

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>AC13910004</b>	(X3) DATE SURVEY COMPLETED  <b>05/16/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>A EVE'S CLINIC &amp; REFERRAL SERVICE, INC.</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 NORTHWEST 79TH AVENUE MIAMI, FL 33156</b>	

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

**0000 INITIAL COMMENTS**

A relicensure survey was conducted on . . . . ., 2016 at A Eve's Clinic & Referral Service, INC.

A Eve's Clinic and Referral Service Inc. had deficiencies found at the time of the visit.

**0600 Clinical Records**

Based on record review and interview, the provider failed to ensure that 1 out of 6 (#3) clinical records were accurately documented.

Findings :

A review of clinical record #3 revealed the Procedure Documentation form have the 1st trimester marked off , however the remaining information shows the procedure was for a 2nd trimester ( & Evacuation).

On . . . . . at 11:08 AM, staff B reviewed clinical record #3 and acknowledged the discrepancy. When asked if clinical record #3 was for a 1st trimester procedure or for a 2nd trimester procedure, Staff B stated it was for a 2nd trimester procedure.



RICK SCOTT  
GOVERNOR

ELIZABETH DUDEK  
SECRETARY

1, 2016

Administrator  
A Eve's Clinic & Referral Service, Inc.  
3900 Northwest 79th Avenue  
Miami, FL 33156

Dear Administrator:

This letter reports the findings of a 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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