

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AC13910029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/10/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WOMEN'S OB-GYN CENTER OF COUNTRYSIDE, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 28960 HWY 19 NORTH, SUITE 110 CLEARWATER, FL 33761
---	--

(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 Re-licensure survey was conducted at Women's OBGYN Center of Countryside on 6/10/19.</p> <p>The facility 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
--	-------	-----------