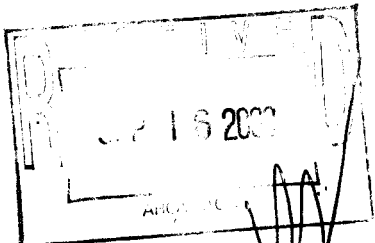


PRINTED: 09/08/2008  
 FORM APPROVED

Agency For Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>AC13928002</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/02/2008</b>
NAME OF PROVIDER OR SUPPLIER <b>HIALEAH WOMEN'S CENTER, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>982 EAST 25TH STREET HIALEAH, 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	INITIAL COMMENTS  An unannounced visit was made to the facility on September 2, 2008, in order to conduct a state licensure survey. The following deficiencies were identified at the time of the licensure survey	A 000	 Our written policies and procedures are contained in the employee manual which is attached.	
A 250	<b>Clinic Policies/Procedures-2nd Trimester</b>  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. These clinic policies and procedures shall include but not be limited to the following: (1) Patient admission; (2) Pre- and post-operative care; (3) Physician's orders; (4) Standing orders with required signatures; (5) Medications, storage and administration; (6) Treatments; (7) Surgical asepsis; (8) Medial aseptic; (9) Sterilization and disinfection; (10) Documentation: Medical records and facility records; (11) Patient discharge; (12) Patient transfer; (13) Emergency measures; (14) Incident reports; (15) Personnel orientation; (16) Inservice education record; (17) Anesthesia; (18) Equipment and supplies: availability and maintenance;	A 250		

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

TITLE  
**CEO**

(X6) DATE  
**9/15/08**

PRINTED: 09/05/2008  
 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>09/02/2008</b>
NAME OF PROVIDER OR SUPPLIER <b>HIALEAH WOMEN'S CENTER, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>982 EAST 28TH STREET HIALEAH, 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 250	Continued From Page 1  (19) Volunteers; and (20) Visitors.  Chapter 58A-9.024, F.A.C.  This Standard is not met as evidenced by: Based on record review, the facility failed to have their written policies and procedures reviewed and approved annually by the clinic's medical director.  Findings include:  A review of the facility's license conducted on 8-2-2008, revealed the clinic is licensed to perform first and second trimester abortions only. The surveyor reviewed the facility's policies and procedures. The last date of revision/review was July 2007. The facility was unable to provide documentation demonstrating that policies and procedures had been reviewed and approved by the facility's medical director on an annual basis.  Class III Correction date: 10-1-2008	A 200	This clinic has no volunteers. Due to confidentiality no visitors are allowed.	

AHCA Form 3020-0001

STATE FORM

001100

CS7P11

If continuation sheet 2 of 2

*Debra Hayes*

9/05/08



CHARLIE CRIST  
GOVERNOR

HOLLY BENSON,  
SECRETARY

September 5<sup>th</sup>, 2008

Dayana Gowdy, Administrator  
Hialeah Women's Center  
952 East 25<sup>th</sup> Street  
Hialeah, Florida 33013

Dear Ms Gowdy:

This letter is to report the findings of the annual Licensure survey, which was completed on September 2, 2008 by Kim Ody, Health Facility Evaluator II, of this office.

Enclosed, please find State Form 3020, Statement of Deficiencies and Plan of Correction, which enumerate the deficiency that was found during the survey and discussed with you and your staff during the survey and at the exit conference.

**Please provide an acceptable Plan of Correction for each deficiency on the State Form 3020 in accordance with the enclosed instructions (Guidelines for Development of Plans of Correction). You must include on your Plan of Correction who, when and how the deficiency is to be corrected as well as how the requirement will be monitored for future compliance. You must sign, date, and return the Statement of Deficiencies/Plan of Correction, State Form 3020, to this office within ten (10) calendar days of receipt. All citations must be corrected within 30 days of survey date.**

Sign and return the original State Form 3020 with the Plan of Correction to:

**R. Steve Emling  
Field Office Manager, Area 11  
Agency for Health Care Administration, HQA Area 11  
Manchester Bldg, 1<sup>st</sup> floor  
8355 N.W 53<sup>rd</sup> Street  
Miami, FL 33166  
(305) 499-2165  
FAX: (305) 499-2190**

Any deficiencies, which were repeated from previous surveys, or deficiencies that are not corrected within the established time frames may be subjected to administrative actions or fines by the department.

Certain documents may be made available for public disclosure as required by law.

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 [www.fdhc.state.fl.us/Publications/](http://www.fdhc.state.fl.us/Publications/), as a first step in providing a web-based interactive consumer

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



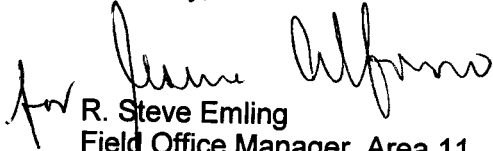
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Area Office 11  
8355 NW 53<sup>rd</sup> street  
Manchester Building 1<sup>st</sup> Floor  
Miami, Florida 33166

satisfaction survey system. You may access the questionnaire through the link under **Forms** 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 every assistance provided during this survey process. If you have any questions regarding this report, please call Ric Garcia, RNC and Supervisor of the HHA/Hospital Unit of this office at (305) 499-2165.

Sincerely,

A handwritten signature in black ink, appearing to read "R. Steve Emling". The signature is written in a cursive style with a large initial "R" and "E".

R. Steve Emling  
Field Office Manager, Area 11  
Division of Health Quality Assurance

Enclosure: State Form 3020, and Instructions  
Copies to: Hospital and Outpatient Services