

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 10/23/2017
NAME OF PROVIDER OR SUPPLIER: PHILADELPHIA SURGERY CENTER, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE: 124 N. NARBERTH AVENUE NARBERTH, PA 19072		
STATE LICENSE NUMBER: 23291501				
(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)	(X5) COMPLETE DATE
S 0000	INITIAL COMMENT This report is the result of a unannounced, re-visit State Licensure survey, conducted on-site, on October 23, 2017, at Philadelphia Surgery Center, Inc. It was determined that the facility was in compliance with the requirements of the Pennsylvania Department of Health's Rules and Regulations for Ambulatory Care Facilities, Annex A, Title 28, Part IV, Subparts A and F, Chapters 551-573, November 1999.	S 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:



Certified End Page

PHILADELPHIA SURGERY CENTER, INC.

STATE LICENSE NUMBER: 23291501

SURVEY EXIT DATE: 10/23/2017

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Handwritten signature of Nancy J. Lescavage in black ink.

Nancy J. Lescavage
Deputy Secretary for Quality Assurance

Handwritten signature of Rachel L. Levine, MD in black ink.

Rachel L. Levine, MD
Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY