

MA DPH/Division of Health Care Facility Licensure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4WSC	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/20/2019
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NAME OF PROVIDER OR SUPPLIER HEALTHQUARTERS, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 100 CUMMINGS CENTER, SUITE 131-Q BEVERLY, MA 01915
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(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
C 000	<p>INITIAL COMMENTS</p> <p>An onsite licensure renewal survey was conducted on 6/20/19 for the provision of medical services.</p> <p>Approval of the site is based on the Clinic's compliance with applicable requirements of 105 CMR 140.000: Licensure of clinics.</p> <p>Compliance was determined by surveyor observations, interviews and review of documentation submitted by the Clinic.</p> <p>Additional satellites visited on 6/27/19:</p> <p>280 Merrimack Street, Suite 501 Lawrence, MA 01840 Services: Medical</p> <p>215 Summer Street, Suite 16 Haverhill, MA 01830 Services: Medical</p>	C 000		

MA Division of Health Care Facility Licensure and Certification
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____