Additional examples of the above was also noted on 6/8, and 6/11/13. 3. Additional examples of the above were also found in the records of Patient's #1, #2, #3, #4, #7, #8, and #9. 4. Per record review, Patient #4 dialyzed on 6/7/13. The physician's order was for 5 hours of dialysis. The "Hemodialysis Session" record showed the patient only dialyzed for 4.5 hours. There was no documentation as to why the time was shortened. Patient #4 dialyzed on 6/17/13. The physician's order was for 5 hours of dialysis. The "Hemodialysis Session" record showed the patient dialyzed for 5.3 hours. There was no documentation as to why the time was extended.	V 544		

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V 544	Continued From page 6 The above noted examples were verified by Staff #3 who provided access to the electronic medical record. II. Based on medical record review, 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 4 of 10 records reviewed for blood flow rates (Patient #1, #2, #3, #4). 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: 1. Per record review, Patient #1 dialyzed on 6/4/13. Per physician orders, the patient's BFR was to be "400". A review of the "Hemodialysis Session" form in the record showed that staff reduced the BFR to "260" at 1:33 PM and it remained at this rate to the completion of dialysis at 2:20 PM. The record did not provide evidence why the rate was reduced, nor that the physician had been notified and changed the order. Additional examples of the above were also noted during treatments on 6/11, 6/18, 6/20, 6/22, and 6/24/13. 2. Per record review, Patient #2 dialyzed on 5/23/13. Per physician orders, the patient's BFR was to be "400". A review of the "Hemodialysis Session" form in the record showed that staff reduced the BFR to "350" at 7:57 PM and it remained at this rate to the completion of dialysis at 10:26 PM. The record did not provide evidence why the rate was reduced, nor that the physician had been notified and changed the order. The above observation was also noted to	V 544		

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V 544	Continued From page 7 occur on 5/28, and 6/6/13. 3. Per record review, Patient #3 dialyzed on 6/21/13. Per physician orders, the patient's BFR was to be "400". A review of the "Hemodialysis Session" form in the record showed that staff reduced the BFR to "350" at 7:17 AM and it remained at this rate to the completion of dialysis at 10:21 AM. The record did not provide evidence why the rate was reduced, nor that the physician had been notified and changed the order. 4. Additional examples of the above were also found in the records of Patients #4 on 6/14/13. The above noted examples were verified by Staff #3 who provided access to the electronic medical record.	V 544		
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 the initiation of the Comprehensive Interdisciplinary Assessment for 6 of 9 patients reviewed (Patient #1, #2, #3, #4, #5, #6). Failure to complete a comprehensive assessment of a dialysis patient's needs impairs the facility's ability to develop an effective plan for care.	V 558		

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V 558	Continued From page 8 Findings: 1. Per review of Patient #1's record, the annual assessment was completed in July 2012. The physician signed a completion date of 6/18/12, the dietician signed on 6/28/12, the social worker signed on 6/19/12. The date of the care planning team meeting was identified as 7/18/12. Thus, the meeting was at least 15 days late. 2. Per review of Patient #2's record, the annual assessment was completed in April 2013. The physician signed a completion date of 3/19/13. The date of the care planning team meeting was identified as 4/11/12. Thus, the meeting was 8 days late. 3. Per review of Patient #3's record, the annual assessment was completed in April 2013. The social worker signed completion of his/her assessment on 3/27/13. The date of the care planning team meeting was identified as 4/16/13. Thus, the meeting was 5 days late. 4. Per review of Patient #4's record, the annual assessment was completed in July 2012. The social worker signed completion of his/her assessment on 6/20/12. The date of the care planning team meeting was identified as 7/10/12. Thus, the meeting was 5 days late. 5. Per review of Patient #5's record, the annual assessment was completed in February 2013. The social worker signed completion of his/her assessment on 1/31/13. The date of the care planning team meeting was identified as 2/20/13. Thus, the meeting was 5 days late. 6. Per review of Patient #6's record, the annual	V 558		

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V 558	Continued From page 9 assessment was completed in April 2013. The social worker signed completion of his/her assessment on 3/26/13. The date of the care planning team meeting was identified as 4/19/13. Thus, the meeting was 9 days late.	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: Surveyor #1 Based on review of Dialysis Facility Reports (DFR), facility Quality Assessment and Process Improvement (QAPI) documents and administrative staff interview, the facility failed to have documentation that the 2012 DFR reported data had been reviewed, analyzed, and interventions developed to improve outcomes, where needed. Failure to review DFR data within the QAPI program places patients at risk of harm because the facility did not identify potential problem areas and put corrective action in place. Findings: Per review of the 2012 DFR, based on data from the Centers for Medicare & Medicaid Services (CMS), the facility was noted as having the	V 628		

