DEPARTMENT OF PUBLIC HEALTH
CENTERS FOR MEDICARE AND MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555136	A. BUILDING _____ B. WING _____	1/22/14

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Tovay Healthcare Center	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEEDED 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/[redacted] Complaint # CA00384323 THE INVESTIGATION WAS LIMITED TO THE SPECIFIC COMPLAINT/[redacted] INVESTIGATED AND DOES NOT REPRESENT THE FINDINGS OF A FULL INSPECTION OF THE FACILITY. REPRESENTING THE DEPARTMENT OF PUBLIC HEALTH: 17131 MFEN 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 stated above are disclosable 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/SUPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
CElamm	Rn	1/22/14