

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AC13960123	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/01/2019
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NAME OF PROVIDER OR SUPPLIER AMERICAN FAMILY PLANNING	STREET ADDRESS, CITY, STATE, ZIP CODE 6115 VILLAGE OAKS DRIVE PENSACOLA, FL 32504
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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>On August 1, 2019, a desk review revisit survey was completed for the survey ending April 5, 2019 to re-instate an inactive license at American Family Planning Abortion Clinic. Based on an acceptable plan of correction, supporting documentation and interview with the Administrator, deficiencies were found corrected.</p>	{A 000}		

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