

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: SA00020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/19/2018
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NAME OF PROVIDER OR SUPPLIER ABORTIONCLINICS ORG, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 10401 OLD GEORGETOWN ROAD, SUITE 104 BETHESDA, MD 20814
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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>Initial Comments</p> <p>A complaint investigation survey of Abortionclinics.org was conducted on November 19, 2018.</p> <p>Complaint number: MD00132857. This complaint was substantiated. However, there were no deficiencies cited.</p> <p>The survey included: interview of the staff, review of patient medical records and review of the policy and procedure manual.</p> <p>A key code for the patients was provided to the facility.</p> <p>Findings in this report are based on data present in the administrative records at the time of the review. The facility staff was kept informed of the investigational findings as the investigation progressed. The agency was given the opportunity to present information relative to the findings during the course of the investigation.</p> <p>Abortionclinics.org is in compliance with COMAR 10.12.01.00- 10.12.01.20 F. for Surgical Abortion Facilities.</p>	A 000		

OHCQ LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____