

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 923175 AB0009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/03/2021
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NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD OF WINSTON SALEM	STREET ADDRESS, CITY, STATE, ZIP CODE 3000 MAPLEWOOD AVE STE 112 WINSTON-SALEM, NC 27103
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(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
E 000	<p>Initial Comments</p> <p>An onsite survey was conducted on conducted November 3, 2021 in order to determine compliance with NC Rules governing Certification of Abortion Clinics. No deficiencies were cited.</p>	E 000		

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