

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>AB0032</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/27/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PLANNED PARENTHOOD OF CENTRAL NORTH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1765 DOBBINS ROAD CHAPEL HILL, NC 27514</b>
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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 unannounced on-site survey was conducted February 26, 2019 through February 27, 2019 to ascertain compliance with the North Carolina Rules Governing the Certification of Abortion Clinics. No deficiencies were found.</p>	E 000		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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