California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA240000154	A. BUILDING _____ B. WING _____	C 07/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PACIFICA CONVALESCENT HOSPITAL	3662 PACIFIC AVENUE RIVERSIDE, CA 92509

(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
A 000	Initial Comments The following reflects the findings of the Califoria Department of Public Health during the investigation of a complaint. Complaint number: CA00263195. Representing the Department of Public Health: Surveyor 16490/1549. The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. No deficiencies were issued for complaint number CA00263195.	A 000		

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Exec. Vice President — (X6) DATE: 9/26/11

STATE FORM 6899 EIXR11 If continuation sheet 1 of 1

DScala HFES 10/25/11