

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/29/2020</b>	
NAME OF PROVIDER OR SUPPLIER: <b>PLANNED PARENTHOOD KEYSTONE - WILKES BARRE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>101 NORTH MAIN STREET, SUITE 201 WILKES BARRE, PA 18701</b>		
STATE LICENSE NUMBER: <b>35BB8701</b>				
(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
M 0000	<p>INITIAL COMMENT</p> <p>This report is the result of an Initial Registration survey conducted on January 13, 2020 and January 29, 2020, at Planned Parenthood Keystone-Wilkes Barre. 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		

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

TITLE:

(X6) DATE:



# Certified End Page

**PLANNED PARENTHOOD KEYSTONE - WILKES BARRE**

**STATE LICENSE NUMBER: 35BB8701**

**SURVEY EXIT DATE: 01/29/2020**

**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