PRINTED: 08/31/2020 FORM APPROVED

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED			
011133				B. WING		08/	08/18/2020		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	T ADDRESS, CITY, STATE, ZIP CODE					
CLINIC FO	R WOMEN		B.	16TH ST STE 2B APOLIS, IN 46222					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CORRESTRICTION OF THE APPROPRIATE DEFICIENCY)			
D 000	INITIAL COMMENTS			D 000					
	This visit was for a licensure survey.								
	Facility Number: 011133								
	Survey Date: 8-17-20 and 8-18-20								
	Clinic for Women, is in compliance with 410 IAC 26.5, Abortion Clinics Performing Drug Induced Abortions Licensure Rules.								
	QA: 8/30/20								
If deficiencies	are cited, an approved plan	of correction is requisite to	continued progra	am narticination			•		

STATE FORM 021199 L4E611 If continuation sheet 1 of 1

TITLE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB	CLIA ER:	1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
011133				B. WING	***************************************	08/1	08/18/2020	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
CLINIC FO	R WOMEN			THIST STE 2B DLIS, IN 46222				
(X4) ID PREFIX TAG	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
T 000	This visit was for a lice 8-1 Facility Number: 011 Survey Date: 8-17-26	ensure survey.  133  0 and 8-18-20  in compliance with 410		T 000			DATE	

If deficiencies are cited, an approved plan of correction is requisite to continued program participation. LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATE FORM 021199 L4E611 If continuation sheet 1 of 1