

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 110748	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/12/2015
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NAME OF PROVIDER OR SUPPLIER NORTH DURHAM WOMEN'S HEALTH, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 400-B CRUTCHFIELD ST DURHAM, NC 27704
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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
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E 000	<p>INITIAL COMMENTS</p> <p>An announced initial licensure survey was conducted on 06/12/2015. No deficiencies cited. State Agency recommends licensure effective 06/12/2015.</p>	E 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____