

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CA930001400	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/09/2011
NAME OF PROVIDER OR SUPPLIER WEST COAST DIALYSIS CENTER, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3780 KILROY AIRPORT WAY SUITE 110 LONG BEACH, CA 90806		
(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 Department of Public Health during an Administrative Review of the entity reported incident.</p> <p>Representing the Department: K. Phinyo, RN, Supervisor, HFEN</p> <p>The inspection was limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the facility.</p> <p>Entity Reported Incident: CA00261671</p> <p>No deficiencies were issued for this entity reported incident.</p>	L 000			

Licensing and Certification Division

TITLE

(X6) DATE

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