					PRINTED: 1 FORM AF	1/17/2016 PROVED
STATEMEN	for Health Care Adm IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
		AC13960104	B. WING		10/31	2016
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
A MEDIC	AL OFFICE FOR WO		3 STREET SU IAMI BEACH,			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
A 000	INITIAL COMMEN	TS	A 000			
	conducted on	e-licensure survey was , 2016. A Medical Office #899 had deficiencies found isit				
A 150	59A-9.0225(1), FA Stand2nd Trimes	C Clinic Supplies/Equip. ster	A 150			
	59A-9.0225 Clinic Standards for Sec	Supplies and Equipment ond Trimester Abortions.				
	trimester abortions supplies and equip subsections (1) this second trimester a clinic which is in o of this rule and pro abortions shall be meet these standa (a) A surgical or table(s):	examination				
	(b) A bed or reclin (c) with ficequivalent; (d) Mechanical su (e) minimum, (f) Emergency me and related suppli (g) Sterile suturing (h) Adiustable exe	equipment to include, at a bags and oral airways; dications, es and equipment; q equipment and supplies;				

This Statute or Rule is not met as evidenced by: Based on observation and interview the provider LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(j) Appropriate equipment for the administering of , if applicable.

> (X6) DATE TITLE

If continuation sheet 1 of 20 F3LU11 STATE FORM

						PPROVED
STATEMEN	T Health Care Adm T OF DEFICIENCIES OF CORRECTION	inistration (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		AC13960104	B. WING		10/3	1/2016
	PROVIDER OR SUPPLIER	909 NE 16	ORESS, CITY, S 3 STREET S IAMI BEACH			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
A 150	failed to have esse equipment such as	nge 1 ntial clinic supplies and and non-expired irred for licensed second	A 150			
		ation/tour of the facility on am, there was no				

A 151

at 11:12 am, the Medical

at 11:33 am, the Medical

Assistant stated that they had to get a new tank, as they have ordered a new one but

Assistant acknowledged there wasn't an

A 151 59A-9.0225(2), FAC Clinic Supplies/egpt.-2nd

59A-9.0225 Clinic Supplies and Equipment Standards for Second Trimester Abortions. (2) Emergency equipment shall be provided for immediate use, maintained in functional condition, and capable of providing at least the

it has not been put in place.

tank available at the clinic.

Trimest-Emerg eapt

following services: (a) Inhalation (b)

monitoring;

AHCA Form 3020-0001 STATE FORM

(c) (d) Suctioning; and, (e) Maintenance of patient airway.

Interview on

Interview on

A ===== 1	or Health Care Adm	inistration				11/17/2016 APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE S COMPL	SURVEY LETED
		AC13960104	B. WING			
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
A MEDIC	AL OFFICE FOR WO		3 STREET S IAMI BEACH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
A 151	Continued From pa	age 2	A 151			
	Based on observat failed to have emer					
	Findings :					
	at 11:12 a	ation/tour of the facility on am, there was no defibrillator or g machine.				
	At 11:12 am, the M don't have a defibri machine.	edical Assistant stated they illator or a monitoring				
	At 11:30 am, the M there wasn't a defit machine available					
A 153	59A-9.0225(4), FAG Trimes-Resuscitati	C Clinic Suppl/eqt-2d ve Meds	A 153			
		Supplies and Equipment and Trimester Abortions.				
	The clinic shall have the cart must include, a emergency medical	ledications Required. re a crash cart at the location s being carried out. The crash at a minimum, those titions to support the ned as determined by the				

medical director.

Agency	for Health Care Adm	inistration				APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
		AC13960104	B. WING		10/3	1/2016
	PROVIDER OR SUPPLIER	MEN 909 NE 16	DRESS, CITY, S 33 STREET S NAMI BEACH			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCE)	D BE	(X5) COMPLETE DATE
A 153	Continued From pa	age 3	A 153			
		e is not met as evidenced by:				

Findings:

During the observation/tour of the facility on at 11:12 am, there was no crash cart stocked with emergency medication, located in is being carried out. the area where

failed to provide a crash cart stocked with emergency medications, at the location the

licensed second trimester clinics.

is being carried out as required for

At 11:12 am, the Medical Assistant stated they don't have a crash cart stocked with emergency medication

At 11:30 am, the Medical Assistant acknowledged

there wasn't a crash cart stocked with emergency medication available at the clinic A 250 59A-9,024, FAC Clinic Policies/Procedures-2nd Trimester

