

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011117	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/02/2020
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD OF INDIANA AND KENTUCKY IN			STREET ADDRESS, CITY, STATE, ZIP CODE 421 S COLLEGE AVE BLOOMINGTON, IN 47403		
(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 DEFICIENCY)	(X5) COMPLETE DATE	
D 000	<p>INITIAL COMMENTS</p> <p>This visit was for a licensure survey.</p> <p>Facility Number: 011117</p> <p>Survey Date: 9-1-2020</p> <p>Planned Parenthood Of Indiana And Kentucky, is in compliance with 410 IAC 26.5, Abortion Clinics Performing Drug Induced Abortions Licensure Rules.</p> <p>QA: 9/11/20 and 9/17/20</p>	D 000			

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

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T 000	<p>INITIAL COMMENTS</p> <p>This visit was for a licensure survey.</p> <p>Facility Number: 011117</p> <p>Survey Date: 9-2-2020</p> <p>Planned Parenthood Of Indiana And Kentucky, is in compliance with 410 IAC 26, Licensure Rules for Clinics Performing Surgical Abortions.</p> <p>QA: 9/11/20 and 9/17/20</p>	T 000			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
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