

Health Standards Section

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: BO0004641 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 03/08/2019 |
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| NAME OF PROVIDER OR SUPPLIER WOMENS HEALTH CARE CENTER INC | STREET ADDRESS, CITY, STATE, ZIP CODE 2701 GENERAL PERSHING STREET NEW ORLEANS, LA 70115 |
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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 |
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| S 000 | <p>Initial Comments</p> <p>Complaint Survey# LA00051125. No deficiencies cited as a result of this complaint.</p> | S 000 | | |

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| DHH/Health Standards Section LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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