

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AC13940024	(X3) DATE SURVEY COMPLETED 03/15/2016
NAME OF PROVIDER OR SUPPLIER ADVANCE WOMAN'S CARE CENTER, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 2742 SOUTHWEST 8TH STREET #20 MIAMI, FL 33147	

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

0000 INITIAL COMMENTS

A relicensure survey was conducted on _____, 2016 at Advance Woman's Care Center Inc .

Advance Woman's Care Center Inc had Licensure a deficiency found at the time of the visit.

0202 Clinic Personnel-2nd Tri-Orientation/Trainina

Based on record review and interview, the provider failed to ensure that 1 out of 1 (staff B) employee received in-service training annually.

Findings:

A review of staff B record revealed the last in-service training was conducted on ____ / ____ .

On ____ / ____ at 10:20 AM, staff B acknowledged _____ as the last date of in-service training.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

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

Dear Administrator:

This letter reports the findings of a State Re-licensure 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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