ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555772	A. BUILDING _____ B. WING _____	10/10/2011

ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
:SERT MANOR	8515 CHOLLA AVE YUCCA VALLEY, CA 92284

(4) 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
A 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of an entity reported incident. Entity reported incident: CA00281672 Representing the Department: 28907, HFEN. The inspection was limited to specific entity reported incidents and does not represent the findings of a full inspection of the facility. No deficiencies were issued for complaint number CA00281672	A 000		

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LIC. & CERT.
SAN BERNARDINO COUNTY

STATE DEPT. OF PUBLIC HEALTH

eficiencies are cited, an approved plan of correction is requisite to continued program participation.

IORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Adm.		10-13-11

10/21/11 DW