

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>SA000007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/05/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ASSOCIATES IN OB/GYN CARE, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6005 LANDOVER ROAD</b> <b>CHEVERLY, MD 20785</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
A 000	<p><b>Initial Comments</b></p> <p>A complaint investigation was conducted at American Women's Services (aka Associates in OB/GYN Care, LLC) on August 3-5, 2016. The complaint was anonymous. Complaint reference number: #7257492</p> <p>The investigation included unannounced on-site visits, tour of one facility and staff interviews. The complaint was unsubstantiated.</p>	A 000		

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

TITLE

(X6) DATE