

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 C 05/25/2016
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NAME OF PROVIDER OR SUPPLIER REPRODUCTIVE HEALTH SERVICES / PLANNI	STREET ADDRESS, CITY, STATE, ZIP CODE 4251 FOREST PARK AVENUE SAINT LOUIS, MO 63108
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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
L 000	<p>Initial Comments</p> <p>An on-site, unannounced allegation survey was conducted on 05/17/16, and continued off-site until 05/25/16, for complaint #MO00114829. The allegation was found to be unsubstantiated.</p>	L 000		

Missouri Department of Health and Senior Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE