

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AC1396D052	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/01/2014
NAME OF PROVIDER OR SUPPLIER BLUE CORAL WOMEN'S CARE, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 7360 CORAL WAY SUITE 16 MIAMI, FL 33155	

(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 relicensure survey was conducted on May 1, 2014 at Blue Coral Women's Care Inc. located at 7360 Coral Way Suite 16 Miami FL, 33155. Blue Coral Women's Care Inc. had a deficiency found at the time of the visit.	A 000	In response of the initial comments stated on the Licencensure survey with the id prefix tag A 000.	5/15/14
A 100	Physical Plant Req.-2nd Trimester The following are minimum standards of construction and specified minimum essential physical plant requirements which must be met when providing second trimester abortions. (1) Consultation room(s) with adequate private space specifically designated for interviewing, counseling, and medical evaluations; (2) Dressing rooms designated for staff and patients. (3) Handwashing station(s) equipped with a mixing valve and wrist blades and located in each patient exam/procedure room or area; (4) Private procedure room(s) with adequate light and ventilation for abortion procedures. (5) Post procedure recovery room(s) equipped to meet the patient's needs. (6) Emergency exits wide enough to accommodate a standard stretcher or gurney; (7) Cleaning and sterilizing area(s) adequate for the cleaning and sterilizing of instruments; (8) Adequate and secure storage area(s) for the storage of medical records and necessary equipment and supplies; and	A 100	As it states under the summary statement of deficiencies we state that Blue Coral Women's Care Inc meet the requirement accord with the standards. And we reconfirm that we do not perform 22 trimester cases. 22 trimester cases are sending to North shore hospital.	5/15/14 5/20/14

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

Maria A. Fernandez *[Signature]*

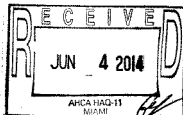
TITLE: Administrator
 (X5) DATE: 5/25/14

STATE FORM

MM

X89111

If continuation sheet 1 of 2



AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: AC13860052	A. BUILDING: _____	COMPLETED 05/01/2014
NAME OF PROVIDER OR SUPPLIER BLUE CORAL WOMEN'S CARE, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 7360 CORAL WAY SUITE 15 MIAMI, FL 33155		
(X) 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)	DATE COMPLETE
A 100	Continued From page 1 (9) If not otherwise required by the Florida Building Code, at least one general use toilet room equipped with a hand washing station. Chapter 59A-9.022, F.A.C. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the hand-washing station in the procedure room is equipped with wrist-blade faucet handles. The findings include: A tour of the facility was conducted on 5/1/2014 beginning at 10:30 am with the facility's Administrator. An observation of the hand-washing station in the procedure room revealed the faucet had two round, plastic knob handles (one for hot and one for cold) rather than wrist-blade handles. An interview conducted with the Administrator at this time confirmed this is the hand-washing sink the physician uses during procedures. A follow-up interview conducted with the Administrator on 5/1/2014 at 10:55 am also confirmed the faucet in the procedure room does not have wrist-blade handles.	A 100	In response of initial comments stated on the licensed survey with prefix 100. It is correct that the hand-washing station is not equipped with wrist blade faucet handles. This will be corrected changing the faucet for electronic hands free faucet. picture attached	5/25/14 5/25/14

AHCA Form 3020-0001
STATE FORM

X99111

If continuation sheet 2 of 2



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

May 15, 2014

Administrator
Blue Coral Women's Care, Inc.
7360 Coral Way Suite 16
Miami, FL 33155

Dear Administrator:

This letter reports the findings of a State Re-licensure survey that was conducted on May 1, 2014 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 May 30, 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.



Blue Coral Women's Care, Inc.

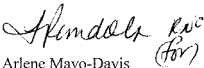
May 2, 2014

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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,

A handwritten signature in cursive script that reads "Arlene Mayo-Davis". To the right of the signature, there are initials "AM" and a circled "FD" in the bottom right corner.

Arlene Mayo-Davis
Field Office Manager, Area 11

Enclosure: State (3020) Form