FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AC13960091	A. BUILDING _____ B. WING _____	R 08/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST FLORIDA WOMEN'S CLINIC	710-12 PONDELLA ROAD N FT MYERS, FL 33903

(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 follow-up to the Relicensure survey was conducted on 8/14/12 at Southwest Florida Women's Clinic, the facility was not cleared of all deficiencies, A156 was re-cited. The following is a description of non-compliance:	{A 000}		
{A 156	Clinic Supplies/equip. Stand.-2nd Trimester Equipment Maintenance. (a) When patient monitoring equipment is utilized, a written preventive maintenance program shall be developed and implemented. This equipment shall be checked and/or tested in accordance with manufacturer's specifications at periodic intervals, not less than annually, to insure proper operation, and a state of good repair. After repairs and/or alterations are made to any equipment, the equipment shall be thoroughly tested for proper calibration before returning it to service. Records shall be maintained on each piece of equipment to indicate its history of testing and maintenance. (b) All anesthesia and surgical equipment shall have a written preventive maintenance program developed and implemented. Equipment shall be checked and tested in accordance with the manufacturer ' s specifications at designated intervals, not less than annually, to ensure proper operation and a state of good repair. (c) All surgical instruments shall have a written preventive maintenance program developed and implemented. Surgical instruments shall be cleaned and checked for function after use to ensure proper operation and a state of good repair.	{A 156}	Autoclave was serviced by Clinical Equipment Repair on 6.29.12 and a report was received from them which was prepared 7.3.12. Manufacturer's specifications state autoclave should be cleaned every 20 uses. We use about 2 to 3 times weekly so have instituted monthly cleanings. Have also ordered a testing kit to test the efficacy of the sterilizer. This will also be done on a monthly basis. Will formulate a written plan stating these objectives, and will begin keeping a written log with dates of cleaning and testing, and results of testing.	9/15/12

AHCA Form 3020-0001

Sally L Arjona — Office Manager — 8/30/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

STATE FORM 8XQT12 If continuation sheet 1 of 2

PRINTED: 08/20/2012
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	AG13960091	A. BUILDING _____ B. WING _____	R 08/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST FLORIDA WOMEN'S CLINIC	710-12 PONDELLA ROAD N FT MYERS, FL 33903

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{A 156}	Continued From page 1 Chapter 59A-9.0225(7), F.A.C. This STANDARD is not met as evidenced by: Based on observation during the clinic tour and staff interview, the clinic failed to provide a written preventive maintenance program for the, Auto Calve, sterilization machine. The clinic failed to follow the manufacturer's specifications for periodic checking and testing to insure proper operation, and failed to provide documentation of a maintenance program ensuring reused equipment is sanitization. The Findings include: On 8/14/12 at 2:45 a.m., during the tour of clinic the Auto Clave was observed in the back room. The date on the label attached to the Auto Clave is 6/29/12, the nurse stated, it was put on when we had to get it fixed. The clinic was able to provide a form from Clinical Equipment Repair, LLC dated 7/3/12. On 8/14/12 at 2:45 a.m., during interview the nurse stated, "I clean it once or twice in the month. I might have cleaned it twice since the annual survey. I do not have a log." The clinic was not able to provide a log as noted in the plan of correct submitted to the field office, "We will also begin to keep a log of the dates the autoclave is cleaned." Furthermore the clinic was not able to provide a policy. Class III Correction Date: 9/15/12	{A 156}		

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AC13960091	A. Building B. Wing	8/14/2012

Name of Facility	Street Address, City, State, Zip Code
SOUTHWEST FLORIDA WOMEN'S CLINIC	710-12 PONDELLA ROAD N FT MYERS, FL 33903

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 A0350 Reg. # LSC	Correction Completed 08/14/2012	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
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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	Date:	Signature of Surveyor:	Date:
	[signature]	8-20-12	Lewis for R Scavella	8/20/12
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 5/31/2012

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

August 20, 2012

Administrator
Southwest Florida Women's Clinic
710-12 Pondella Road
N Ft Myers, FL 33903

Dear Administrator:

This letter reports the findings of a state licensure survey revisit conducted on August 14, 2012 by a representative of this office.

Enclosed is the provider copy of the Statement of Deficiencies and Plan of Correction, State (3020) Form, which reference the uncorrected deficiencies and/or new deficiencies identified during the revisit.

Please provide a plan of correction to this Field Office, in accordance with enclosed instructions, for the identified deficiencies **within ten working days of receipt of this faxed report**. You will not receive a copy of this report in the mail, you will only receive this faxed report. **All deficiencies shall be corrected no later than September 14, 2012.**

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 this office at (239) 335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

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Enclosures: State Form and Revisit Report

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Fort Myers Field Office
2295 Victoria Avenue, Room 340
Fort Myers, FL 33901
Phone (239) 335-1315; Fax (239) 338-2372

AGENCY FOR HEALTH CARE ADMINISTRATION

INSTRUCTIONS FOR-PLAN OF CORRECTION

Please review the following Prior to completing the
Plan of Correction section of AHCA 3020-0001

1. Prepare your reply by using a typewriter or computer to ensure legibility.

2. Note that each deficiency is consecutively numbered with an ID Prefix tag. This tag number is repeated in column #3, and your plan of correction (POC) should begin opposite the number.

3. The POC must be specific and realistic, have reasonable time frames based on dates discussed during the exit conference and state exactly how the deficiency was (or will be) corrected. Stating simply that "staff will be trained", is not acceptable. An acceptable POC might state that "staff were trained regarding policy and procedure, before and after tests were given, daily staff monitoring will be performed, staff will be re-evaluated in one month, then quarterly."

4. POC's should address the problem and be aimed at correction in a systematic sense, as opposed to correcting an example or an isolated problem.

5. The plan may not be argumentative. Generalized, unsubstantiated arguments are not acceptable. A deficiency may be disputed provided it is supported by factual attached documentation. For example, attached is the controlled substance verification log which has the date, time and signature of oncoming and outgoing nurses who have counted controlled substances.

6. The responsibility for correction and ongoing monitoring should be assigned to a specific position to preclude recurrence.

7. You must sign the bottom of page 1 of the statement of deficiencies, include your title and date.

After the completed POC is received, it will be evaluated. Failure to submit a timely report may result in a finding of non-compliance.