

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  AB0024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/23/2015
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NAME OF PROVIDER OR SUPPLIER  EASTOWNE OB-GYN AND INFERTILIT	STREET ADDRESS, CITY, STATE, ZIP CODE 180 PROVIDENCE RD #3 CHAPEL HILL, NC 27514
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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 unannounced, onsite relicensure survey was conducted on July 23, 2015. No deficiencies were cited.</p>	E 000		
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Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X8) DATE
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