

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OHX00248	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/10/2018
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6721 KARL ROAD COLUMBUS, OH 43229
--	---

(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
C 000	<p>Initial Comments</p> <p>Complaint Inspection</p> <p>Complaint Number OH00098894</p> <p>Your Choice Healthcare was found to be not operating as an ASF at the time of the complaint inspection completed on 07/10/18.</p>	C 000		

Ohio Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------