

**State Form: Revisit Report**

(Y1) Provider / Supplier / CLIA / Identification Number AC13910038	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 3/15/2010
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Name of Facility ALL WOMEN'S HEALTH CENTER OF JACKSONVILLE	Street Address, City, State, Zip Code 4331 S UNIVERSITY BLVD, S JACKSONVILLE, FL 32216
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This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>A0153</u>	Correction Completed <u>02/04/2010</u>	ID Prefix <u>A0300</u>	Correction Completed <u>02/05/2010</u>	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	

Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: <i>Helen [Signature]</i>	Date: <u>3/16/10</u>
State Agency _____			Signature of Surveyor: <i>for Nancy Mackay RN</i>	Date: _____
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
CMS RO _____				

Followup to Survey Completed on: <u>2/4/2010</u>	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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CHARLIE CRIST  
GOVERNOR

*Better Health Care for all Floridians*

THOMAS W. ARNOLD  
SECRETARY

March 16, 2010

Administrator  
All Women's Health Center of Jacksonville  
4331 S University Blvd, S  
Jacksonville, FL 32216

Dear Administrator:

This letter reports the findings of a state licensure survey revisit conducted on March 15, 2010 by a representative of this office.

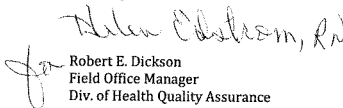
Attached is the provider's copy of the Revisit Report, which indicates the previously cited deficiencies were found corrected on the day of the revisit.

In accordance with the Florida Statutes, this report of inspection must be posted in a prominent location to be accessible to all residents and the public.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions, please call this office at 359-6046.

Sincerely,

  
for Robert E. Dickson  
Field Office Manager  
Div. of Health Quality Assurance

NKM/cw  
Enclosure

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Headquarters  
2727 Mahan Drive  
Tallahassee, FL 32308  
<http://ahca.myflorida.com>



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Jacksonville Field Office  
921 N. Davis St., Bldg. A, Suite 115  
Jacksonville, FL 32209  
Phone (904) 359-6046; Fax (904) 359-6054