

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AC13960129	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/28/2015
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NAME OF PROVIDER OR SUPPLIER A WOMAN'S OPTION	STREET ADDRESS, CITY, STATE, ZIP CODE 1933 W 60TH ST HIALEAH, FL 33012
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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 APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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{A 000} INITIAL COMMENTS	<p>{A 000}</p> <p>A follow-up desk review was conducted on April 28, 2015 to the State Re-licensure survey, which was completed on March 18, 2015. Based on an acceptable plan of correction, the deficiencies identified on the survey were determined to be corrected.</p>			
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AHCA Form 3020-0001

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

TITLE

(X6) DATE

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA /
Identification Number
AC13960129

(Y2) Multiple Construction
A. Building
B. Wing

(Y3) Date of Revisit
4/28/2015

Name of Facility
A WOMAN'S OPTION

Street Address, City, State, Zip Code
1933 W 60TH ST
HIALEAH, FL 33012

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix A0156 Reg. # LSC	Correction Completed 04/28/2015	ID Prefix A0201 Reg. # LSC	Correction Completed 04/28/2015	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By
State Agency
Reviewed By
CMS RO

Reviewed By
Reviewed By

Date:
Date:

Signature of Surveyor:
Kim Ody
Signature of Surveyor:

Date:
4-28-15
Date:

Followup to Survey Completed on:
3/18/2015

Check for any Uncorrected Deficiencies. Was a Summary of
Uncorrected Deficiencies (CMS-2567) Sent to the Facility?

YES NO



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

April 28, 2015

Administrator
A Woman's Option
1933 W 60th ST
Hialeah, FL 33012

Dear Administrator:

This letter reports the findings of a follow-up desk review that was conducted on April 28, 2015 to the State Re-licensure survey, which was completed on March 18, 2015. 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

