

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>8-2206</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>05/13/2015</b>
NAME OF PROVIDER OR SUPPLIER: <b>HILLCREST WOMEN'S MEDICAL CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2709 NORTH FRONT STREET HARRISBURG, PA 17110</b>		
STATE LICENSE NUMBER: <b>00098701</b>				
(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)	(X5) COMPLETE DATE
M 0000	INITIAL COMMENT  This report is the result of unannounced complaint investigation CHL15C529H conducted on May 13, 2015, 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: 05/13/2015**

**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*



THIS IS A CERTIFICATION PAGE

**PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY