

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>AC13910038</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>01/12/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ALL WOMEN'S HEALTH CENTER OF JACKSONVILLE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4331 UNIVERSITY BLVD, SOUTH JACKSONVILLE, FL 32216</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
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A 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor visited All Women's Health Center of Jacksonville on January 12, 2015, in order to conduct a re-licensure survey.</p> <p>Surveyor found All Women's Health Center of Jacksonville Abortion Clinic vacant, with no person inside or about the facility, located at 4331 University Boulevard South; Jacksonville, FL 32216. It was apparent that no services were being provided at this location.</p> <p>No survey could be accomplished.</p>	A 000		
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AHCA Form 3020-0001

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

TITLE

(X6) DATE