An abortion clinic providing second trimester abortions shall have written policies and procedures to implement policies and to assure that quality patient care shall relate specifically to the functional activities of clinic services. These written procedures shall apply to second trimester abortions and shall be available and accessible to clinic personnel and shall be reviewed and approved annually by the clinic's medical director. A 250

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Agency (for Health Care Adm	inistration				11/17/2016 APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE: COMPI	
		AC13960104	B. WING		10/3	1/2016
NAME OF I	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
A MEDIC	AL OFFICE FOR WO	MEN	3 STREET S			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
A 250	Any abortion clinic time of adoption of timester abortions within which to com and procedure requested to the limited to (1) Patient admission (4) Standing orders (5) Medications, std. (6) Treatments; (7) Surgical (8) Medications, std. (8) Medications, std. (10) Documentation records; (11) Patient dischard (12) Patient transfer (13) Emergency m (15) Personnel orie (16) Inservice eduction (17) (18) Equipment and (17) This Statute or Rull Based on record reprovider falled to prolicies and and accessible to colicies and proceed processible to a colicies and proceed colicies and colicies a	which is in operation at the this rule and providing second shall be given six months ply with these clinic policies internents which shall include to the following: on; care; rs; with required signatures; prage and administration; ; ; in: Medical records and facility rge; gr; assures; s; intation; attoric record; d supplies: availability and	A 250			

AHCA Form 3020-0001 STATE FORM

Findings:

A == = = + f	or Health Caro Adm	inictration				11/17/2016 APPROVED
STATEMEN	or Health Care Adm T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE :	
		AC13960104	B. WING			i
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
A MEDIC	AL OFFICE FOR WO		3 STREET S IAMI BEACH	I, FL 33162		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.DBE	(X5) COMPLETE DATE
A 250	available for the clii review revealed no policies and procec approved annually Interview conducte Medical Assistant a policies and procec clinic personnel an documentation tha had been reviewe medical director. 59A-9.025(1), FAC Trimester (1) Each abortion of trimester abortions written patient care	at 11:00 am, revealed d procedures were not nic personnel. Further record documentation that the tures had been reviewed and by the clinic's medical director.	A 300			
	patients undergoin and shall maintain such patient that re services. Any abor trimester abortions patient care policie undergoing second but not limited to the (a) Admission crite (b) Identification in physician(s) and n	g second trimester abortions a medical record for each coords history, care and tion clinic that performs second shall comply with these is and procedures for patients trimester abortions, to include the following: ria and procedures; the medical record of urse(s) involved in providing d for patients undergoing				

(c) Specific details regarding the procedures performed, to include:

1. History and physical examination, to include verification of , estimation of

Agency for Health Care Admi	inistration		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	AC13960104	B. WING	10/31/2016

NAME OF	PROVIDER OR SUPPLIER STRE	EET ADDRESS, CITY, STA	TE, ZIP CODE	
A MEDIC		NE 163 STREET SUI RTH MIAMI BEACH, F		
(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 300	Continued From page 6	A 300		
	age, identification of any past surgeries, preexisting conditions or complications; including to medications, solutions, or latex; and a complete obstetric and history. 2. Special examinations, lab procedures, and consultations required, to include ultrasonog to confirm age and a physical examination including a bimanual examinatio estimating uterine size and palpation of the adnexa. The physician shall keep original prior feach examination of a patient patient's medical history file. or it for shall be performed before the abortion procedure. This Statute or Rule is not met as evidences Based on record review and interview the provider failed to maintain a medical record out of 9 sampled patients (patients 1,3,6,8 a that included an ultrasonography to confirmage, as required for licensed sectimester clinics.	d/or raphy on ints in the ests dd by:		
	The findings:			
	Record review on / at 10:30 am, rev no documentation of an ultrasonography to confirm age located in Patient #1 #6, #8, #9 clinical records.			- Company
	Interview on // at 11:05 am, the Administrator stated the is used to verify the age and the should be attached to the charts. At 11:33 at the Medical Assistant acknowledged the			

ultrasonography to confirm

age, were

Agency 1	for Health Care Adm	inistration				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE COMP	
		AC13960104	B. WING		10/3	1/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
A MEDIC	AL OFFICE FOR WO	MEN	3 STREET S NAMI BEACH	SUITE 402 1, FL 33162		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
A 300	Continued From pa	ge 7	A 300			
	of Patient #1, #3, # Assistant stated that age via	ne clinical file (medical record) 6, #8, #9. The Medical at the clinic determines the ultrasonography, therefore the inside the clinical file.				
A 600	59A-9.031(1), FAC	Clinical Records	A 600			
	kept on each clinic be complete, accur	dividual clinical record shall be patient. Clinical records shall ately documented, and nized to facilitate storage and				

progress note is entered in the clinical record to provide pertinent information. This Statute or Rule is not met as evidenced by: Based on record review and interview the provider failed to ensure 5 out of 9 sampled

patients (patients 1.3.6.8 and 9) clinical records

(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

reports signed by the physician performing the second trimester abortion shall be recorded in the clinical record immediately following the procedure or that an

