

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/29/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052759	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/03/2009
NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE DIABLO CONCORD			STREET ADDRESS, CITY, STATE, ZIP CODE 508 D CONTRA COSTA BOULEVARD PLEASANT HILL, CA 94523		
(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) COMPLETION DATE	
V 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 22301 The following reflects the findings of the California Department of Public Health during the investigation of a complaint.</p> <p>Complaint number: CA00127707.</p> <p>Representing the Department: Lutgarda F. Sturms RN HFEN.</p> <p>The inspection was limited to the specific complaint investigated and does not reflect a full inspection of the facility.</p> <p>No deficiency was issued for Complaint number CA00127707.</p>	V 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.