

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>AC13960090</b>	(X3) DATE SURVEY COMPLETED  <b>10/04/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>A GYN DIAGNOSTIC CENTER INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>375 EAST 49 ST SUITE 2 HIALEAH, FL 33013</b>	

SUMMARY STATEMENT OF DEFICIENCIES  
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

**0000 INITIAL COMMENTS**

A relicensure survey was conducted on 4, 2016. A Gyn Diagnostic Center Inc, license #882.

A Gyn Diagnostic Center Inc. had deficiencies identified at the time of the survey.

**Z818 Minimum Licensure Requirement - Client Notice**

Based on record review and interview, the provider failed to ensure that 10 out of 10 (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10) sample patients were informed of the toll-free numbers for complaints, and Medicaid fraud.

Findings:

Record review revealed no documentation showing sample patients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10 were informed of the toll-free numbers for complaints, and Medicaid fraud.

On at 11:37 AM, the administrator acknowledged that the sample patients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10 were not informed of the toll-free numbers for complaints, and Medicaid fraud.



RICK SCOTT  
GOVERNOR

JUSTIN M. SENIOR  
INTERIM SECRETARY

, 2016

Administrator  
A Gyn Diagnostic Center Inc  
375 East 49 Street Suite 2  
Hialeah, FL 33013

Dear Administrator:

This letter reports the findings of a state relicensure survey that was conducted on 2016 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call Faith Randolph, Registered Nurse Consultant at 305-593-3100.

Sincerely,

  
Arlene Mayo-Davis  
Field Office Manager, Area 11

Enclosure: State (5000-3547) Form

XG90

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