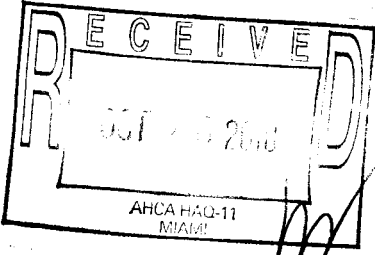


Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>AC13960067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/05/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>A CHOICE FOR WOMEN, INC.</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>6660 SW 117TH AVE MIAMI, FL 33183</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)	(X5) COMPLETE DATE
A 000	INITIAL COMMENTS  An unannounced visit was made to A Choice For Women, Inc. on October 5, 2010, in order to conduct a Renewal State licensure survey. The facility was not in compliance with 390.014 F.S., 59A-9 F.A.C. at the time of the survey. The following deficiency was identified. Recommend a plan of correction.	A 000	 <p>Completed 10/10/2010 10/19/2010</p>	
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	A 156		

AHCA Form 3020-0001

*[Signature]*  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE  
*administrator*

(X6) DATE

*10/19/2010*

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>AC13960067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/05/2010</b>
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NAME OF PROVIDER OR SUPPLIER  <b>A CHOICE FOR WOMEN, INC.</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6660 SW 117TH AVE MIAMI, FL 33183</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 156	<p>Continued From page 1</p> <p>repair.</p> <p>Chapter 59A-9.0225(7), F.A.C.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure preventive maintenance was completed on all surgical equipment, and equipment utilized for patient monitoring.</p> <p>Findings include:</p> <p>During a tour conducted on 10-5-2010 at 10:50 am, the surveyor observed the following equipment needing current preventive maintenance: Ultrasound, suction unit, vacuum, sterilization machine, and cardiac monitor, with a calibration due date of August 2010.</p> <p>Staff stated on 10-5-2010 at approximately 11:15 am, he/she contacted the company to schedule their routine preventative maintenance and have all equipment checked, but his/her telephone call was not returned. Staff advised the administrator is currently on vacation and most likely knows a company that will be able to come and service the equipment. Staff confirmed the due date for service on the equipment was August 2010.</p> <p>Correction date: November 4, 2010</p>	A 156	<p><i>Completed 10/19/2010</i></p> <p><i>By PACE Medical</i></p> <p><i>Inspection and calibration was done 10/19/10</i></p> <p><i>By PACE Medical</i></p> <p><i>maintenance - we now list our preventive maintenance renewal on our license report that is reviewed monthly</i></p> <p><i>We have already scheduled our 2011 pm, and have implemented a system to confirm the appointment for maintenance 30 days and 7 days prior, so as to know the company is aware of their commitment</i></p>	<p><i>10/19/2010</i></p>
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*W. Raymond*

*Administrator*

*10/19/2010*



CHARLIE CRIST  
GOVERNOR

*Better Health Care for all Floridians*

ELIZABETH DUDEK  
INTERIM SECRETARY

October 11, 2010

Administrator  
A Choice For Women, Inc.  
6660 SW 117th Ave  
Miami, FL 33183

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on October 5, 2010 by a representative of this office.

Enclosed is the provider's copy of the State Form 3020, which indicates the deficiencies that were identified on the day of the visit.

Please mail or deliver a plan of correction to this Field Office, in accordance with enclosed instructions, for the identified deficiencies **within ten (10) calendar days of receipt of this report. All deficiencies shall be corrected no later than November 4, 2010.**

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,

*E. Carrillo*  
R. Steve Emling *for SE*  
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) 499-2190