

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-3903	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/12/2019
NAME OF PROVIDER OR SUPPLIER: ALLENTOWN WOMENS' CENTER, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE: 31 SOUTH COMMERCE WAY, SUITE 100 BETHLEHEM, PA 18017		
STATE LICENSE NUMBER: 00038701				
(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
S 0000	INITIAL COMMENT This report is the result of a revisit survey completed on March 12, 2019, following a previous State licensure survey conducted on September 26, 2018, at Allentown Women's Center. It was determined the facility was in compliance with the requirements of the Pennsylvania Department of Health's Rules and Regulations for Ambulatory Care Facilities, Annex A, Title 28, Part IV, Subparts A and F, Chapters 551-573, November 1999.	S 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:



Certified End Page

ALLENTOWN WOMENS' CENTER, INC.

STATE LICENSE NUMBER: 00038701

SURVEY EXIT DATE: 03/12/2019

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

Handwritten signature of Susan Coble in black ink on a light gray background.

Susan Coble
Deputy Secretary for Quality Assurance

Handwritten signature of Rachel L. Levine, MD in black ink on a light gray background.

Rachel L. Levine, MD
Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY