

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>AC13960083</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/13/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>AASTRA WOMENS CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>10 SW 44TH AVE PLANTATION, FL 33317</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>An unannounced relicensure survey was conducted on 2/13/20 at Aastra Womens Center. The facility had no deficiencies 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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