

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

**PRINTED: 04/01/2016
FORM APPROVED**

| | | |
|---|--|---|
| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AC13920002 | (X3) DATE SURVEY COMPLETED R 04/01/2016 |
| NAME OF PROVIDER OR SUPPLIER HIALEAH WOMEN'S CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 952 EAST 25TH ST HIALEAH, FL 33013 | |

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

0000 INITIAL COMMENTS

A follow-up desk review was conducted on April 1, 2016 to the State Re-licensure survey, which was completed on March 21, 2016. Based on an acceptable plan of correction, the deficiencies identified on the survey were determined to be corrected.

STATE FORM: REVISIT REPORT

| | | | | | |
|--|----|---|--|-----------------------------|----|
| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AC13920002 | y1 | MULTIPLE CONSTRUCTION A. Building B. Wing | y2 | DATE OF REVISIT 4/1/2016 | y3 |
| NAME OF FACILITY HIALEAH WOMEN'S CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 952 EAST 25TH ST HIALEAH, FL 33013 | | |

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

| ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 |
|----------------------------|------------|-----------------|------------|-----------------|------------|
| ID Prefix A0202 | Correction | ID Prefix _____ | Correction | ID Prefix _____ | Correction |
| Reg. # 59A-9.023(4-5), FAC | Completed | Reg. # _____ | Completed | Reg. # _____ | Completed |
| LSC _____ | 04/01/2016 | LSC _____ | _____ | LSC _____ | _____ |
| ID Prefix _____ | Correction | ID Prefix _____ | Correction | ID Prefix _____ | Correction |
| Reg. # _____ | Completed | Reg. # _____ | Completed | Reg. # _____ | Completed |
| LSC _____ | _____ | LSC _____ | _____ | LSC _____ | _____ |
| ID Prefix _____ | Correction | ID Prefix _____ | Correction | ID Prefix _____ | Correction |
| Reg. # _____ | Completed | Reg. # _____ | Completed | Reg. # _____ | Completed |
| LSC _____ | _____ | LSC _____ | _____ | LSC _____ | _____ |
| ID Prefix _____ | Correction | ID Prefix _____ | Correction | ID Prefix _____ | Correction |
| Reg. # _____ | Completed | Reg. # _____ | Completed | Reg. # _____ | Completed |
| LSC _____ | _____ | LSC _____ | _____ | LSC _____ | _____ |
| ID Prefix _____ | Correction | ID Prefix _____ | Correction | ID Prefix _____ | Correction |
| Reg. # _____ | Completed | Reg. # _____ | Completed | Reg. # _____ | Completed |
| LSC _____ | _____ | LSC _____ | _____ | LSC _____ | _____ |

| | | | | |
|---|------------------------|---|---------------------------|----------------|
| REVIEWED BY STATE AGENCY <input type="checkbox"/> | REVIEWED BY (INITIALS) | DATE | SIGNATURE OF SURVEYOR | DATE 4/1/16 |
| REVIEWED BY CMS RO <input type="checkbox"/> | REVIEWED BY (INITIALS) | DATE | TITLE | DATE |
| FOLLOWUP TO SURVEY COMPLETED ON 3/21/2016 | | <input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? | | |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | |



RICK SCOTT
GOVERNOR
ELIZABETH DUDEK
SECRETARY

April 1, 2016

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

Dear Administrator:

This letter reports the findings of a follow-up desk review that was conducted on April 1, 2016 to the State Re-licensure survey, which was completed on March 21, 2016. Based on an acceptable plan of correction, the deficiencies identified on the survey were determined to be corrected.

Attached is the provider's copy of the Revisit Report.

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: Revisit Report

J5XD

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