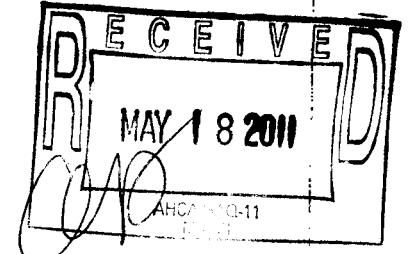


Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>AC13860104</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R <b>04/21/2011</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 visit was made to A Medical Office For Women on April 21, 2011, in order to conduct an on-site Follow-up Survey to a State licensure survey conducted on June 8, 2010. The facility was found to be in non-compliance with 390.014 F.S., 59A-9 F.A.C. at the time of the survey. Deficient practice was identified at the time of the survey.</p>	{A 000}		
{A 150}	<p><b>Clinic Supplies/Equip. Stand.-2nd Trimester</b></p> <p>Each abortion clinic providing second trimester abortions shall provide the following essential clinic supplies and equipment:</p> <ul style="list-style-type: none"> <li>(a) A surgical or gynecological examination table(s);</li> <li>(b) A bed or recliner(s) suitable for recovery;</li> <li>(c) Oxygen with flow meters and masks or equivalent;</li> <li>(d) Mechanical suction;</li> <li>(e) Resuscitation equipment to include, at a minimum, resuscitation bags and oral airways;</li> <li>(f) Emergency medications, intravenous fluids, and related supplies and equipment;</li> <li>(g) Sterile suturing equipment and supplies;</li> <li>(h) Adjustable examination light;</li> <li>(i) Containers for soiled linen and waste materials with covers; and</li> <li>(j) Appropriate equipment for the administering of</li> </ul>	{A 150}		

AHCA Form 3020-0001

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


TITLE  
*president*

(X6) DATE  
*5/11/11*

H97512

If continuation sheet 1 of 3

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  AC13960104	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 04/21/2011
NAME OF PROVIDER OR SUPPLIER  A MEDICAL OFFICE FOR WOMEN		STREET ADDRESS, CITY, STATE, ZIP CODE 909 NE 163 STREET SUITE 402 NORTH MIAMI BEACH, FL 33162	
(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)
{A 150}	Continued From page 1  general anesthesia, if applicable.  Chapter 59A-9.0225(1), F.A.C.  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their emergency medications.  Findings include:  During a tour of the facility conducted on 4-21-2011 at 10:28 am, the surveyor requested to see the medications in the facility's crash cart. The surveyor observed on 4-21-2011 at 10:28 am 500 milliliters Lactated Ringer's Intravenous Solution in a bag with an expiration of April 2009, Atropine 1 milligram expiration of November 2010, and Lidocaine Hydrochloride 2% injection expired on 11/2010. The facility's staff observed the expiration dates on the medications and confirmed they had expired as of the day of the survey.	{A 150}	Completed on 5/1/11
{A 151}	Clinic Supplies/equip. Stand.-2nd Trimester  Emergency equipment shall be provided for immediate use, maintained in functional condition, and capable of providing at least the following services:  (a) Inhalation therapy  (b) Defibrillation  (c) Cardiac monitoring  (d) Suctioning	{A 151}	A-150 Expired medication have been removed and replaced  Medical Director will monitor exp. dates periodically no patients were affected  

AHCA Form 3020-0001  
STATE FORM

6899 H9T512

If continuation sheet 2 of 3

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>04/21/2011</b>
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>	
(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)
{A 151}	<p>Continued From page 2</p> <p>(e) Maintenance of patient airway</p> <p>Chapter 59A-9.0225(2), F.A.C.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide for immediate use, Defibrillation.</p> <p>Findings include:</p> <p>During a tour of the facility conducted on 4-21-2011 at approximately 10:38 am, the surveyor requested to see the facility's defibrillator. Facility staff stated on 4-21-2011, she did not know what happened to the defibrillator, it was placed on a metal shelf in the procedure room. Staff stated she will contact the physician. Staff stated she was advised by the physician he took the defibrillator for repairs/service. Staff confirmed the facility did not have a defibrillator at the time of the survey.</p>	{A 151}	<p><i>Defibrillator was in the shop for calibration</i></p> <p>A-151 Defibrillator is provided</p> <p><i>Physicians will leave with their spare defibrillator at all times</i></p> <p><i>No patients were affected</i></p> <p><i>Completed on 5/1/11</i></p> <p><i>[Signature]</i></p>



