

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>AC13960112</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/19/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>A WOMAN'S CENTER OF HOLLYWOOD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3829 W HOLLYWOOD BLVD HOLLYWOOD, FL 33021</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 commenced on 2/17/20, and concluded on 2/19/20 at A Woman's Center of Hollywood. 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 \_\_\_\_\_ (X6) DATE \_\_\_\_\_