

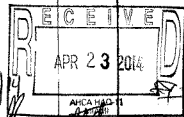
Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  AC12660104	(02) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(03) DATE SURVEY COMPLETED  03/12/2014
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NAME OF PROVIDER OR SUPPLIER  A MEDICAL OFFICE FOR WOMEN	STREET ADDRESS, CITY, STATE, ZIP CODE 909 NE 163 STREET SUITE 402 NORTH MIAMI BEACH, FL 33162
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(04) 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)	(05) COMPLETE DATE
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A 000	INITIAL COMMENTS  A relicensure survey was conducted on 2014. A Medical Office For Women had Licensure deficiencies found at the time of the visit.	A 000		
A 302	<p>Medical Screening/eval-2nd Trimester  Laboratory Equipment and Supplies.</p> <p>(a) All equipment and supplies for the collection, storage, and testing of specimens shall meet the provisions of Rule 59A-7 F.A.C., and shall be maintained according to manufacturer's instructions and in a manner that ensures accurate test results.</p> <p>(b) Temperature controlled spaces for the storage of specimens or testing supplies shall be monitored and recorded to ensure that the proper storage temperature is maintained.</p> <p>(c) All dated supplies and materials shall not be used beyond their expiration date.</p> <p>(d) Adequate facilities and supplies for the collection, storage and transportation of laboratory specimens shall be available on site.</p> <p>Chapter 59A-9.025(3), F.A.C.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure laboratory supplies were maintained according to manufacturers instructions and in a manner that ensures accurate test results.</p> <p>Findings include:</p>	A 302	<p><b>Plan of corrections.</b> Date of compliance - March 13, 2014. Corrections: All lab. Supplies will be checked on arrival for an expiration dates. Office manager, _____ will be responsible for this task. No patients were affected. All expired tubes were discarded.</p> <p>4/23/14 <i>[Signature]</i></p>	



AHCA Form 3020-0001 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i> STATE FORM	DATE 4/9/2014 TXR011	TITLE President	(06) DATE 4/9/14 If continuation sheet 1 of 2
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4/14/14  
*[Signature]*

PRINTED: 04/03/2014  
FORM APPROVED

## Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  AC13960104	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  03/12/2014
NAME OF PROVIDER OR SUPPLIER  A MEDICAL OFFICE FOR WOMEN		STREET ADDRESS, CITY, STATE, ZIP CODE 909 NE 163 STREET SUITE 402 NORTH MIAMI BEACH, FL 33162		
(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 302	Continued From page 1  During a tour of the facility conducted on 12, 2014 at approximately 10:12 am, the surveyor observed outdated/expired specimen collection supplies. The tubes had an expiration date of 2013 and were stored in a drawer.  During an interview conducted with staff accompanying the surveyor while touring on 2014 at approximately 10:12am, she observed the date of 2013 and stated they don't use the tubes often, only when needed.	A 302		



RICK SCOTT  
GOVERNOR

ELIZABETH DUDEK  
SECRETARY

2014

Administrator  
A Medical Office For Women  
909 Ne 163 Street Suite 402  
North Miami Beach, FL 33162

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on \_\_\_\_\_, 2014 by representatives of this office.

Attached is the provider's copy of the 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 \_\_\_\_\_, 2014.**

**The plan of correction must include the following:**

1. Identify how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
2. Describe how the facility will identify other residents having the potential to be affected by the same deficient practice.
3. Explain measures to be put into place or systemic changes made to ensure that the deficient practice will not recur.
4. Identify how the facility will monitor its corrective action to ensure the deficient practice is being corrected and will not recur; i.e., what program will be put into place to monitor the continued effectiveness of the systemic change.
5. Ensure that no protected or other confidential information (i.e., resident or staff names) are included in the plan.
6. State the completed date; the date that the facility identifies compliance can be achieved, which must be after the exit date.
7. You must sign the bottom of page 1 of the statement of deficiencies; include your title and date.



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 surveyors. Should you have any questions please call Faith Randolph, Registered Nurse Consultant at (305) 593-3100.

Sincerely,



Arlene Mayo-Davis (fir)  
Field Office Manager, Area 11

Enclosure: State (3020) Form



RICK SCOTT  
GOVERNOR

ELIZABETH DUDEK  
SECRETARY

**IMPORTANT NOTICE – ACTION NECESSARY**

**POC NOT ACCEPTABLE/RECEIVED LETTER**

2014

Via facsimile to 305-441-2947

Administrator  
A Medical Office For Women  
909 NE 163 Street Suite 402  
North Miami Beach, FL 33162

RE: PLAN OF CORRECTION

Dear Administrator:

You were notified by our letter dated \_\_\_\_\_ 2014 of deficiencies found at the \_\_\_\_\_ 2014 survey of your facility. We requested you submit a plan of correction for the deficiencies cited within ten days of receipt of our notification letter. You were advised that the plan of correction must be acceptable in content and time frames.

We received your revised plan of correction on \_\_\_\_\_ 2014. We have reviewed your submission and find that it is unacceptable for the following reasons:

**The Plan of Corrections is not in the correct format**  
**There were pages missing from the plan**

Since we did not receive an acceptable plan of correction, we will forward your case to the Licensing Unit.

If you have questions regarding this letter, please contact me at 305-593-3100.

Sincerely,  
Faith Randolph, RNC  
Agency For Health Care Administration 





RICK SCOTT  
GOVERNOR

ELIZABETH DUDEK  
SECRETARY

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We received your plan of correction on \_\_\_\_\_ 2014. We have reviewed your submission and find that it is unacceptable for the following reasons:

**The Plan of Corrections is not in the correct format**

**The Plan lack how the facility will monitor its corrective action to ensure the deficient practice is being corrected and will not recur**

**The Plan do not state the completed date; the date that the facility identifies compliance can be achieved, which must be after the exit date.**

We are providing another opportunity for you to submit an acceptable plan of correction for the cited deficiencies. You must respond WITHIN 1 CALENDAR DAYS OF RECEIPT of this notice and provide a plan of correction that is acceptable in content and time frames.

If we do not receive an acceptable plan of correction WITHIN 1 CALENDAR DAYS from receipt of this notice, we will forward your case to the Licensing Unit.

If you have questions regarding this letter, please contact me at 305-593-3100.

Sincerely,   
Faith Randolph, RNC  
Agency For Health Care Administration 3111

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