

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 630012930	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/11/2011
NAME OF PROVIDER OR SUPPLIER HAYWARD MISSION HILLS DIALYSIS		STREET ADDRESS, CITY, STATE, ZIP CODE 1663 INDUSTRIAL PARK W HAYWARD, CA 94544		
(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) COMPLETE DATE
L 000	<p>Initial Comments</p> <p>The following reflects the findings of the California Department of Public Health during an initial licensing visit conducted on 3/11/2011.</p> <p>Representing the Department: Dorothy Rice, HFEN.</p> <p>No deficiencies were identified under CFR part 494, Condition for Coverage, for End Stage Renal Disease Facilities.</p> <p>No deficiencies were identified under Title 22 for Specialty Clinics.</p> <p>There were 20 hemodialysis stations approved (including an isolation room).</p>	L 000		

Licensing and Certification Division

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE