

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-1507	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/05/2019
NAME OF PROVIDER OR SUPPLIER: PPSP WEST CHESTER HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 8 SOUTH WAYNE STREET WEST CHESTER, PA 19382		
STATE LICENSE NUMBER: 00208701				
(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 occupancy survey conducted onsite (at the distant site location) on September 6, 2019, and offsite December 5, 2019 for PPSP WestChester, which included addition of Telemedicine Services, it was determined the facility was in compliance with all applicable requirements of the Pennsylvania Department of Health's Rules and Regulations for Hospitals, 28 Pa Code, Part IV, Subparts A and B, November 1987, as amended June 1998 and the current edition of the Guidelines for Design and Construction of Hospital and Health Care Facilities.	S 0000		

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

TITLE:

(X6) DATE:



Certified End Page

PPSP WEST CHESTER HEALTH CENTER

STATE LICENSE NUMBER: 00208701

SURVEY EXIT DATE: 12/05/2019

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