Il continuation sheet 1 of 5

STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING: B. WING 130061 09/16/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4600 GULF FREEWAY, SUITE 300 PLANNED PARENTHOOD CENTER FOR CHOIC HOUSTON, TX 77023 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION). CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) T 000 Ambulatory Surgery Centers T 000 Note: The State Form is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be referred to the Office of the Texas Attorney General (OAG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced relicensure survey of this ambulatory surgery center was conducted. This process was to determine the center's compliance with the State Licensing Regulations under Title 25 Texas Administrative Code (TAC), Chapter 135 (Ambulatory Surgical Centers). Subchapter A (Operating Requirements for Ambulatory Surgical Centers). An entrance conference was held on the morning of 9/15/2020 with key administrative personnel. The purpose, scope, and process of the visit was explained and an opportunity for questions and discussion was provided. An exit conference was held on the afternoon of 9/16/2020 with key administrative personnel. Findings of the survey were discussed and an opportunity for questions and discussion was provided. SOD - State Form TITLE (X6) DATE LABORATORY RESENTATIVE'S SIGNATURE Administrator 10/08/20

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GMR311

Texas Health and Human Services Commission

STATE FORM

Texas Health and Human Services Commission STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ B. WING _ 130061 09/16/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4600 GULF FREEWAY, SUITE 300 PLANNED PARENTHOOD CENTER FOR CHOIC HOUSTON, TX 77023 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REPERENCED TO THE APPROPRIATE DEFICIENCY)

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Texas Health and Human Services Commission (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING _ 09/16/2020 130061 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4600 GULF FREEWAY, SUITE 300 PLANNED PARENTHOOD CENTER FOR CHOIC HOUSTON, TX 77023 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)

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Texas Health and Human Services Commission (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: ____ B. WING ___ 09/16/2020 130061 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4600 GULF FREEWAY, SUITE 300 PLANNED PARENTHOOD CENTER FOR CHOIC HOUSTON, TX 77023 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY)

Texas Health and Human Services Commission (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: __ B. WING ___ 09/16/2020 130061 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4600 GULF FREEWAY, SUITE 300 PLANNED PARENTHOOD CENTER FOR CHOIC HOUSTON, TX 77023 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) iD (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY)

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