

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>AC13920002</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/27/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>A HIALEAH WOMAN'S CARE CENTER INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>952 EAST 25TH ST HIALEAH, FL 33013</b>
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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><b>INITIAL COMMENTS</b></p> <p>A re-licensure survey was conducted at the A Hialeah Woman's Care Center Inc on _____ The provider 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 \_\_\_\_\_