

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AC13910007	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/31/2017
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NAME OF PROVIDER OR SUPPLIER ALL WOMEN'S HEALTH CENTER OF TAMPA, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 3330 WEST KENNEDY BLVD. TAMPA, FL 33609
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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 Licensure survey was conducted at All Women's Health Center of Tampa, Inc. an abortion clinic located in Tampa, Fl. on 8/31/17. License #812.</p> <p>The provider had no deficiencies at the time of the visit.</p>	A 000		

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