Printed: 12/07/2012 FORM APPROVED OMB NO. 0938-0391

DEPART	MENT OF HEALTH	AND HUMAN SERVICE	ES			FORM	APPROVED 0038-0391
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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X2) PROVIDERSUPPLIER (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) WING	
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ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6)	DATE

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 instructions.) Except for nursing homes, the findings stated above are disclosable 90 days allowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 program participation.

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Printed: 10/08/2012

DEPART CENTER	MENT OF HEALTH	AND HUMAN SERV & MEDICAID SERV	ICES				FORM	: 11/26/2012 MAPPROVED), 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	· · · · · · · · · · · · · · · · · · ·	(X3) DATE S COMPLI	ETED
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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 instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For hursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days flowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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SBDO L&C 12/04/2012 08:57 024 Printed: 10/23/2012 FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER! (XX) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A. BUILDING C B, WING 05A208 10/23/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SHANDIN HILLS BEHAVIOR THERAPY CENTE 4164 NORTH 4TH AVENUE SAN BERNARDINO, CA 92407 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL (X4) ID PREFIX (XE) COMPLETION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) INITIAL COMMENTS F 000 FOOD The following reflects the findings of the California Department of Public Health during an abbreviated survey to investigate an entity reported incident. Entity reported incident number: CA00329124 Representing the California Department of Public Health: 23045 The investigation was limited to the specific entity reported incident investigated and does not represent the findings of a full inepaction of the facility. No deficiencies were issued for entity reported incident number: CA00329124

RROVINER BUPPLIER, REPRESENTATIVE'S SIGNATURE

Any deficiency statement ending with an asteriak ("I denotes a deficiency which the institution may be excused from correcting providing it is actormined that other sateguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are discloseble 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are discloseble 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program panicipation.

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Printed: 11/05/2012 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO 0938-0391 (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEPICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A BUILDING B. WING _ 06A208 10/30/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER SHANDIN HILLS BEHAVIOR THERAPY CENTE 4164 NORTH 4TH AVENUE SAN BERNARDINO, CA 92407 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) IO PREFIX COMPLETION DATE (X4) ID PREFIX TAG DAT F 000 INITIAL COMMENTS F 000 The following reflects the findings of the California Department of Public Health during an abbreviated survey to investigate an entity reported incident. Entity reported incident number: CA00313369 Representing the California Department of Public Health: 23045 SAN BERNARDINO COUNTY The investigation was limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the facility. No deficiencies were issued for entity reported incident number: CA00313369

Any deficiency statement ending with an asterick (*) 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 instructions.) Except for nursing homes, the findings stated above are disclosable 90 days days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 described program participation.

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(X6) DATE

PRINTED: 10/03/2012 FORM APPROVED

NAME OF PROVIDER OR SUPPLIER SHANDIN HILLS BEHAVIOR THERAPY CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 4164 NORTH 4TH AVENUE SAN BERNARDINO, CA 92407 (X5)		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	MBER:	(X2) MULTIP A. BUILDING B. WING	LE CONS'TRUCTION	(X3) DATE SU COMPLE	TED
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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 instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 deficiencies are cited, an approved plan of correction is requisite to continued

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

TITLE

(X8) DATE

Printed: 12/06/2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 09/24/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE ŜI COMPLE	TED	
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other safeg	uards provide sufficient e date of survey whethe	th an asterisk (*) denotes a deficience protection to the patients. (See instru- r or not a plan of correction is provide ments are made available to the facili	ictions.) Except for ed. For nursing hor	on may be excused from com- nursing homes, the findings s nes, the above findings and p	stated above are disclo- lans of correction are d	sable 90 days isclosable 14

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FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B, WING 09/24/2012 05A208 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4164 NORTH 4TH AVENUE SHANDIN HILLS BEHAVIOR THERAPY CENTE SAN BERNARDINO, CA 92407 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 000 F 000 INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a standard abbreviated survey. Intake number: CA00325783 Representing the Department of Public Health: 23045 No deficiencies were written for intake number: CA00325783

Any deficiency statement ending with an asterial contents a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

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

If continuation sheet Page 1 of 1

(X8) DATE

Printed: 09/24/2012

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	ER/CLIA MBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE SI COMPLE	URVEY (TED	
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Printed: 07/17/2012

FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE BURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED DENTIFICATION NUMBER: a. Building AND PLAN OF CORRECTION B. WINC 07/17/2012 05A2D8 STREET ADDRESS, CITY, STATE, ZIF CODE NAME OF PROVIDER OR SUPPLIER 4164 NORTH 4TH AVENUE SHANDIN HILLS BEHAVIOR THERAPY CENTE SAN BERNARDINO, CA 92407 (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF GORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX COEFIX TAG DEFICIENCY) F 000 INITIAL COMMENTS F 000 The following reflects the findings of the Department of Public Health during an abbreviated standard survey. Entity reported incident: CA00312674 Representing the department: 29492. HFEN The Inspection was limited to the specific entity reported event and does not represent the findings of a full inspection of the facility. No deficiencies were written as a result of entity reported incident CA0031264. ANDERWARDING COUNT (XB) DATE CYNERALIPPLIER PEPRESENTATIVE'S SIGNATURE Any deficiency statement anding with an actorick (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that officer safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosuble 90 days following the date of survey whether or not a plan of correction are disclosuble 14 days following the date these documents are made svallable to the facility. If deficiencies are cited, an experience of correction is regularite to continued program participation.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 09/17/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES	
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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

05A208

B. WING

09/17/2012

NAME OF PROVIDER OR SUPPLIER

SHANDIN HILLS BEHAVIOR THERAPY CENTE

STREET ADDRESS, CITY, STATE, ZIP CODE 4164 NORTH 4TH AVENUE SAN BERNARDINO, CA 92407

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(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-PEFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
F 000	INITIAL COMMENTS	F 000		
	The following reflects the findings of the California Department of Public Health during an abbreviated survey.			
	Intake number: CA00324835			
	Representing the Department of Public Health: 23045			
	No deficiencies were written for intake number: CA00234835	· warmen in the contract of th		
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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 instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Printed: 09/24/2012 FORM APPROVED

CENTERS FOR MEDICARE	& MEDICAID SERVI	CES		OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM 05A208		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 09/24/2012
NAME OF PROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STATE, ZIP CODE	

SHANDIN HILLS BEHAVIOR THERAPY CENTE

4164 NORTH 4TH AVENUE

X4) ID REFIX 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)	(XS) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
	The following reflects the findings of the California Department of Public Health during a standard abbreviated survey.			
	Intake number: CA00324820			
	Representing the Department of Public Health: 23045			
	No deficiencies were written for intake number: CA00324820	!		
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