## Statement of Deficiencies and Plan of Correction

### A. Building _____________________________

#### (X1) Provider/Supplier/CLIA Identification Number:
- 345206

#### (X3) Date Survey Completed
- C 08/24/2016

### B. Wing _____________________________

#### (X4) ID Prefix Tag
- F 000

#### (X5) Completion Date
- F 000

### Summary Statement of Deficiencies

**(X4) ID Prefix Tag**
- F 000
**Summary Statement of Deficiencies**

No deficiencies were identified during the complaint survey completed 8/24/16 (Event ID 5YNY11).

### Provider's Plan of Correction

**ID Prefix Tag**
- F 000

**Provider's Plan of Correction**

(Each corrective action should be cross-referenced to the appropriate deficiency)

### Laboratory Director's or Provider/Supplier Representative's Signature

- 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.