Indiana State Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 013765 | A. BUILDING: ______ B. WING ______ | 09/14/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLANNED PARENTHOOD OF INDIANA AND KENTUCK | 964 MEZZANINE DR<br>LAFAYETTE, IN 47905 |

| (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 | INITIAL COMMENTS<br><br>This visit was for a licensure survey.<br><br>Facility Number: 013765<br><br>Survey Date: 9-14-2020<br><br>Planned Parenthood Of Indiana And Kentucky, is in compliance with 410 IAC 26.5, Abortion Clinics Performing Drug Induced Abortions Licensure Rules.<br><br>QA: 9/17/20 | D 000 | | |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE   TITLE   (X6) DATE