The findings:

were complete.

and secure. (c)

Record review on at 10:30 am, revealed no documentation of an ultrasonography located in Patient #1, #3, #6, #8, #9 clinical records to confirm the _____age.

Agency for Health Care Adm STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	AC13960104	B. WING	10/31/2016

NAME OF PROMINED OR SURBLUED

STREET ARRESS CITY STATE 719 CODE

NAME OF PROVIDER OR SUPPLIER A MEDICAL OFFICE FOR WOMEN		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
		909 NE 163 STREET SUITE 402 NORTH MIAMI BEACH, FL 33162			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICI (EACH DEFICIENCY MUST BE PRECED REGULATORY OR LSC IDENTIFYING INI	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
A 600	Continued From page 8		A 600		
	Interview on / . at 11:05 am, Administrator stated the verify the should be attached to the charts. / the Medical Assistant acknowledge ultrasonography to confirm not in the clinical file of Patient #1, The Medical Assistant stated that it determines the _ lage via ultrasonography, therefore the prin inside the clinical file.	At 11:33 am, ad the age, were #3, #6, #8, #9. he clinic			
AZ814	435.12(2)(b-d), FS Background Sc Clearinghouse	reening	AZ814		
	435.12(2) Care Provider Backgrout Clearinghouse. (b) Until such time as the fingerprir in the national retained print program at the Federal Bureau of I an employee with a break in service 90 days from a position that require by a specified agency must submit screening if the person returns to a requires screening by a specified agency must registe clearinghouse and maintain the emstatus of all employees within the clinitial employment status and any status must be reported within 10 to (d) An employer must register with criminal history checks through the before referring an employee or po employee for electronic fingerprint the Department of Law Enforceme	its are enrolled notification investigation, e of more than as screening to a national position that gency. It o screening r with the ployment learinghouse hanges in ousiness days, and initiate all clearinghouse tential submission to			

AHCA Form 3020-0001

STATE FORM

6899

10/31/2016

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED

AC13960104

NAME OF PROVIDER OR SUPPLIER

B. WING ______
STREET ADDRESS, CITY, STATE, ZIP CODE

909 NE 163 STREET SUITE 402 A MEDICAL OFFICE FOR WOMEN NORTH MIAMI BEACH, FL 33162 DROVIDED'S BLANCE CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID DDEELA (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREEIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY AZ814 Continued From page 9 A7814 registration must include the employee's full first name, middle initial, and last name; social security number: date of birth; mailing address; and race, Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpaver identification number. This Statute or Rule is not met as evidenced by: Based on record review and interview, the provider failed to ensure the Administrator and the Financial Officer were listed on the clearinghouse roster. The findings: Record review revealed the Administrator and the Financial Officer were not listed on the clearinghouse roster. at 11:33 am, the Medical Assistant acknowledged the Administrator and the Financial Officer were not listed on the clearinghouse roster AZ815 AZ815 408.809; 435.02(2); 435.06 FS Background Screening: Prohibited Offenses 408,809 Background screening; prohibited offenses -(1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are considered employees for the purposes of

AHCA Form 3020-0001

conducting screening under chapter 435: (a) The licensee, if an individual.

6800

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

AC13960104

AC13960104

B. WING

10/31/2016

	AC13500104			
NAME OF F		DRESS, CITY, S	STATE, ZIP CODE	
A MEDIC	AL OFFICE FOR WOMEN	NAMI BEACH		
(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) COMPLETI DATE
AZ815	Continued From page 10	AZ815		
	(b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider. (c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider. (d) Any person who is a controlling interest if the agency has reason to believe that such person has been convicted of any offense prohibited by s. 435.04. For each controlling interest who has been convicted of any such offense, the licensee shall submit to the agency a description and explanation of the conviction at the time of license application. (e) Any person, as required by authorizing statutes, seeking employment with a licensee or provider who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, contracting with a licensee or provider whose responsibilities require him or her to provide personal care or personal services directly to clients or her to provide personal care or personal services directly to clients or personal property.			
	(3) All fingerprints must be provided in electronic format. Screening results shall be reviewed by the agency with respect to the offenses specified in s. 435.04 and this section, and the qualifying of isqualifying status of the person named in the request shall be maintained in a database. The qualifying or disqualifying status of the person named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee's behalf. (4) In addition to the offenses listed in s. 435.04,			

AHCA Form 3020-0001 STATE FORM

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Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _____ B. WING _____ 10/31/2016 AC13960104

NAME OF	PROVIDER OR SUPPLIER S	TREET ADDRESS, CIT	1,014.2,21 0002				
	9	09 NE 163 STREE	T SUITE 402				
MEDIC	MEDICAL OFFICE FOR WOMEN NORTH M		MAMI BEACH, FL 33162				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATION	ILL PREFIX	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLET DATE			
AZ815	Continued From page 11	AZ815					
	all persons required to undergo backgrour screening pursuant to this part or authroiz's statutes must not have an awaiting disposition for, must not have been found of, regardless of adjudication, or entered a nolo contendere or guilly to, and must not been adjudicated delinquent and the record have been sealed or expunged for any of following offenses or any similar offense or another jurisdiction: (a) Any authorizing statutes, if the offense felony. (b) This chapter, if the offense was a felon (c) Section 409.920, relating to Medicaid pfraud. (d) Section 409.9201, relating to Medicaid (e) Section 777.04, relating to domestic vit (f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an oilsted in this subsection. (g) Section 817.034, relating to fraudulent through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems. (f) Section 817.234, relating to false and fraudulent insurance claims. (g) Section 817.505, relating to patient browing guing a false or expired credit card or othe device, if the offense was a felony. (g) Section 817.505, relating to patient browing. (g) Section 817.505, relating to patient browing. (g) Section 817.60, relating to otaminal uspersonal identification information. (m) Section 817.61, relating to obtaining a card through fraudulent means. (n) Section 817.61, relating to obtaining a card through fraudulent means. (n) Section 817.61, relating to fraudulent ucredit cards, if the offense was a felony.	ing final guilty plea of have d not the f was a ly. Provider fraud, olence, offense acts					

AHCA Form 3020-0001 STATE FORM

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SIA EMERI OF DELICITIONS		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	AC13960104		B. WING		10/31/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AC	DRESS CITY S	STATE, ZIP CODE	,	
NAME OF F	PROVIDER OR SUPPLIER		3 STREET S			
A MEDIC	AL OFFICE FOR WO		IIAMI BEACH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
AZ815	Continued From pa	age 12	AZ815			
<i>n</i> .2.619	(p) Section 831.02, instruments. (q) Section 831.07, checks, drafts, or (r) Section 831.09, bank bills, checks, (s) Section 831.31, medicinal drugs. (t) Section 831.31, manufacture, delivintent to sell, manu counterfeit controll was a felony. (u) Section 896.03 collection of unlaw (v) Section 896.03 collection of unlaw (v) Section 896.10 Laundering Act. If, upon rescreening employed or contraction of the last screening, exemption from the last screening, exemption from thand, if agreed to be to perform his or the last screening exemption if the pexemption and the by the agency ned for the rescreening of the pexemption and the by the agency ned for the rescreening of the pexemption and the by the agency ned for the rescreening of the pexemption and the by the agency ned for the rescreening of the resc	relating to uttering forged relating to forging bank bills, nomissory notes. relating to tutering forged drafts, or promissory notes relating to tutering forged drafts, or promissory notes. relating to fraud in obtaining relating to fraud in obtaining relating to the sale, eny, or possession with the facture, or deliver any ed substance, if the offense, relating to racketeering and ful debts. I, relating to the Florida Money g, a person who is currently acted with a licensee as of d was screened and qualified and 435.04, has a disqualifying of a disqualifying of a disqualifying of a disqualifying of ense at the eening, but is a current se and was committed before he or she may apply for an e appropriate licensing agency the employer, may continue er duties until the licensing decision on the application for erson is eligible to apply for an exemption request is received ater than 30 days after receipt results by the person.				
	(5) A person who	serves as a controlling interest , or contracts with a licensee o	n			

i, 2010, who has been screened and qualified according to standards specified in s. 435.03 or s. 435.04 must be rescreened by 31, 2015, in compliance with the following

STATE FORM

Agency for Health Care Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _____ B. WING ___ AC13960104 10/31/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

A MEDICAL OFFICE FOR WOMEN 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	
AZ815	Continued From page 13	AZ815			
	schedule. If, upon rescreening, such person has a disqualifying offense that was not a disqualifying offense that time of the last screening, but is a current disqualifying offense as the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency within 30 days after receipt of the rescreening results by the person. The rescreening schedule shall be: (a) Individuals for whom the last screening was conducted on or before 1, 2004, must be rescreened by 1, 2013. (b) Individuals for whom the last screening conducted was between 1, 2005, and 1, 2008, must be rescreened by 31, 2014. (c) Individuals for whom the last screening conducted was between 1, 2009, through 1, 2011, must be rescreened by 1, 2011. (d) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening.				

