

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AC13910006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/06/2020
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NAME OF PROVIDER OR SUPPLIER ALL WOMEN'S HEALTH CENTER OF SARASOTA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 SOUTH TAMiami TRAIL, SUITE 5 SARASOTA, FL 34239
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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 relicensure survey was conducted on 1/6/20 at the All Women's Health Clinic, an abortion clinic in Sarasota, Florida.</p> <p>No deficiencies were found at the time of the visit.</p>	A 000		

AHCA Form 3020-0001 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X8) DATE
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