

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AC13960065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/06/2024
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NAME OF PROVIDER OR SUPPLIER PRESIDENTIAL WOMEN'S CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 100 NORTHPOINT PARKWAY WEST PALM BEACH, FL 33407
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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
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{A 000}	<p>INITIAL COMMENTS</p> <p>An unannounced revisit to the Complaint survey, complaint #2024010211 was conducted on 11/06/2024 at Presidential Women's Center. The previously cited deficiencies were found corrected at the time of the survey.</p>	{A 000}		
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AHCA Form 3020-0001 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X8) DATE
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