STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 054009 03/17/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **760 WESTWOOD PLAZA** RESNICK NEUROPSYCHIATRIC HOSPITAL AT UCLA LOS ANGELES, CA 90024 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 000 **Initial Comments** F 000 Surveyor: 17116 The following reflects the findings of the Department of Public Health during a complaint investigation. Complaint Number CA00143934 Inspection was limited to the specific complaints investigated, and does not represent the findings of a full inspection of the facility. Representing the Department of Public Health: , Health Facilities Evaluator, Nursing F 476 T22 DIV5 CH2 ART6-71507(a)(9) Patients' Rights (9) All other rights as provided by law or regulation.

Licensing and Certification Division

TITLE (X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		COMPLET	(X3) DATE SURVEY COMPLETED	
				B. WING		<b>I</b>	С	
054009			STREET ADDE	TREET ADDRESS, CITY, STATE, ZIP CODE				
NAME OF PROVIDER OR SUPPLIER  RESNICK NEUROPSYCHIATRIC HOSPITAL AT UCLA			760 WESTWOOD PLAZA LOS ANGELES, CA 90024					
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	CTION SHOULD BE COMPL OF THE APPROPRIATE DATE		
F 476	Continued From page 1							
			I					

Licensing and Certification Division #
STATE FORM

		1				<u> </u>		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED C	
	054009			B. WING		03/	17/2008	
				RESS, CITY, STA	TE, ZIP CODE	1 00/	1172000	
PESNICK NEUROPSYCHIATRIC HOSPITAL AT LICEA			760 WESTV	VOOD PLAZA LES, CA 9002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)		
F 476	Continued From page	e 2						
F 533	shall be reported to the accordance with Section Subchapter 1, Chapter Administrative Code. epidemic outbreak, praccident, disaster, other occurrence which the health of patients, per reported as soon as a by telephone or	ses or Unusual es of reportable diseas ne local health officer in tion 2500, Article 1, er 4, Title 17, California Any occurrence such oisoning, fire, major her catastrophe or unu eatens the welfare, saf reasonably practical, e legraph, to the local he partment. The hospital ritinent information rela the local health officer	n a sual fety or I be ither ealth shall ited to					

6899#

Licensing and Certification Division #
STATE FORM

			ER: STREET ADDRE	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  RESS, CITY, STATE, ZIP CODE  WOOD PLAZA		(X3) DATE SURVEY COMPLETED C 03/17/2008		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	RRECTIVE ACTION SHOULD BE COMPLETE ERENCED TO THE APPROPRIATE DATE		
F 533	Continued From page	÷ 3		F 533				

Licensing and Certification Division #