

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AC13910034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/17/2019
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NAME OF PROVIDER OR SUPPLIER BREAD AND ROSES WELL WOMAN CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1233 N.W. 10TH AVENUE GAINESVILLE, FL 32601
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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 re-licensure survey was conducted for Bread and Roses Well Woman Care on December 17, 2019. The provider had no deficiencies at the time of the visit. The Clinic was in compliance with the requirements of Chapter 390 F.S. and 59 A-9 F.A.C.</p>	A 000		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____