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V 628	Continued From page 10 following: a) a higher rate of hospitalized patients with septicemia during 2008-2011; b) a lower rate of patient receiving transplantation than expected; and c) a lower rate of patients on the kidney transplant waitlist. Per review of the QAPI program documents, no evidence was found that the above identified issues had been incorporated into the program. Per interview with Staff #1 and #2 on 6/25/13, no evidence of investigation, analysis or corrective action could be produced to show that the data from the DFR had been incorporated into the QAPI program. The above noted was verified by Staff #1 and Staff #2 during the QAPI interview on 6/26/13. THIS IS A REPEAT DEFICIENCY	V 628		
V 638	494.110(b) QAPI-MONITOR/ACT/TRACK/SUSTAIN IMPROVE 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: Based on review of current and previous survey information, the facility failed to monitor its performance, take actions that result in performance improvements, and track performance to ensure that improvements are sustained over time. Failure to sustain improvements over time places all patients at risk of harm related to the potential that unimproved performance issues can directly affect patient well-being.	V 638		

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V 638	Continued From page 11 Findings: Refer to tag V-0628 as repeat deficiency that has remained uncorrected from the date of the last full survey	V 638		
V 726	494.170 MR-COMPLETE, ACCURATE, ACCESSIBLE The dialysis facility must maintain complete, accurate, and accessible records on all patients, including home patients who elect to receive dialysis supplies and equipment from a supplier that is not a provider of ESRD services and all other home dialysis patients whose care is under the supervision of the facility. This Standard is not met as evidenced by: Surveyor #1 Based on record review and interview, the facility failed to ensure that patient medical record included accurate information regarding the length of time of dialysis treatments for 7 of 9 patient records reviewed for treatments (Patients #1, #2, #4, #6, #7, #8, #9). Failure to accurately document the length of time of dialysis limits the ability to assess the adequacy of dialysis treatment. Findings: 1. Per record review, Patient #6's "Hemodialysis Session" paperwork showed a "Heparin Remaining" column that was completed, by the technician. On 5/14/13 the machine was set to deliver 1000 units of heparin every hour. The form showed the remaining heparin was 4000 units at 7:12 AM. At 9:12 AM the recording was	V 726		

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V 726	Continued From page 12 2000 units. At 10:12 AM staff recorded the remaining heparin as "0 units", even though the machine had delivered an additional 1000 units since 9:12 AM and the recording should have been 1000 units. The documentation continued to show "0 units" until dialysis was discontinued at 11:30 AM. Patient #6's "Hemodialysis Session" paperwork showed on 5/16/13 the machine was set to deliver 1000 units of heparin every hour. The form showed the remaining heparin was 4000 units at 7:00 AM. At 9:00 AM the recording was 2000 units. At 9:30 AM staff recorded the remaining heparin as "2000 units", even though the machine had delivered an additional 500 units since 9:00 AM and the recording should have been 1500 units. At 10:00 AM the recorded remaining amount was 1000 units. At 10:30 AM the technician recorded the remaining amount as "1000 units", even though the machine had delivered an additional dose of 500 units. Thus, the correct annotation should have been "500 units". At 11:00 AM the technician recorded the remaining amount as 500 units, even though the correct annotation for heparin remaining, as delivered by the machine, was "0 units". Additional examples of the above inaccurate medical record annotations were found on 5/23, 6/6, 6/13, and 6/20/13. 2. Additional examples of the above were also noted in the records of Patients: #1 (6/4, 6/8, 6/11, 6/13, 6/18, 6/20, and 6/24/13); #4 (6/7, 6/10, and 6/21/13); #7 (6/11, 6/15, 6/18, and 6/22/13); #8 (6/10, 6/12, 6/19, and 6/24/13), and #9 (6/7, 6/12, 6/14, and 6/24/13). 3. Per record review, Patient #2 dialyzed on 6/11/13. The "Hemodialysis Session" form showed that the patient received 3000 units of	V 726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	502523	A. BUILDING _____ B. WING _____	06/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST SEATTLE KIDNEY CENTER	4045 DELRIDGE WAY SW SEATTLE, WA 98106

