

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AB0055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/12/2019
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NAME OF PROVIDER OR SUPPLIER A PREFERRED WOMENS' HEALTH CEN	STREET ADDRESS, CITY, STATE, ZIP CODE 3320 LATROBE DRIVE CHARLOTTE, NC 28211
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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
E 000	<p>Initial Comments</p> <p>An unannounced licensure survey was conducted June 11, 2019 through June 12, 2019 to determine compliance with NC Division of Facility Services Rules Governing the Certification of Abortion Clinics. No deficiencies were cited as a result of the survey.</p> <p>NC00151193</p>	E 000		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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