

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MOA-0014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/21/2014
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REPRODUCTIVE HEALTH SERVICES / PLANNI	STREET ADDRESS, CITY, STATE, ZIP CODE 4251 FOREST PARK AVENUE SAINT LOUIS, MO 63108
--	---

(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
L 000	<p>Initial Comments</p> <p>An unannounced on-site state licensure survey was conducted at this facility on 01/21/14, in conjunction with an allegation survey for complaint #MO00089716. The complaint was unsubstantiated, and the facility was found to be in substantial compliance with CSR 30-20.060.</p>	L 000		

Missouri Department of Health and Senior Services LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------