

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TNPL53526</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>04/03/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>KNOXVILLE CENTER FOR REPRODUCTIVE HEALTH</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1547 WEST CLINCH AVENUE KNOXVILLE, TN 37916</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 DEFICIENCY)	(X5) COMPLETE DATE
{A 001}	1200-8-10 Initial  A desk review for the Plan of Correction (POC) was conducted for all previous deficiencies cited on 3/5/19. All deficiencies have been corrected and no new noncompliance was found. The facility is in compliance with all regulations surveyed.	{A 001}		

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

TITLE

(X6) DATE