| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AC13940024 | 10/12/2016 |
| NAME OF PROVIDER OR SUPPLIER<br>**ADVANCE WOMAN'S CARE CENTER, INC.** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**2742 SOUTHWEST 8TH STREET #20**<br>**MIAMI, FL 33147** | |

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

**0000 INITIAL COMMENTS**

A relicensure survey was conducted on 12, 2016. Advanced Woman's Care Center, license #766 had licensure deficiencies found at the time of the visit.

**Z814 Backaround Screenina Clearinahouse**

Based on record review and interview, the provider failed to ensure that the administrator /-chief financial officer were listed on the clearing house roster.

Findings include:

Record review revealed the administrator is listed as the chief financial officer. Further record review revealed the administrator/chief financial officer is not listed on the clearing house roster.

On at 11:07 AM, the administrator/chief financial officer acknowledged not being listed on the clearing house roster.

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Advance Woman's Care Center, Inc.
2742 SW 8th Street #20
Miami, FL 33147

Dear Administrator:

This letter reports the findings of a state relicensure survey that was conducted on , 2016 by a representative 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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