

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>AC13960104</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R <b>10/17/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>A MEDICAL OFFICE FOR WOMEN</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>909 NE 163 STREET SUITE 402 NORTH MIAMI BEACH, FL 33162</b>
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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}	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced follow-up visit was conducted on October 17, 2011 to the State Relicensure Survey, which was completed on September 15, 2011 at A Medical Office For Women located at 909 NE 163rd Street, Suite #40233162, Miami, Florida 33135. A Medical Office For Women was in compliance with Chapters 381 and 390 Florida Statutes and 59A-9 Florida Administrative Code requirements for Abortion Clinics at the time of the survey.</p>	{A 000}		
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AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

5999

LDBE12

If continuation sheet 1 of 1

**State Form: Revisit Report**

(Y1) Provider / Supplier / CLIA / Identification Number AC13960104	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 10/17/2011
Name of Facility A MEDICAL OFFICE FOR WOMEN		Street Address, City, State, Zip Code 909 NE 163 STREET SUITE 402 NORTH MIAMI BEACH, FL 33162

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 <b>A0150</b> Reg. # _____ LSC _____	Correction Completed 10/17/2011	ID Prefix <b>A0156</b> Reg. # _____ LSC _____	Correction Completed 10/17/2011	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: <i>Marcy Lubin for S. Rando</i>	Date: 10/31/2011
State Agency _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
Reviewed By _____	Reviewed By _____	Date: _____		Date: _____
CMS RO _____				

Followup to Survey Completed on: 9/15/2011	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <input type="checkbox"/> YES <input type="checkbox"/> NO
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RICK SCOTT  
GOVERNOR

*Better Health Care for all Floridians*

ELIZABETH DUDEK  
SECRETARY

October 26, 2011

Administrator  
A Medical Office For Women  
909 Ne 163 Street, Suite 402  
North Miami Beach, FL 33162

Dear Administrator:

This letter reports the findings of a follow-up visit conducted on October 17, 2011 to the State Licensure survey completed on September 15, 2011.

Attached is the provider's copy of the Revisit Report, which indicates the previously cited deficiencies were found corrected on the day of the 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 (3020) Form and Revisit Report

