

Health Standards Section

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 R-C 09/27/2018
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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
{S 000}	<p>Initial Comments</p> <p>An onsite revisit was conducted for all previous deficiencies cited on 06/19/2018. All deficiencies from this survey have been corrected.</p>	{S 000}		

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