

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-6704	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/06/2019
NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD KEYSTONE - YORK		STREET ADDRESS, CITY, STATE, ZIP CODE: 728 SOUTH BEAVER STREET YORK, PA 17401		
STATE LICENSE NUMBER: 00198701				
(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 an occupancy survey conducted on August 6, 2019 at Planned Parenthood Keystone-York which included adding TeleMedication Abortion. Based on the occupancy survey, it was determined the facility was in compliance with all applicable 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.	M 0000		

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

TITLE:

(X6) DATE:



Certified End Page

PLANNED PARENTHOOD KEYSTONE - YORK

STATE LICENSE NUMBER: 00198701

SURVEY EXIT DATE: 08/06/2019

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 cursive.

Susan Coble
Deputy Secretary for Quality Assurance

Handwritten signature of Rachel L. Levine, MD in cursive.

Rachel L. Levine, MD
Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY