

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AC13910038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/15/2017
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NAME OF PROVIDER OR SUPPLIER ALL WOMEN'S HEALTH CENTER OF JACKSONVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1545 HUFFINGHAM ROAD JACKSONVILLE, FL 32216
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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 on-site re-licensure survey conducted on 9/15/2017 at All Women's Health Center of Jacksonville, an abortion clinic located in Jacksonville, FL. (License # 800)</p> <p>All Women's Health Center of Jacksonville was found to be in compliance with the Florida Abortion Clinic requirements of FS 390.</p>	A 000		

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