RICK SCOTT  
GOVERNOR

*Better Health Care for all Floridians*

ELIZABETH DUDEK  
SECRETARY

April 29, 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 April 21, 2011 to the State Licensure survey completed on June 8, 2010.

Enclosed is the provider copy of the Statement of Deficiencies and Plan of Correction, State (3020) Form and Revisit Report, which reference the uncorrected 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 May 21, 2011.**

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 surveyors. Should you have any questions please call Faith Randolph, Registered Nurse Consultant at (305) 593-3100.

Sincerely,

Donah Heiberg  
Interim Field Office Manager, Area 11

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



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Miami Field Office  
8333 N.W. 53rd Street, Suite 300  
Miami, FL 33166  
Phone (305) 593-3100; Fax (305) 593-3121



RICK SCOTT  
GOVERNOR

ELIZABETH DUDEK  
SECRETARY

A Medical Office for Women  
909 NE 163 Street Suites 402  
North Miami Beach, Fl. 33182

May 2, 2011

RE: Notice of Unacceptable Plan of Correction

Dear Administrator:

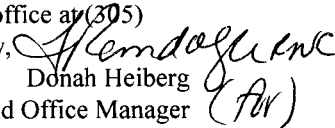
Your Plan of Correction for the deficiencies cited on 4/21/2011 survey was received on 5/2/2011. It was reviewed and is considered unacceptable as written.

The following reasons have been identified:

1. The Plan of Correction for the citations should also include:
  - a) Specific and realistic, **time frames** based on dates discussed during the exit conference. It must 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 "staffs 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."
  - b) 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.
  - c) The plan may not be generalized, it should address what measures will be put into place.
  - d) The PoC must indicate how the facility will monitor its performance (QI/QA) to make sure that solutions are sustained.
  - e) You must then sign the bottom of page 1 of the statement of deficiencies; include your title and date.

We are asking for the submission of a revised Plan of Correction by the next business day. **If not received, or if deemed unacceptable, we have no other option than to submit our recommendations to the Regional Office that remedies be imposed effective as soon as notice requirements are met.**

Thank you for your prompt attention to this matter. If you have any questions, please contact this office at (305) 593-3100.

Sincerely,   
Donah Heiberg  
Field Office Manager





RICK SCOTT  
GOVERNOR

ELIZABETH DUDEK  
SECRETARY

A Medical Office for Women  
909 NE 163 Street Suites 402  
North Miami Beach, Fl. 33182

May 6, 2011  
RE: Notice of Unacceptable Plan of Correction

Dear Administrator:

An attempt was made by this office to reach you  
The **second** Plan of Correction for the deficiencies cited on 4/21/2011 survey was received on 5/2/2011. It was reviewed and is considered unacceptable as written.

The following reasons have been identified: **Due to no completion dates listed at each of the citation.**

1. The Plan of Correction for the citations should also include:
  - a) Specific and realistic, **time frames** based on dates discussed during the exit conference. It must 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 "staffs 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."
  - b) 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.
  - c) The plan may not be generalized, it should address what measures will be put into place.
  - d) The PoC must indicate how the facility will monitor its performance (QI/QA) to make sure that solutions are sustained.
  - e) You must then sign the bottom of page 1 of the statement of deficiencies; include your title and date.

We are asking for the submission of a revised Plan of Correction by the next business day. **If not received, or if deemed unacceptable, we have no other option than to submit our recommendations to the Regional Office that remedies be imposed effective as soon as notice requirements are met.**

Thank you for your prompt attention to this matter. If you have any questions, please contact this office at (305) 593-3100.

Sincerely,

Donah Heiberg  
Field Office Manager

