

KH
5-21-12

PRINTED: 05/16/2012
FORM APPROVED

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CA030000029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/21/2012
NAME OF PROVIDER OR SUPPLIER WINE COUNTRY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 321 WEST TURNER ROAD LODI, CA 95240		
(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	<p>Initial Comments</p> <p>The following reflects the findings of the California Department of Public Health during the investigation of an entity reported incident #CA00300279</p> <p>Representing the Department of Public Health: HFEN 1452/14808</p> <p>Inspection was limited to the specific entity reported incident(s) investigated and does not represent the findings of a full inspection of the facility.</p> <p>The Department was unable to substantiate a violation of regulations.</p>	A 000			

Licensing and Certification Division

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

STATE FORM

6899

WCS211

TITLE

Administrator

(X6) DATE

5/17/12

If continuation sheet 1 of 1