

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>AC13960098</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/28/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>A HIALEAH WOMEN CENTER, INC.</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>697 E. 9TH STREET HIALEAH, FL 33010</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  A relicensure survey was conducted on April 28, 2014. A Hialeah Women Center, Inc. had no Licensure deficiencies found at the time of the visit.	A 000		

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

TITLE

(X6) DATE



RICK SCOTT  
GOVERNOR

ELIZABETH DUDEK  
SECRETARY

May 14, 2014

Administrator  
A Hialeah Women Center, Inc.  
697 E. 9th Street  
Hialeah, FL 33010

Dear Administrator:

This letter reports findings of a State Re-licensure survey that was conducted on April 28, 2014 by a representative of this office. Attached is the provider's copy of the State (3020) Form, which indicates there were no discernible deficiencies noted on the date of the survey.

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 black ink that reads "Arlene Mayo-Davis" with a stylized flourish at the end.

Arlene Mayo-Davis  
Field Office Manager, Area 11

Enclosure: State (3020) Form

