STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	8-2206	A. BLDG: 00 B. WING:	03/14/2016

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HILLCREST WOMEN'S MEDICAL CENTER STATE LICENSE NUMBER: **00098701**	**2709 NORTH FRONT STREET** **HARRISBURG, PA 17110**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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	(X5) COMPLETE DATE
M 0000	INITIAL COMMENT This report is the result of an Annual Registration survey conducted on march 14, 2016, at Hillcrest Women's Medical Center. It was determined the facility was in compliance with the requirements of the Pennsylvania Department of Health Regulations § 28 Pa Code, Chapter 29, Subchapter D, Ambulatory Gynecological Surgery in Hospitals and Clinics.	M 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE: (X6) DATE:

Certified End Page

HILLCREST WOMEN'S MEDICAL CENTER

STATE LICENSE NUMBER: 00098701

SURVEY EXIT DATE: 03/14/2016

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Christine C. Filipovich, MSN, RN

Christine C. Filipovich, MSN, RN
Deputy Secretary For Quality Assurance

Karen M. Murphy, PhD, RN

Karen M. Murphy, PhD, RN
Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY