

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNPL53526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN B. WING _____	(X3) DATE SURVEY COMPLETED 06/18/2018
--	--	--	---

NAME OF PROVIDER OR SUPPLIER KNOXVILLE CENTER FOR REPRODUCTIVE HI	STREET ADDRESS, CITY, STATE, ZIP CODE 1547 WEST CLINCH AVENUE KNOXVILLE, TN 37916
---	---

(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 002	1200-8-10 No Deficiencies During the Life Safety portion of the licensure survey conducted on 6/18/18, no deficiencies were cited under 1200-8-10, Standards for Ambulatory Surgical Treatment Facilities.	A 002		
-------	---	-------	--	--

Division of Health Care Facilities

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

Kim Jensen

TITLE

Administrator

(X6) DATE

7/9/18