MA DPH/Division of Health Care Facility Licensure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44H1	A. BUILDING: _____ B. WING _____	R 09/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR WOMEN	**150 EMORY STREET GROUND FLOOR ATTLEBORO, MA 02703**

(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}	INITIAL COMMENTS A desk audit survey was completed as follow-up to an onsite licensure renewal survey conducted on 7/31/19. It was determined that the deficient practices associated with this survey event were corrected.	{C 000}		

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