| **Statement of Deficiencies** | **(X1) Provider/Supplier/CLIA Identification Number**<br><br>23D0941535 | **(X3) Date Survey Completed**<br><br>01/02/2018 |
|---|---|---|
| **Name of Provider or Supplier**<br><br>Kevin J Gaffney Md Pc | **Street Address, City, State**<br><br>1352 S Linden Rd, Flint, MI | |

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** |
|---|---|
| **No Tags** | No deficiency details available. |