(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 726	Continued From page 13 heparin via the automatic delivery system. The dialysis started at 5:51 PM and was terminated at 9:51 PM. The machine should have only delivered a little over 1600 units, yet the record showed that the full amount had been given during the shortened dialysis time period. The above noted examples were verified by Staff #3 who provided access to the electronic medical record.	V 726		

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

1 July 2013

Administrator
NKC-West Seattle Kidney Center
4045 DELRIDGE WAY SW
Seattle, WA 98106

Dear Ms. Bennett;

This letter contains information regarding the recent survey of NKC-West Seattle Kidney Center by the Washington State Department of Health. Your Medicare Re-certification survey was completed on 6/26/2013.

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

S. Mickschl

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: SHEILA BENNETT **Date: JULY 1, 2013**

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

PLAN OF CORRECTION

REQUIREMENTS:

1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies.

2. EACH plan of correction statement **must include** the following:
   - The regulation number and/or the tag number;
   - **HOW** the deficiency will be corrected;
   - **WHO** is responsible for making the correction;
   - **WHAT** will be done to prevent reoccurrence and how you will monitor for continued compliance; and
   - **WHEN** the correction will be completed.

3. Your PLAN OF CORRECTION must be returned within 10 **calendar** days from the date you receive the Statement of Deficiencies.

   Your PLAN OF CORRECTION should be returned approximately by **JULY 15, 2013**.

4. **The Administrator or Representative's signature is required on the first page of the original. Each subsequent page must be INITIALED IN THE LOWER RIGHT HAND CORNER.**

5. Return the original report with the required signatures.

HELPFUL HINTS:

1. An incomplete and or incorrectly completed PLAN OF CORRECTION cannot be accepted and may be returned to the facility.

2. The regulation number immediately precedes the text of the statement of deficiency. The "Tag" number is found in the margin to the far left of the statement of deficiency. Your plan of correction cannot be processed without the reference numbers.

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

   The Required Date of Correction must be no later than: **AUGUST 26, 2013**.

3. Keep a copy of the Statement of Deficiencies and your Plan of Correction for your records.

4. The first page of the original report must be signed, and each subsequent page **must** be initialed to avoid being returned.

Please return the completed reports to: Stephen B. Mickschl, MS, RN P.O. Box 1870, Blaine, WA. 98231-1870
If you have any questions, please call me at (360) 371-7899.

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

July 18, 2013

Administrator
NKC-West Seattle Kidney Center
4045 DELRIDGE WAY SW
Seattle, WA 98106

Dear Ms. Bennett;

I have received your Plan of Correction for the deficiencies identified during the 6/25-26/2013 survey of your facility. The Plan of Correction has been found **not acceptable** and is being returned to you for the following reasons:

- The regulation number and/or the tag number:
  V-638> was not addressed in the plan

- **WHAT** will be done to prevent reoccurrence and how you will monitor for continued compliance:
  V-113> how many audits will be completed?; how often will the audits be completed?; how long will you be auditing staff?; audits need to be reported to the QAPI committee

  V-558> How will I know the tracking tool actually fixes the problem? There needs to be some review of data and submitted to QAPI committee.

  V-726> The deficiency was not just about "recording the heparin". You must address how you will ensure that "what is recorded" is an accurate representation of what was actually given to the patient. This is what makes the medical record inaccurate.

Please return your revised PLAN OF CORRECTION to me within ten days of receipt of this letter on approximately July 31, 2013 to the address listed above.

Please call me if you have any questions at (360) 371-7899.

Sincerely,

S. Mickschl

Stephen Mickschl, MS, RN

Received 7/26/13

Plan of Correction for West Seattle Kidney Center
Provider number 502523
Page 1

V 113 494.30(a)(1) IC-WEAR GLOVES/HAND HYGEINE

HOW: During the survey it was noted that a staff touched a "dirty" machine hose, a dialysate container and a cap with ungloved hands and another staff touched the dialysis blood tubing during a patient's treatment with ungloved hands. A staff was seen touching a clean piece of equipment with "dirty gloves" and then cross contaminating by answering a machine alarm at a different station using these same "dirty gloves". A staff was seen answering a machine alarm with a glove over the tips of his/her fingers rather than pulling the glove completely over the hand for full protection.

This will be corrected by:

1. Staff re-education by reviewing the principles of "clean" and "dirty" with all staff members at a staff meeting.
2. Providing an in-service by the Infection Control Department.
3. Each staff member must give a return demonstration showing an understanding of these principles.

WHO: Roseni Roche, Nurse Manager, Rudy Lizama, Nurse Educator/Case Manager, Sheila Bennett, Clinical Director.

WHAT: Random infection control audits will be performed and then reviewed with staff. Staff that does not adhere to CDC and NKC standards will be placed in disciplinary action.

WHEN: Staff education and return demonstration showing an understanding of infection control practices for all WSKC staff will be completed by Aug. 15, 2013. Ongoing monthly infection control audits will be performed and reviewed at the monthly QAPI meetings. Audit results will be communicated to all staff. Ongoing infection control competencies will be completed on all staff annually.

Received 7/15/13

SB

V 413 494.60(d)(3) PE-ER EQUIP ON PREMISES-02, AED, SUCTION

HOW: During the survey it was noted that 3 of 5 oxygen bottles located adjacent to the nurse's station were not properly secured in storage racks/stands. Only 2 portable oxygen bottles are needed and will be kept in the 2 storage racks. The 3 additional oxygen bottles were immediately removed from the unit on June 26, 2013.

WHO: Roseni Roche, Nurse Manager and Isa Abdus Salaam, Facility Systems Specialist

WHAT: No more than 2 portable oxygen bottles will be kept in the unit and in storage racks. Checking that oxygen bottles are secured in the racks was added to the daily emergency check-list.The Nurse Manager and Facility Systems Specialist will review and sign off on the emergency check-list monthly.

WHEN: This was corrected on June 26, 2013.

SB

V 417 494.60(e)(1) PE-FIRE SAFETY-LIFE SAFETY

HOW: On June 26, 2013 it was noted that two of the four fire extinguishers had not been checked since April 2013. This was an oversight on the part of the Facility System Specialist in the month of May 2013. The requirement is that inspection is required monthly. The fire extinguishers will be checked monthly by the Facility Systems Specialist.

WHO: Roseni Roche, Nurse Manager and Isa Abdus-Salaam.

WHAT: Monthly checking of the fire extinguishers will be added to the Monthly Emergency Equipment and Supply Audit completed by the Nurse Manager and Facility Systems Specialist. The audit form will be reviewed at the monthly QAPI meeting with the Medical Director.

WHEN: The audit form was changed on July 10, 2013 to include checking the fire extinguishers and will be reviewed at the next QAPI meeting on August 22, 2013.

SB

V 544 494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE

HOW: Review of the medical records and interview on June 26, 2013 revealed multiple occurrences of failure to follow the physician orders for heparin, blood flow and treatment time. There was no supporting documentation stating a reason for the changes. This will be corrected through staff education and close monitoring of all treatment parameters including heparin, blood flow and treatment time by the Charge Nurse and Nurse Manager.

WHO: Roseni Roche, Nurse Manager, Sheila Bennett, Clinical Director, all West Seattle Kidney Center Charge Nurses.

WHAT: Staff education will be done to include correct calculation of heparin dosage and documentation of the reasons why the dialysis prescription wasn't followed. The Charge Nurse will ensure that adequate documentation is complete prior to closing the dialysis session in the electronic medical record. The Nurse Manager and/or Clinical Director will complete random chart audits at least monthly and communicate results to the clinical staff. Disciplinary action will be initiated if staff do not follow the dialysis prescription and do not document a reason. Staff audits and progress will be reviewed at the monthly QAPI meeting with the Medical Director.

WHEN: The first audit including a random sample of a dialysis session of 9 of 81 patients and representing 9 different staff members was completed on July 7, 2013. Staff education will be completed by July 31, 2013. Staff disciplinary action will start August 1, 2013 if necessary. Audits will continue monthly on an ongoing basis.

V 558 494.90(b)(2) POC-IMPLEMENT UPDATE-15 DAYS P PT ASSESS

How: Review of medical records on June 26, 2013 revealed failure to insure the patient's plan of care was implemented within 15 days of the initiation of the Comprehensive Interdisciplinary Assessment. NKC policy on Comprehensive Assessment and Plan of Care was updated by the Operations Committee in March 2013 to comply with the Conditions for Coverage. All dieticians (RD's) and social workers (MSW's) and nephrologists were notified of this policy change. Care Plans will reflect this change.

WHO: Mary McHugh, Vice President and Dr. Ahmad, Chief Medical Officer.

