

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: 10/14/2020
NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD KEYSTONE - HARRISBURG			STREET ADDRESS, CITY, STATE, ZIP CODE: 1514 NORTH SECOND STREET HARRISBURG, PA 17102		
STATE LICENSE NUMBER: 3N8L8701					
(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 Annual Licensure survey conducted on October 14, /2020, at Planned Parenthood Keystone - Harrisburg. 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:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:
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PLANNED PARENTHOOD KEYSTONE - HARRISBURG

STATE LICENSE NUMBER: 3N8L8701

SURVEY EXIT DATE: 10/14/2020

**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**

A handwritten signature in cursive script that reads "Susan Coble".

Susan Coble
Deputy Secretary for Quality Assurance

A handwritten signature in cursive script that reads "Alison V. Beam".

Alison V. Beam
Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY