

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AC13910046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/26/2018
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NAME OF PROVIDER OR SUPPLIER ST PETERSBURG WOMAN'S HEALTH CENTER, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 3401 66TH STREET NORTH SAINT PETERSBURG, FL 33710
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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>An unannounced re-licensure survey was conducted on 1/26/2018 at St. Petersburg Woman's Health Center, license #802. The facility was found in compliance with state licensure requirements at the time of the survey.</p>	A 000		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____