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| 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: 08/05/2020 |
| NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD OF WESTERN PENNSYLVANIA, INC. | | STREET ADDRESS, CITY, STATE, ZIP CODE: 933 LIBERTY AVENUE PITTSBURGH, PA 15222 | | |
| STATE LICENSE NUMBER: 00248701 | | | | |
| (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 unannounced Special Monitoring Survey conducted on August 05, 2020, at Planned Parenthood of Western Pennsylvania. 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 | | |

(X6) DATE:



Certified End Page

PLANNED PARENTHOOD OF WESTERN PENNSYLVANIA, INC.

STATE LICENSE NUMBER: 00248701

SURVEY EXIT DATE: 08/05/2020

**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 Alison V. Beam in cursive.

Alison V. Beam
Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY