PRINTED: 02/25/2013
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AC13960096	A. BUILDING _____ B. WING _____	02/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A HIALEAH WOMEN CENTER, INC.	697 E. 9TH STREET HIALEAH, FL 33010

(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	INITIAL COMMENTS A Licensure Survey was conducted on 02-18-2013. A Hialeah Women Center had deficiencies found at the time of the visit.	A 000	Regarding to the deficiencies on your visit 2/18/13 Correct and following matter:	4/19/13
A 600	Clinical Records A permanent individual clinical record shall be kept on each clinic patient. Clinical records shall be complete, accurately documented, and systematically organized to facilitate storage and retrieval. (a) Clinical records shall be complete, accurately documented, and systematically organized to facilitate storage and retrieval. (b) Clinical records involving second trimester abortion procedures shall be kept confidential and secure. (c) reports signed by the physician performing the second trimester abortion shall be recorded in the clinical record immediately following the procedure or that an progress note is entered in the clinical record to provide pertinent information. Chapter 59A-9.031(1), F.A.C. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to maintain complete and accurate clinical records for 2 out of 5 (#1, #2) patients' records. Findings include: Records review conducted on	A 600	a) Complete patient files, ongoing and kept away in a confidential file. b) My license, only has permission To operate First Trimester. c) We will permanent have operative Reports For Dr's To sign Optoe termination at time of service	

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE President (X6) DATE 04/19/13

STATE FORM 6899 CHQM11 If continuation sheet 1 of 2

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AC13960098	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A HIALEAH WOMEN CENTER, INC.	697 E. 9TH STREET HIALEAH, FL 33010

(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 600	Continued From page 1 revealed that patient #1 and patient #2 received abortion procedures on . . . . . Further review revealed no documentaition that showed recovery period for patients #1 and #2 immediately after their . . . . . abortion procedures. On . . . . . at 12:30pm staff #2 acknowledged the findings and stated that the recovery documentation for patient #1 and patient #2 were probably locked and she did not have a key.	A 600		

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
A Hialeah Women Center, Inc.
697 E. 9th Street
Hialeah, FL 33010

Dear Administrator:

This letter reports the findings of a State Licensure survey that was conducted on , 2013 by a representative of this office.

Attached is the provider's copy of the Statement of Deficiencies, POC Guidelines and State (3020) Form which indicates the deficiencies that were identified on the day of the visit.

Please provide a plan of correction to this Field Office, in accordance with enclosed instructions, for the identified deficiencies **within ten calendar days of receipt of this faxed report**. You will not receive a copy of this report in the mail, you will only receive this faxed report. **All deficiencies shall be corrected no later than 2013.**

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 /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 (for)
Field Office Manager, Area 11

Enclosures: State (3020) Form and POC Guidelines

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone (305) 593-3100; Fax (305) 593-3121