

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: SA00020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/05/2018
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NAME OF PROVIDER OR SUPPLIER ABORTIONCLINICS ORG, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 10401 OLD GEORGETOWN ROAD, SUITE 104 BETHESDA, MD 20814
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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
A 000	<p>Initial Comments</p> <p>A complaint investigation was conducted at Abortionclinics Org, Inc on 7/5/18. The complaint included: interview of the staff; an observational tour of the physical environment; observation of bio-hazardous material area; review of the policy and procedure manual; review of clinical records; review of professional credentialing; review of personnel files and review of the quality assurance and infection control programs.</p> <p>There were three allegations and all were unsubstantiated.</p> <p>Findings in this report are based on data present at the time of review. The staff was kept informed of the findings as the complaint progressed. The staff was given the opportunity to present information relative to the findings during the course of the complaint.</p>	A 000		

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