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 _____ B. WING _____	04/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF TENNESSEE ANI	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: An annual health licensure survey was conducted on 4/22/19. An entrance conference was held on 4/22/19 at 8:00 AM with the Clinical Manager. An exit conference was held on 4/22/19 at 3:30 PM with the Clinical Manager.	A 001		
A 002	1200-8-10 No Deficiencies This Rule is met as evidenced by: An annual licensure survey was conducted at this facility on 4/22/19. This facility complies with all Standards reviewed for Ambulatory Surgical Treatment Center Facilities.	A 002	This is for your records. You do not have to return this state form. Ce	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE