

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MOA-0014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/12/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>REPRODUCTIVE HEALTH SERVICES / PLANNI</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4251 FOREST PARK AVENUE SAINT LOUIS, MO 63108</b>
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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><b>Initial Comments</b></p> <p>An investigation was conducted on 07/12/16 for the purpose of review of one complaint, #MO00116700, in relation to the Missouri Regulations for Abortion Facilities.</p> <p>The complaint was unsubstantiated and the facility was found to be in substantial compliance with 19 CSR 30-30.060.</p>	L 000		

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