STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	052536	A. BUILDING ______ B. WING ______	R 04/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAN DIEGO DIALYSIS SERVICES, INC	**303 WEST 26TH STREET NATIONAL CITY, CA 91950**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{V 000}	INITIAL COMMENTS The following represents the findings of the Department of Public Health during a recertification revisit survey conducted on 4/13/11. The facility census at the time of the survey was 120 hemodialysis patients. Representing the Department were: Health Facility Evaluator Nurse (HFEN) 22383 and HFEN 15932. Glossary of Terms CCHT Certified Clinical Hemodialysis Technician CM Clinic Manager	{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: Based on observation, interview and record review, the facility failed to ensure staff used gloves when touching a dialysis machine that was in use. The facility failed to ensure a television was disinfected after a dialysis treatment. Findings: 1. On 4/13/11 at 1:15 P.M., CCHT 1 touched the dialysis machine at station 16 with ungloved hands as Patient 2 received treatment.	V 113		4/29/11

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 CCHT 1 stated during an interview on 4/13/11 at 1:18 P.M., "I had the gloves in my hand when I touched the machine." The facility policy titled Personal Protective Equipment:Gloves, issued 10/10/08, read in part, "Disposable gloves must be used: When touching any part of the dialysis machine or equipment at the dialysis station while a patient is connected." 2. When Patient 2 completed his dialysis treatment on 4/13/11 at 1:25 P.M., CCHT 1 failed to disinfect the TV located at the station. CCHT 1 stated during an interview on 4/13/11 1:30 PM, "I have to wipe it. I forgot. Thank you." The facility policy titled Cleaning Individual Patient Televisions and Direct Touch Systems, issued 10/10/08, read in part, "The television shall be cleaned after each patient use."	V 113		
{V 122}	494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [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: Based on observation, interview and record review, the facility failed to ensure staff maintained contaminated items separate from	{V 122}		

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{V 122}	Continued From page 2 clean items. Findings: On 4/13/11 at 12:55 P.M., RN 1 was observed with ungloved hands, removing a sheet of paper from the top of a dialysis machine at Station 2, as Patient 1 received dialysis. RN 1 then sat the paper on the blanket Patient 1 used to cover her legs. Without sanitizing her hands, RN 1 typed on the computer at Station 2, picked up the paper from the blanket and carried it to the medication preparation counter and began writing on it. She then took the paper to the copier and made a copy. RN 1 acknowledged during an interview on 4/13/11 at 1:03 P.M., the medication area was a "clean area." She further stated that, "I found the paper on top of the machine and just took it off quickly." The facility policy titled Dialysis Precautions, issued 10/10/08, read in part, "The patient treatment area shall have designated "clean" and "dirty" areas. Clean area: An area designated for clean and unused equipment and supplies and medications..." and "Dirty area: An area where there is a potential for contamination with blood or body fluids...Examples of dirty areas include the laboratory preparation area and the entire patient station while the patient is dialyzing."	{V 122}		