

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5130	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/20/2019
NAME OF PROVIDER OR SUPPLIER: PPSP SURGICAL LOCUST STREET HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1144 LOCUST STREET PHILADELPHIA, PA 19107		
STATE LICENSE NUMBER: 00238701				
(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
S 0000	INITIAL COMMENT This report is the result of an unannounced onsite revisit survey conducted on March 20, 2019, following a state licensure survey conducted on September 11, 2018, at Ppsp Surgical Locust Street Health Center. It was determined the facility was in compliance with the 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.	S 0000		

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

TITLE:

(X6) DATE:



Certified End Page

PPSP SURGICAL LOCUST STREET HEALTH CENTER

STATE LICENSE NUMBER: 00238701

SURVEY EXIT DATE: 03/20/2019

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