STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	552672	A. BUILDING ______ B. WING ______	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWARD MISSION HILLS DIALYSIS	**1663 INDUSTRIAL PARK W HAYWARD, CA 94544**

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V 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an Initial Certification survey conducted on 4/8/2011. Representing the Department : Dorothy Rice, HFEN. Two deficiencies were issued.	V 000		
V 319	494.50(b)(1) ENVIRONMENTAL SAFETY REGARDING CHEMICALS 8.5 Environmental safety: regarding chemicals The dialysis facility shall have written procedures for safe storage and handling of chemicals used in reprocessing (see National Institute for Occupational Safety and Health [NIOSH]/OSHA, 1980; Sax, 1979; material safety data sheets [MSDS]). This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that one (Reuse Technician) of one staff interviewed was knowledgeable about the procedures for containing minor and major spills of Renalin (strong germicidal agent used in disinfecting dialyzer-artificial kidneys). This failure placed patients and staff at risk for injury in case of a Renalin spill. Findings: During on-site visit on 4/8/11 observation revealed that the facility utilized peracetic acid (Renalin) disinfectant to reprocess dialyzers (artificial kidneys).	V 319		

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 319	Continued From page 1	V 319		

The facility policy titled, "Peracetic Acid Concentrate Spill Procedure", revised September, 2010 instructed the staff:
"Small spills of 1 quart or less of concentrate, teammates (staff) may contain spill.
Large spills of greater than 1 quart of concentrate, call Fire Department and Hazardous Material personnel.
Reuse teammate should perform Drager Air Test if small spill of Peracetic Acid occurs. If air testing results are elevated, teammate should not attempt to clean spill. Fire Department and Hazardous Material Personnel are to be contacted to clean spill.

The policy further instructed staff in case of a Renalin spill on the floor or counters:
"Neutralize spill with bicarbonate powder. Wait three (3) minutes.
Use wet mob or sponge and carefully soak up spill.
Flush to drain, diluting approximately 1:1 with water. Rinse out mop or sponge.
Wash down the area and allow to dry.
All material wetted with peracetic acid will be placed in unsealed, clean trash bags and discarded as appropriate.
Remove any contaminated clothing immediately and immerse in water. Wash as soon as possible.
Teammates are to seek medical attention if eye exposure occurs. In the event of skin contact, wash affected area with large amounts of water."

On 4/8/11 at approximately 1:04 p.m., the surveyor asked the Reuse Technician to describe the procedure he would use if there was a

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V 319	Continued From page 2 Renalin spill on the floor. The Reuse Technician stated that he would wear the appropriate personal protective clothing, but only alluded to containing the spill on the floor with bicarbonate. When the surveyor asked if there were any additional steps to the procedure, the Reuse Technician added that he would notify administration. When the surveyor asked if there was a different procedure utilized for a small Renalin spillage versus a large Renalin spillage, the Reuse Technician again stated that he would contain the spillage, but was unable to verbalize the steps required.	V 319		
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 interview and record review, the facility failed to maintain complete medical records that included the accurate amount of saline solution given during the intravenous administration of Epogen (red blood cell stimulating medication) and Hectorol (Vitamin D preparation medication) during treatment for two of two patient records reviewed. (Patients 1, 2) This practice increased the risk of blood backing up into the saline line and the risk of medications mixing.	V 726		

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V 726	Continued From page 3 Findings: Facility policy on "Administration of Epogen", dated March 2010, was reviewed on 4/8/11 and instructed staff to flush the infusion line with 50 ml (milliliters) of saline solution prior to the administration of Epogen and then again after the drug was infused, and to document the administration of Epogen and saline. The facility policy for "Administration of Parenteral Medications [Non-EPO]", dated September 2010, instructed staff to flush the line with 50 ml saline prior to and after medication was administered. The policy also stated, "If more than one medication is being administered, flush saline line with 50 ml of saline between each medication" and, "Document administration of the medication and saline flush.." On 4/8/11 observation showed that Clinical Coordinator administered Epogen and Hectorol to Patient 1 and Patient 2 in accordance to the above policy and procedure. Review of the clinical records showed that both Patient 1 and Patient 2 had physician orders for Epogen and Hectorol to be given during treatment. However, the flowsheets dated 3/25/11, 3/28/11, 3/30/11, 4/1/11, 4/4/11, and 4/6/11 for Patient 1 showed documented only 100 ml saline being administered instead of the 150 ml required by the facility policy and procedure. Patient 2's flowsheets, dated 3/25/11, 3/28/11, 3/30/11, 4/4/11, and 4/6/11, showed only 100 ml of saline documented as being given instead of the 150 ml required.	V 726		

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V 726	Continued From page 4 Clinical Coordinator and Clinical Service Specialist confirmed the findings on 4/8/11.	V 726		