

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FAS01031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/24/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PLANNED PARENTHOOD OF SOUTHERN NEW ENGL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>175 BROAD STREET PROVIDENCE, RI 02903</b>
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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
V 0	<p><b>INITIAL COMMENTS</b></p> <p>A change of location state inspection survey was conducted at this facility, and no deficiencies were identified.</p>	V 0		

Facilities Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_