AHCA Form 3020-0001

10/31/2016

Agency for Health Care Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING: COMPLETED B. WING ___

AC13960104

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

A MEDICAL OFFICE FOR WOMEN 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	
AZ816	Continued From page 14 2. Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification. (b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may grant an exemption from disqualification to a person who is subject to this section and who has received a professional license or certification from the Department of Health or a regulatory board within that department and that person is providing a service within the scope of his or her licensed or certified practice. (8) The agency and the Department of Health may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, chapter 435, and authorizing statutes requiring background screening and to implement and adopt criteria relating to retaining fingerprints pursuant to s. 943.05(2). (9) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this section, terminates the person against whom the report was issued, whether or not that person has filed for an exemption with the Department of Health or the agency.	AZ815			
and the second of the second o	435.06 Exclusion from employment- (1) If an employer or agency has reasonable cause to believe that grounds exist for the denial or termination of employment of any employee as a result of background screening, it shall notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of				

AHCA Form 3020-0001

STATE FORM

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Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING:

AC13960104

B. WING

10/31/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 909 NE 163 STREET SUITE 402 A MEDICAL OFFICE FOR WOMEN NORTH MIAMI BEACH, FL. 33162 SUMMARY STATEMENT OF DESICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE DDEELY (FACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) AZ815 Continued From page 15 A7815 the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity (2)(a) An employer may not hire select or otherwise allow an employee to have contact with person that would place the employee in a role that requires background screening until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of employment. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select. or otherwise allow the employee to have contact person that would place the employee in a role that requires background screening unless the employee is granted an exemption for the disqualification by the agency as provided under s. 435.07. (b) If an employer becomes aware that an employee has been for a disqualifying offense, the employer must remove the employee from contact with any person that places the employee in a role that requires background screening until the in a way that the employer determines that the employee is still eligible for employment under this chapter. (c) The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of this chapter or place the employee in a position for which background screening is not required unless the employee is granted an exemption from disqualification pursuant to s. 435.07. (d) An employer may hire an employee to a position that requires background screening

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before the employee completes the screening

Agency	for Health Care Adm	inistration				APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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	i-lowever, the emplicontact with screening process employee demonst no behaviors that w termination of employee vs. of the screening or information necess including fingerprin disqualified for emplicontact with the screening or information necess including fingerprin disqualified for emplicontact with the screening or information notice of a constant of the screening or information for damages upon notice of a consqualifying offens terminates the persuas issued or who whether or not that exemption pursuar 435.02 Definitions. chapter, the term: (2) "Employee" me law to be screened including, but not licontractors, license This Statute or Rul Based on record re provider failed to e and Financial Official for the screening of the	who refuses to cooperate in- refuses to timely submit the any to complete the screening, ts if required, must be oloyment in such position or, if dismissed. mployment assistance or other in the part of, and no cause of against, an employer that, inviction or for a le listed under this chapter, son against whom the report was, regardless of person has filled for an it to this chapter, -For the purposes of this ans any person required by pursuant to this chapter, mitted to, persons who are				

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The findings:

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Agency for Health Care Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: _____ COMPLETED B. WING ____ AC13960104 10/31/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

