

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>CA630011242</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/17/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>DOWNEY REGIONAL DIALYSIS CENTER, LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>8333 IOWA STREET, SUITE 100 DOWNEY, CA 90241</b>		
(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>Surveyor: 15727 The following reflects the findings of the Department of Public Health during an Initial Licensing Survey.</p> <p>Representing the Department of Public Health:</p> <p>Rosalinda Ramos, RN, HFEN Sylvia Villaflores, REHS, HFE</p> <p>No deficiencies noted.</p>	L 000		

Licensing and Certification Division

TITLE

(X6) DATE

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