

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AF-0020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/10/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER CHARLOTTESVILLE MEDICAL CENTER FOR WOMEN	STREET ADDRESS, CITY, STATE, ZIP CODE 2321 COMMONWEALTH DRIVE CHARLOTTESVILLE, VA 22901
---	---

(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
{T 000}	<p>12 VAC 5- 412 Initial comments</p> <p>An unannounced Revisit Licensure Abortion Facility survey, following the facility's July and October 2014 Biennial Licensure surveys, was conducted on 12/10/2014. Two Medical Facilities Inspectors from the Office of Licensure and Certification, Virginia Department of Health conducted the survey.</p> <p>The agency was in compliance with 12 VAC- 412 Regulations for the Licensure of Abortion Clinics. (Effective 06/20/2013) No deficiencies were cited.</p>	{T 000}		

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