

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CA110001194	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/08/2011
NAME OF PROVIDER OR SUPPLIER GRASS VALLEY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 360 CROWN POINT CIRCLE, SUITE 210 GRASS VALLEY, CA 95945		
(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	
L 000	<p>Initial Comments</p> <p>The following reflects the findings of the California Department of Public Health during the investigation of a complaint.</p> <p>Complaint: 255135</p> <p>The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.</p> <p>Representing the Department: HFEN 26654 and HFEN 27945</p> <p>No deficiencies were issued for complaint 255135.</p>	L 000			

Licensing and Certification Division

TITLE

(X6) DATE

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