Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	35D0408215	01/03/2018
Name of Provider or Supplier	**Street Address, City, State**	
Chi Lisbon Health	905 Main St, Lisbon, ND	

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.