

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AC13910019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/04/2019
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NAME OF PROVIDER OR SUPPLIER LAKELAND WOMEN'S HEALTH CENTER, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4444 SOUTH FLORIDA AVENUE LAKELAND, FL 33813
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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>A revisit to relicensure survey O3UG11, ending on 09/25/2019, was conducted on 12/04/2019 at Lakeland Women's Health Center. Deficiencies were found to be corrected at the time of the survey.</p>	{A 000}		

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