

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>10/04/2016</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 from 09/30/16 to 10/04/16 for the purpose of review for 1 complaint in relation to the Missouri Regulations for Abortion Facilities.</p> <p>Complaint #MO00119763 was found to be unsubstantiated with no deficiencies.</p> <p>The facility was found to be in substantial compliance with the rules and regulations for abortion facilities found at 19 CSR 30-30.060.</p>	L 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE