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_____	7/7/11

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Poway Healthcare Center	15632 Pomerado Rd. Poway CA 92064

(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 an entity reported incident/complaint investigation. Complaint #: CA00274378 Category: Facility Reported Incident The investigation was limited to the specific entity reported incident/complaint and does not represent the findings of a full inspection of the facility. Representing the California Department Public Health: #29707 Health Facilities Evaluator Nurse No deficiencies were 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 t 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
[signature]	RN/DON	7/7/2011

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