A MEDICAL OFFICE FOR WOMEN 909 NE 163 STREET SUITE 402 NORTH MIAMI BEACH, FL 33162						
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) COMPLE DATE			
Continued From page 17 Record review '/ at 10:34 am, revealed the Administrator and the Financial Officer had not obtained a level 2 background screening conducted through the agency.	AZ815					
Interview on // at 11:33 am, the Medical Assistant acknowledged the Administrator and the Financial Officer had not obtained a level 2 background screening.						
408.810(5) FS Minimum Licensure Requirement - Client Notice	AZ818					
408.810 Minimum licensure requirements. In addition to the licensure requirements specified in this part, authorizing statutes, and applicable rules, each applicant and licensee must comply with the requirements of this section in order to obtain and maintain a license.						
(5)(a) On or before the first day services are provided to a client, a licensee must inform the client and his or her immediate family or representative, if appropriate, of the right to report.						
number for reporting complaints to the agency must be provided to clients in a manner that is clearly legible and must include the words: "To report a complaint regarding the services you						
2. neglectful, or practices. The statewide toll-free telephone number for the central hotline must be provided to clients in a manner that is clearly legible and must include the words: "To report , neglect, or , please call toll-free (phone number)."						
	SUMMARY STATEMENT OF DEFICIENCIES. EACH DEFICIENCY MUST BE PRECEIBED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 Record review // at 10:34 am, revealed the Administrator and the Financial Officer had not obtained a level 2 background screening conducted through the agency. Interview on // at 11:33 am, the Medical Assistant acknowledged the Administrator and the Financial Officer had not obtained a level 2 background screening conducted through the agency. 408.810 (5) FS Minimum Licensure Requirement - Client Notice 408.810 Minimum licensure requirements. In addition to the licensure requirements in addition to the licensure requirements specified in this part, authorizing statutes, and applicable rules, each applicant and licensee must comply with the requirements of this section in order to obtain and maintain a license. (5)(a) On or before the first day services are provided to a client, a licensee must inform the client and his or her immediate family or representative, if appropriate, of the right to report. 1. Complaints. The statewide toll-free telephone number for reporting complaints to the agency must be provided to clients in a manner that is clearly legible and must include the words: "To report a complaint regarding the services you receive, please call toll-free (phone number)." 2 neglectful, or practices. The statewide toll-free telephone number for the central hottler must be provided to clients in a manner that is clearly legible and must include the words: "To report neglect, or practices, or practices, or	SUMMARY STATEMENT OF DEFICIENCIES SEACH DEPICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC DEMTIFYING INFORMATION) Continued From page 17 Record review // at 10:34 am, revealed the Administrator and the Financial Officer had not obtained a level 2 background screening conducted through the agency. Interview on // at 11:33 am, the Medical Assistant acknowledged the Administrator and the Financial Officer had not obtained a level 2 background screening conducted through the agency. AZ818 AZ818	SUMMARY STATEMENT OF DEFICIENCE BY FULL REQUIREMENT OF DEFICIENCE BY FULL REQUIREMENT OF MACHINE BY FULL REPORT OF M			

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AHCA Form 3020-0001 STATE FORM

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		AC13960104	B. WING		10/31/2016	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
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AZ818	Continued From pa	age 18	AZ818			
	telephone number hotline must be prothat is clearly legibl "To report suspects full-free (phone nur The agency shall p advance notice of telephone numbers (b) Each licensees policies and proced to clients. This Statute or Rul Based on record reprovider failed to p toll-free numbers in Healthcare Administ number, the	sublish a minimum of a 90-day a change in the toll-free shall establish appropriate dures for providing such notice le is not met as evidenced by: eview and interview the rovide clients with the required ncluding the Agency for stration (AHCA) complaint /neglect number and the mber, on or before the first day				
	The findings:	/ at 10:30 am, revealed				
	no documentation with the required to	that the clinic provided clients oll-free numbers on or before es were provided to clients.				
		at 11:33 am, the Medical edged that the clinic does not the required toll-free numbers				

including the AHCA complaint number, the
//neglect number and the Medicaid fraud
number, on or before the first day services were
provided to a client. The Medical Assistant stated
that she doesn't know the required toll-free

	or Health Care Adm					APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING:		(X3) DATE SURVEY COMPLETED		
	AC13960104		B. WING		10/31/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET	DDRESS, CITY, S	STATE, ZIP CODE		
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AZ818	Continued From pa	nge 19	AZ818			
	numbers.					

STATE FORM





JUSTIN M. SENIOR

. , 2016

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 Re-licensure survey that was conducted on 31, 2016 by a representative 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 , 2016.

The plan of correction must include the following:

- Identify how corrective action will be accomplished for those residents found to have been affected by the deficient oractice.
- Describe how the facility will identify other residents having the potential to be affected by the same deficient practice.
- Explain measures to be put into place or systemic changes made to ensure that the deficient practice will not recur.
- 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.
- Ensure that no protected or other confidential information (i.e., resident or staff names) are included in the plan.
- State the completed date; the date that the facility identifies compliance can be achieved, which must be after the exit date.
- 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





A Medical Office For Women 2016

Page 2

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 Fav Field Office Manager, Area 11

Enclosure: State (3020) Form

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