WHAT: A tracking tool has been developed to track all completion dates. The Case Manager will complete the form every month and submit it to the Nurse Manager.

When: August 26, 2013

SB

V 628 494.110(a)(2) QAPI-MEASURE/ANALYZE/TRACK QUAL INDICATORS

HOW: The Dialysis Facility Report will be reviewed at the QAPI meeting and documentation will show the data has been reviewed, analyzed and action plans developed to improve outcomes where needed.

WHO: Roseni Roche, Nurse Manager, Sheila Bennett, Clinical Director, Dr. Eric Anderson, Medical Director.

WHAT: The QAPI minutes will be reviewed after completion by the Director of Quality and Infection Control and Employee Health and if acceptable submitted to the Operations Committee.

WHEN: The review of the DFR will be completed at first QAPI meeting following receipt and analyzed and action plans developed to improve outcomes where needed by the second QAPI meeting following receipt.

SB

V 726 494.170 MR-COMPLETE, ACCURATE, ACCESSIBLE

HOW: This will be accomplished using the same plan as given for V 544 494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE. In addition to this plan, staff will be instructed to record heparin hourly rather than every 30 minutes because the size of syringes makes it difficult to read accurately.

WHO: Roseni Roche, Nurse Manager and Sheila Bennett, Clinical Director

WHAT: The monthly record audits will include verifying heparin is recorded only hourly.

WHEN: August 26, 2013

SB

Plan of Correction for WSKC
Provider number 502523
Page 1

V 113 494.30(a)(1) IC-WEAR GLOVES/HAND HYGEINE

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WHEN: The first audit including a random sample of a dialysis session of 9 of 81 patients and representing 9 different staff members was completed on July 7, 2013. Staff education will be completed by July 31, 2013. Staff disciplinary action will start August 1, 2013 if necessary. Audits will continue monthly on an ongoing basis.

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When: August 26, 2013

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WHO: Roseni Roche, Nurse Manager, Sheila Bennett, Clinical Director, Dr. Eric Anderson, Medical Director.

WHAT: The QAPI minutes will be reviewed after completion by the Director of Quality and Infection Control and Employee Health and if acceptable submitted to the Operations Committee.

WHEN: The review of the DFR will be completed at first QAPI meeting following receipt and analyzed and action plans developed to improve outcomes where needed by the second QAPI meeting following receipt.

V 726 494.170 MR-COMPLETE, ACCURATE, ACCESSIBLE

HOW: The root cause analysis showed that some staff can't calculate the total heparin dose correctly, the 20 cc syringes are hard to read when recording heparin every half hour, many heparin doses were less than 1,000 unit increments and machines were not consistently set correctly. All staff will be given 2 test questions to determine if they can calculate the correct amount of heparin for the treatment. Results will be reviewed with staff and instruction given as necessary. Staff will be reminded to only record heparin hourly. Dr. Ahmad CMO, met with the medical staff on 7/11/2013 to discuss changing the heparin protocol to be in increments of 1,000 units. The nurses will be instructed to not accept doses less than 1,000 units. The case manager and unit manager will check current heparin doses and request dose changes to meet the new protocol.

WHO: Roseni Roche, Nurse Manager and Sheila Bennett, Clinical Director

WHAT: The charge nurses will check the heparin setting on the machine against the Rx. and correct if necessary during rounds for each treatment. A QIR will be completed for errors. The unit manager will complete a weekly heparin audit x4 and then monthly on an ongoing basis. If results show less than 100% correctness, individual staff counseling will be done.

WHEN: August 26, 2013

V 638 494.110(b) QAPI-MONITOR/ACT/TRACK/SUSTAIN IMPROVE

HOW: The review process of the annual DFR will be revised in 2013 based on our review of the 2008-2011 Dialysis Facility Report that was completed on August 30 2012.

WHO: The interdisciplinary team including Medical Director, Nursing, MSW and RD.

WHAT: A root cause analysis will be completed for quality measures that are not meeting the acceptable range of the national average. Trends will be identified and action plans developed. The action plan will be evaluated at the designated time frame in the QAPI meeting for effectiveness, to assure sustainability of improvement. All QAPI minutes and action plans will be submitted to the Operations Committee.

WHEN: The Dialysis Facility Report will be reviewed at the first QAPI meeting following receipt of report. The root cause analysis, trends and action plans will be done by the second QAPI meeting following receipt of the Dialysis Facility Report.