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PRINTED: 10/05/2011
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056436	A. BUILDING _____ B. WING _____	08/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICAL CENTER CONV HOSP	467 E GILBERT ST SAN BERNARDINO, CA 92404

(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 a complaint. Complaint Intake #: CA00277568 Representing the Department of Public Health: 18928 The inspection was limited to the specific incident investigated and does not represent the findings of a full inspection of the facility. The allegation was unsubstantiated. No deficiencies issued for CA00277568	A 000		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Frederick D. Bannister — TITLE: Administrator — (X6) DATE: 11-29-11