

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AB0032	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/21/2023
--------------------------------------------------	-------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD OF CENTRAL NORTH CAROLINA	STREET ADDRESS, CITY, STATE, ZIP CODE 1765 DOBBINS ROAD CHAPEL HILL, NC 27514
-----------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------

(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 re-licensure survey and complaint investigaiton was conducted 12/20/2023 through 12/21/2023 to determine compliance with the North Carolina Rules Governing the Certifications of Clinics for Abortion. No deficiencies were identified. NC00198258 and NC00202711</p>	E 000		

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