

PRINTED: 12/07/2009  
FORM APPROVED

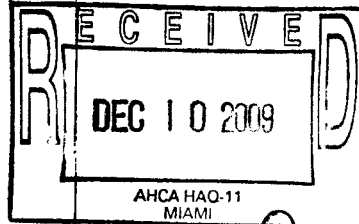
Agency For Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>AC13920002</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/23/2009</b>
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NAME OF PROVIDER OR SUPPLIER <b>HIALEAH WOMEN'S CENTER, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>952 EAST 25TH STREET HIALEAH, FL 33013</b>
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(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 DEFICIENCY)	REVISION SHOULD BE APPROPRIATE	(X5) COMPLETE DATE
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A 000	INITIAL COMMENTS  An unannounced visit was made to Hialeah Women's Center, Inc. on November 23, 2009, in order to conduct a State Licensure Survey. The facility was not in compliance with 390.014 F.S., 59A-9 F.A.C. at the time of the survey. The following deficiency was identified. Recommend a plan of correction.	A 000			
A 156	Clinic Supplies/equip. Stand.-2nd Trimester  Equipment Maintenance.  (a) When patient monitoring equipment is utilized, a written preventive maintenance program shall be developed and implemented. This equipment shall be checked and/or tested in accordance with manufacturer's specifications at periodic intervals, not less than annually, to insure proper operation, and a state of good repair. After repairs and/or alterations are made to any equipment, the equipment shall be thoroughly tested for proper calibration before returning it to service. Records shall be maintained on each piece of equipment to indicate its history of testing and maintenance.  (b) All anesthesia and surgical equipment shall have a written preventive maintenance program developed and implemented. Equipment shall be checked and tested in accordance with the manufacturer's specifications at designated intervals, not less than annually, to ensure proper operation and a state of good repair.  (c) All surgical instruments shall have a written preventive maintenance program developed and implemented. Surgical instruments shall be cleaned and checked for function after use to ensure proper operation and a state of good	A 156			



*[Handwritten signature]*

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

021199

QY7Q11

If continuation sheet 1 of 2

*[Handwritten signature]* CEO 12/10/2009

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Agency For Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>AC13920002</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/23/2009</b>
NAME OF PROVIDER OR SUPPLIER <b>HALEAH WOMEN'S CENTER, INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>952 EAST 25TH STREET HALEAH, FL 33013</b>		
(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 DEFICIENCY)	(X5) COMPLETE DATE	
A 156	Continued From Page 1  repair.  Chapter 59A-9.0225(7), F.A.C.  This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure preventive maintenance was completed on equipment utilized for patient monitoring.  Findings include:  During a tour conducted on 11-23-2009 at 11:00am, the surveyor observed the following equipment needing current preventive maintenance: Ultrasound, defibrillator, suction unit, vacuum, sterilization machine, and cardiac monitor. Interview with staff on 11-23-2009 at 11:25 am, revealed they had an appointment scheduled with the medical equipment maintenance company for last week, but the technician failed to show up. The maintenance company confirmed the staff's statement. Staff received verbal confirmation the technician will be out to complete scheduled maintenance of the facility's equipment.  Correction date: 12-23-2009	A 156	<i>ON NOV. 25 2009 Pace Medical Maintenance, Inc conducted the inspection on the equipment. A copy of their report is attached. Problems were found on the defibrillator. A loaner was issued until the repairs complete. Our next calibration is due 05/200.</i>	<i>11/25/09</i>	
			<i>12/10/2009</i>		

AHCA Form 3020-0001

STATE FORM

02100

QY7Q11

If continuation sheet 2 of 2

*Dora Wang*

*CEO*

*12/10/2009*



CHARLIE CRIST  
GOVERNOR

*Better Health Care for all Floridians*

THOMAS W. ARNOLD  
SECRETARY

December 7, 2009

Administrator  
Hialeah Women's Center, Inc  
952 East 25th Street  
Hialeah, FL 33013

Dear Administrator:

This letter reports the findings of a state licensure renewal survey that was conducted on November 23, 2009 by a representative of this office.

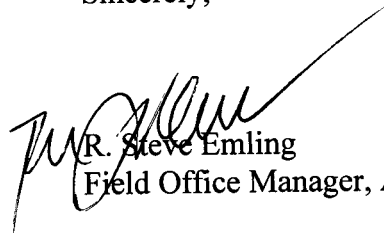
Attached is the provider's copy of the State Form 3020, which indicates the deficiency that was identified on the day of the visit.

Please provide a plan of correction to this Field Office, in accordance with enclosed instructions, for the identified deficiencies **within ten (10) 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 December 23, 2009.**

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 Ric Garcia, RNC and Supervisor Hospital/HHA Unit at (305) 499-2165.

Sincerely,

  
R. Steve Emling  
Field Office Manager, Area 11

Enclosures: State Form 3020 and POC Guidelines.

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Headquarters  
2727 Mahan Drive  
Tallahassee, FL 32308  
<http://ahca.myflorida.com>



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Miami Field Office  
8355 N.W. 53rd Street, First Floor  
Miami, FL 33166  
Phone (305) 499-2165; Fax (305) 499-2190