

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TNPL53544</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>77 - MEMPHIS CENTER FOR REPRODUCTIVE HEALTH</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/17/2018</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MEMPHIS CENTER FOR REPRODUCTIVE HEA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1726 POPLAR AVENUE MEMPHIS, TN 38104</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
A 002	<p>1200-8-10 No Deficiencies</p> <p>This Rule is met as evidenced by: During the annual survey on 10/17/18, this facility was found to be in compliance with the Life Safety Code requirements of the Tennessee Department of Health, Board for Licensing Health Care Facilities, Chapter 1200 -8-10, Standards for Ambulatory Surgical Treatment Centers.</p>	A 002		

Division of Health Care Facilities LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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