

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5143	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/19/2019
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NAME OF PROVIDER OR SUPPLIER: PHILADELPHIA WOMEN'S CENTER, INC. STATE LICENSE NUMBER: 00178701	STREET ADDRESS, CITY, STATE, ZIP CODE: 777 APPLETREE STREET, 7TH FLOOR PHILADELPHIA, PA 19106
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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	(X5) COMPLETE DATE
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M 0000	<p>INITIAL COMMENT</p> <p>This report is the result of an unannounced Special Monitoring survey completed on June 19, 2019, at Philadelphia Women's Center. It was determined the facility was in compliance with the requirements of the Pennsylvania Department of Health Regulations § 28 Pa Code, Chapter 29, Subchapter D, Ambulatory Gynecological Surgery in Hospitals and Clinics.</p>	M 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:

Pennsylvania Department of Health

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S 0000	INITIAL COMMENT This report is the result of an unannounced onsite Special Monitoring survey completed on June 19, 2019, at Philadelphia Women's 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

PHILADELPHIA WOMEN'S CENTER, INC.

STATE LICENSE NUMBER: 00178701

SURVEY EXIT DATE: 06/19/2019

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