

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 630012060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/01/2009
NAME OF PROVIDER OR SUPPLIER HESPERIA DIALYSIS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 14135 MAIN STREET, UNIT 501 HESPERIA, CA 92345		
(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>Surveyor: 18928 The following reflects the findings of the California Department of Public Health during an INITIAL LICENSURE visit conducted on 6/1/09.</p> <p>Representing the Department: Karen A. Eggleston, HFEN.</p> <p>All regulations met for Initial Licensure.</p> <p>Recommend Initial Licensure effective 6/1/09.</p>	A 000		

Licensing and Certification Division

TITLE

(X6) DATE

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