**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**DATE SURVEY COMPLETED**

**DATE COMPLETED**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

**PROVIDER'S PLAN OF CORRECTION**

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

**Form CMS-2567(02-99) Previous Versions Obsolete CWQ411**

**Event ID: CWQ411**

**Facility ID: 923269**

**If continuation sheet Page 1 of 1**

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**An unannounced on-site complaint investigation survey was conducted on 7/13/20 through 7/17/20, and 14 of 14 complaint allegations were not substantiated for Event ID# CWQ411.**

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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.