Department of Health & Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0391

Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number** Unknown CMS Number	**(X3) Date Survey Completed** Unknown Date
Name of Provider or Supplier Unknown Facility	**Street Address, City, State** Unknown Address, Unknown City, Unknown State	
For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.		

(X4) ID Prefix Tag	**Summary Statement of Deficiencies** (Each deficiency should be preceded by full regulatory or LSC identifying information)
Unknown Tag	No deficiency details available.