

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AC13960131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2012	
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD OF SOUTH FLORIDA	STREET ADDRESS, CITY, STATE, ZIP CODE 10111 FOREST HILL BLVD, SUITE 340 WELLINGTON, FL 33414			
(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>Initial Second Trimester Licensure Survey conducted on 12/20/2012.</p> <p>Planned Parenthood Of South Florida &The Treasure Coast had no deficiencies found at the time of the visit.</p>	A 000		

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

6599

LHTX11

If continuation sheet 1 of 1



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

January 9, 2013

Administrator
Planned Parenthood Of South Florida & The Treasure Coast
10111 Forest Hill Blvd. Suite 340
Wellington, FL. 33414

Dear Administrator:

This letter reports findings of an Initial Second Trimester state licensure survey that was conducted on December 20, 2012 by a representative from this office. Attached is the provider's copy of the State (3020) Form, which indicates there were no discernible deficiencies noted on the date of the survey. ****You will not receive a copy of this report in the mail; you will only receive this faxed report.**

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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/ls
Enclosure: State Form 3020

