

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-4613	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/10/2020
NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD SOUTHEASTERN PENNSYLVANIA		STREET ADDRESS, CITY, STATE, ZIP CODE: 1221 POWELL STREET NORRISTOWN, PA 19401		
STATE LICENSE NUMBER: E8RT8701				
(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 unannounced Special Monitoring survey conducted on December 10, 2020. 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 SOUTHEASTERN PENNSYLVANIA

STATE LICENSE NUMBER: E8RT8701

SURVEY EXIT DATE: 12/10/2020

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