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PRINTED: 03/09/2012
FORM APPROVED

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CA030000530	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/26/2012
NAME OF PROVIDER OR SUPPLIER OAK RIDGE HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 310 OAK RIDGE DRIVE ROSEVILLE, CA 95661		
(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 California Department of Public Health during the investigation of entity reported incident number CA00293181. Representing the Department of Public Health; HFEN 2493/29583 The inspection was limited to the specific entity reported incident(s) investigated and does not represent the findings of a full inspection of the facility. The Department was unable to substantiate a violation of regulations.	A 000			

Licensing and Certification Division

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

Administrative TITLE

STATE FORM

0599

JURY11

(X6) DATE

2/17/12

If continuation sheet 1 of 1