

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AC13960099	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MIRAMAR WOMAN CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6161 MIRAMAR PKWY SUITE 300 MIRAMAR, FL 33023
---	---

(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
CZ818 SS=D	<p>408.810(5) FS Minimum Licensure Requirement - Client Notice</p> <p>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.</p> <p>(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:</p> <ol style="list-style-type: none"> 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 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)." 3. Medicaid fraud. An agency-written description of Medicaid fraud and the statewide toll-free telephone number for the central Medicaid fraud hotline must be provided to clients in a manner that is clearly legible and must include the words: "To report suspected Medicaid fraud, please call toll-free (phone number)." <p>The agency shall publish a minimum of a 90-day advance notice of a change in the toll-free telephone numbers.</p> <p>(b) Each licensee shall establish appropriate policies and procedures for providing such notice to clients.</p>	CZ818		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AC13960099	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MIRAMAR WOMAN CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6161 MIRAMAR PKWY SUITE 300 MIRAMAR, FL 33023
---	---

(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
CZ818	<p>Continued From page 1</p> <p>This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide written information to patients for reporting Neglect, Complaints, and Medicaid Fraud for 10 of 10 patients. (Patient #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10).</p> <p>The findings included:</p> <p>Review of 10 patient records reveals no evidence of documentation that written information regarding reporting neglect, complaints, and medicaid fraud was provided to patients in a manner that is clearly legible and includes the required words, on or before the first day of services.</p> <p>Interview with the Administrator on _____, at approximately 1:00 PM confirms this information was not provided to patients. Observation reveals this information was on a placard at the "check in" area of the clinic; however the Administrator states she had no knowledge that the information must be provided to patients, as mandated in AHCA (Agency for Health Care Administration) regulations.</p>	CZ818		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AC13960099	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MIRAMAR WOMAN CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6161 MIRAMAR PKWY SUITE 300 MIRAMAR, FL 33023
---	---

(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	<p>INITIAL COMMENTS</p> <p>An unannounced relicensure survey was conducted on ____ at Miramar Woman Center. The facility had deficiencies at the time of the survey.</p>	A 000		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____