

**STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION**

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

555585

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY COMPLETED

4/7/11

NAME OF FACILITY

SAN Diego Healthcare

STREET ADDRESS, CITY, STATE, ZIP CODE

2828 Meadowlark Dr. San Diego, CA

(X4) ID
PREFIX
TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY SHOULD BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID
PREFIX
TAG

PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS
REFERRED TO THE APPROPRIATE DEFICIENCY)

(X5)
COMPLETION
DATE

THE FOLLOWING REFLECTS THE FINDINGS OF THE
CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
DURING THE INVESTIGATION OF COMPLAINT/SELF-
REPORTED EVENT

Complaint # CA 00263752

THE INVESTIGATION WAS LIMITED TO THE SPECIFIC
COMPLAINT/SELF-REPORTED EVENT INVESTIGATED
AND DOES NOT REPRESENT THE FINDINGS OF A FULL
INSPECTION OF THE FACILITY.

REPRESENTING THE DEPARTMENT OF PUBLIC HEALTH:

[REDACTED]

NO DEFICIENCIES IDENTIFIED FROM THIS
INVESTIGATION.

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 reverse for further instructions.) The findings must be corrected within 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

[Signature]

TITLE

Executive Director

(X6) DATE

4/07/2011