

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: 07/20/2020 |
|---|--|--|--|--|
| NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD KEYSTONE - ALLENTOWN | | STREET ADDRESS, CITY, STATE, ZIP CODE: 29 NORTH 9TH STREET ALLENTOWN, PA 18101 | | |
| STATE LICENSE NUMBER: 00218701 | | | | |
| (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 | INITIAL COMMENT This report is the result of an Annual Registration survey conducted on July 20, 2020, at Planned Parenthood Keystone-Allentown. 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. | M 0000 | | |

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

TITLE:

(X6) DATE:



Certified End Page

PLANNED PARENTHOOD KEYSTONE - ALLENTOWN

STATE LICENSE NUMBER: 00218701

SURVEY EXIT DATE: 07/20/2020

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 black ink.

Susan Coble
Deputy Secretary for Quality Assurance

Handwritten signature of Alison V. Beam in black ink.

Alison V. Beam
Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY