



State of Tennessee
Health Facilities Commission
665 Mainstream Drive, 2nd Floor, Nashville, TN 37243
www.tn.gov/hfc Phone: 615-741-7221

July 31, 2024

Sent Via Email

Danila Nobrega
ADW Diabetes, LLC
2501 NW 34th Pl Ste 35
Pompano Beach, Florida 33069

Facility Type: Home Medical Equipment

Dear Danila Nobrega:

It is my pleasure to inform you that your application for ADW Diabetes, LLC located at 2501 NW 34th Pl Ste 35 Pompano Beach, Florida 33069 has been initially approved for providing Home Medical Equipment services in all counties in Tennessee; effective July 10, 2024. The license number shall be 1439. For this initial approval to become final and permanent, your application must be ratified by the commission pursuant to T.C.A. §68-11-206. The Commission will consider your application at its next meeting, scheduled for August 2024. **You are hereby authorized to commence operation pending the final decision of the Commission** No further action is necessary on your part currently.

For certification purposes, please be advised it is your responsibility to contact your Health Facilities Commission regional office for participation in Medicare/Medicaid. The East Tennessee Regional Office phone number is 865-594-9396 .

If the Commission **does** ratify the approval of your application, the license number listed above will become your permanent license number and a letter will be forwarded to you within three (3) business days; notifying you of the Commission final decision.

If the Commission **does not** ratify the initial approval of your application, a letter will be forwarded to you providing an explanation and specific instructions as to any action(s) you may take to have the decision reviewed, at which time this authorization shall cease to be effective.

Please contact me if I can be of further assistance.

Sincerely,

Niraj Soni

Niraj Soni, ASA 3
Phone: (615) 741-7539
Fax: (615) 253-8798
Email: Niraj.Soni@tn.gov

cc: East Tennessee Regional Administrator



APPROVAL FOR FACILITY LICENSURE OR OCCUPANCY

Facility Type: HME License # (if applicable): _____ County: out of State

Initial X Renovation _____ Satellite/Off Campus Location _____
Physical Plant/Services/New Addition _____ Relocation/Replacement Facility _____
(Circle One) (Circle One)

Facility Name: ADW Diabetes LLC

Address: 2501 NW 34th Place, Suite 35 City: Pompano Beach FL Zip Code: 33069

Application and fee on file in Central Office (CO)? Yes _____ No _____ CON #: _____

Project #: _____ Phase: _____ of _____

Facility approved for (if satellite/off campus site include address): To provide HME services to all counties in Tennessee. _____

Sprinklered: _____ (Full 100%) Partial: _____ (%)

Licensed bed count from: _____ to _____ Number of beds increased/decreased: _____

If secured unit, number of beds in unit: _____ If Alzheimer's unit, number of beds in unit: _____
(NOTE: If this is an increase in the number of beds in a secured Alzheimer's unit, indicate number of beds approved for the increase number only)

Health Surveyor: Robert K. Anderson Date: 7-10-2024

Fire Safety: _____ Date: _____

CD Approved: Yes _____ No _____ N/A _____ Health Survey Required: Yes _____ No _____

Facility's Letter of Notification received in Licensure: Yes _____ No ✓
(Completed by Central Office Licensure Staff)

CMS Paperwork (855, etc) approved and received in regional office: Yes _____ No _____
(NOTE: With exception of Initial Licensure Approvals)

Effective date: July 10, 2024 Licensure is recommended: Yes X No _____
(Completed by Central Office Licensure Staff)

Debra Verna / Tom Lere 7-10-24
Regional Administrator/Facilities Construction Director or Designee Date

Mary S 7/31/24
Licensure Program Unit Staff Date

**RECEIVED**

By Mary Louise Clark at 9:36 am, Mar 22, 2024

East/ITSD File #1439 App #23063

HOME MEDICAL EQUIPMENT**APPLICATION FOR INITIAL LICENSURE**

All applicable laws, rules, policies, and guidelines affecting your practice are available for viewing at <https://www.tn.gov/hfc/division-of-licensure-and-regulation/hfc-licensure/licensure-applications.html>. Please check this website periodically for updates.

Name of the Facility/Agency ADW Diabetes, LLC**Location of the Facility:**Street 2501 NW 34th PL Ste 35 City Pompano BeachCounty Broward State FL Zip 33069Phone Number (877) 241-9002 Fax Number (954) 975-3786Twenty-four (24) Hour Emergency Phone Number (877) 241-9002Business Customer Service Phone Number with twenty-four (24) hour access/seven (7) days a week (877) 241-9002E-Mail Address DANOBREGA@ADW Diabetes.comDoes your facility have a physical location in the state of Tennessee? Yes ☐ No ☒**Administrator Information:**Administrator Daniela NobregaHave you (Administrator) ever been convicted of a crime involving injury or harm to person(s), financial or business management (e.g., assault, battery, robbery, embezzlement, or fraud)? Yes ☐ No ☒

If yes, what charge(s)? _____

Location of Conviction _____ Date _____
(City) (County) (State)**Mailing address if different from the Facility location address:**Name SAME

Street _____

City _____ State _____ Zip _____

Ownership of Building:Name Michael Maguire Phone Number (877) 241-9002Street 2501 NW 34th PL Ste 35City Pompano Beach State FL Zip 33069

1. Are you a provider providing manufactured or distributing company-branded Insulin Infusion Pumps and related supplies? Yes ☒ No ☐ (If so, the following are requirements, which must be met).
- a. Do you have an employee presence within the state of Tennessee? Yes ☐ No ☒
(Please describe the nature of the employee's physical presence in the state) _____
- b. Provide Joint Commission Accreditation (JCAHO). (Please provide JCAHO letter and complete report in accordance with T.C.A. TCA 68-11-226(e)) The Compliance Team.
2. Geographic area served by Agency: (list county or counties) If additional space is needed, please use a separate page.
All Counties
3. Number of branch offices: N/A
Address of each branch office: (If additional space is needed, please use a separate page)
N/A
4. Provide proof of the ability to meet the financial needs of the facility.

OWNERSHIP OF BUSINESS:

1. a. Check the type of Legal Entity:
☐ Individual ☐ Partnership ☐ Corporation ☒ Limited Liability Company
☐ Church Related ☐ Government/County ☐ Other
- b. Check one: For Profit ☒ Non-profit ☐
- c. Legal Entity checked in 1.a:
Name ADW Diabetes, LLC Phone Number (877) 241-9002
Street 2501 NW 34th PL Ste 35
City Pompano Beach State FL Zip 33069
- d. List name(s) and address(es) of individual owners, partners, directors of the corporation, or head of the governmental entity:
Michael Maguire 2501 NW 34th PL Ste 35 Pompano Beach FL
Name Street City, State, Zip
Christopher Maguire 2501 NW 34th PL Ste 35 Pompano Beach FL
Name Street City, State, Zip

Name Street City, State, Zip
(If additional space is needed, please use a separate sheet)
- e. If a government/county owned facility, does the administrator have authority to act on behalf of the government/county as it relates to the operation of this facility? Yes ☒ No ☐

- f. If no to e., who has said authority? _____
2. a. Is your facility/organization accredited by a federally approved accrediting body but not limited to JCAHO, CARF, etc.? Provide proof of accreditation.
Yes ☒ No ☐ Expiration Date 1/10/27
3. If you have a parent company, please provide the following information:
Name _____ Phone Number () _____
Address _____
4. a. If a corporation, is there a holding company? Yes ☐ No ☒
b. If yes, list the name, address and phone number of the holding company:
Name _____ Phone Number () _____
Street _____
City _____ State _____ Zip _____
5. a. Are any owners of the disclosing entity or also owners of other health care facilities in Tennessee and/or other states? Yes ☐ No ☒
b. If yes, list names and addresses of all such facilities:

6. a. Do you have a contract with a management firm to operate this facility? Yes ☐ No ☒
If yes, specify dates: From _____ To _____
b. If yes, please specify name of firm: _____
Phone Number () _____

Street _____ City, State, Zip _____
7. a. Have any owners of the disclosing entity ever been denied a license, had a license suspended or revoke, had a suspension of admissions or paid any civil monetary penalties for a health care facility in Tennessee or in any other state? Yes ☐ No ☒
b. If yes, where? _____ When? _____
c. For what reason? _____

VERIFICATION BY NOTARY PUBLIC:

Signee for application certifies that he or she is of responsible character and able to comply with the minimum standards and regulations established by Tennessee pertaining to the type of facility or agency for which application for licensure is made and with the rules promulgated under Tennessee Code Annotated (TCA) § 68-11-201.

Signee also certifies that a policy has been implemented to inform all employees of their obligation under TCA

§ 71-6-103 to report incidents of abuse or neglect.

☐ By checking this box, you acknowledge that you will ensure access to a secure online portal is available to Health Facilities Commission surveyors in order to conduct all necessary and required surveys related to licensure.

Applicant Signature

President, CEO

3/20/24
Date

STATE OF TENNESSEE

County of Broward

The above named applicant (print name) Michael Maguire, being by me duly sworn on his/her oath, deposes and says that he/she has read the forgoing application and knows the contents thereof: that the statements concerning the above named facility or agency, therein contained, are correct and true to his/her own knowledge.

Subscribed to and sworn to on this 20th day of March 2024
(Month) (Year)



BRIANA SUTTON
Commission # HH 428879
Expires August 2, 2027

Notary Public:

Briana Sutton

My commission expires: August 2, 2027

FEE SCHEDULE: (FEES ARE NON-REFUNDABLE)

\$1,404



State of Tennessee

Health Facilities Commission

665 Mainstream Drive, 2nd Floor, Nashville, TN 37243

www.tn.gov/hfc

Phone: 615-741-7221

March 22, 2024

Sent Via Email

ADW Diabetes, LLC
2501 NW 34th PL, Suite 35
Pompano Beach, Florida 33069

Dear ADW Diabetes, LLC:

This is to acknowledge receipt of your application and fee to apply for licensure of ADW Diabetes, LLC. Please review the instruction sheet that you received with the application to apply for licensure so that you are aware of the process for obtaining licensure of your facility. If a certificate of need is required to provide services, you will need to contact *Health Services and Developmental Agency* at (615) 741-2364.

Please remember that if you are applying for licensure of a facility that requires an architectural plans review contact Plans Review for complete and details and procedures at (615) 741-6998. You must submit those plans along with the plans review fee prior to scheduling a survey. **For Homes for the Aged facilities specifically; TCA-368-11-202 allows "schematics shall be submitted to the department for approval of plans and specifications, converting and existing single family dwelling" with six (6) or less beds.**

It is your responsibility to contact the East Tennessee Regional Office to request a survey of your facility. Please submit the request in writing to East Tennessee, Regional Administrator, 7175 Strawberry Plains Pike, Suite 103, Knoxville, Tennessee 37914. If you would like to fax the request to Debra Verna) the fax number is 865-594-5739.

Your application and fee will be held in a pending status until you are recommended by the Regional Office for licensure. Once the recommendation for licensure is received from the regional office, your facility will receive a letter for "Initial Approval." Admission of patients MAY NOT occur until the facility's receipt of the "Initial Approval" letter. Your application will be presented before the Board for Licensing Health Care Facilities for ratification and final approval at the next regularly scheduled board meeting. Your facility CAN operate once you receive the "Initial Approval."

This application will only be good for one (1) years from the date of receipt. If the initial licensure has not occurred within that one (1) year period you will be required to submit a new application and fee unless you have contacted our office in writing extending your application.

In the event that a certificate of need is required prior to obtaining a license for this facility the application file will be closed the day following the expiration date of the certificate of need.

Should you have any questions or if I can be of assistance to you please call me at (615) 741-7202 or you may email me at Mary.2.Clark2tn.gov.

Sincerely,

Mary Louise Clark

Mary Louise Clark, ASA 2



Tennessee Department of Health
Cash Listing Report

Client: 343 - DEPARTMENT OF HEALTH

Batch #: 183

Total \$ Entered: \$ 1,404.00

Receipt: 1

Receipts Entered: 1

Origin: Deposit

Fiscal Year: 2024

Deposit #: 03212024

Deposit Date: 2024-03-21

Total: \$ 1,404.00

Status: Deposited

Receipt #	DLN	Received	Disp	Pmt	Bad Check?	Unassigned	Prof	Remitted By / Beneficiary	File #	License #	Assigned
1446	37394775	\$ 1,404.00	DEP	CHK		\$ 1,404.00	548	AD ~~AD~~ DIABETES, LLC	1439		
Total:		\$ 1,404.00				\$ 1,404.00					

* DUPLICATE ****



STATE OF TENNESSEE
Health Services and Dev Agency
Office: Andrew Jackson, 8
3/21/2024 1:01 PM

Cashier: MARYL1011002
Batch #: 1588173
Trans #: 5

Health Care Facilities
Account #: 37394775

it Total: \$1,404.00
ction Total: \$1,404.00
21 \$1,404.00

Thank you for your payment.
Have a nice day!