Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING: **01 - MEMPHIS REGIONAL PLANNED PARENTHOOD** B. WING _____	R **11/19/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS	**2430 POPLAR AVE MEMPHIS, TN 38104**

(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 This Rule is met as evidenced by: A Life Safety revisit survey was conducted on 11/19/2018 for all previous deficiencies cited on 10/19/2018. All deficiencies have been corrected, and no new non compliance was found. The facility is in compliance with all regulations surveyed.	{A 001}		