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Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  AC13950034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  03/26/2014
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NAME OF PROVIDER OR SUPPLIER  A WOMAN'S CHOICE, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 18400 NW 75 PL SUITE #118 HIALEAH, FL 33015
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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
A 000	INITIAL COMMENTS  A re-licensure survey was conducted on March 26, 2014. A Woman's Choice, Inc. had licensure deficiencies found at the time of the visit.  The following is a description of the non-compliance:	A 000		
A 100	Physical Plant Req.-2nd Trimester  The following are minimum standards of construction and specified minimum essential physical plant requirements which must be met when providing second trimester abortions.  (1) Consultation room(s) with adequate private space specifically designated for interviewing, counseling, and medical evaluations;  (2) Dressing rooms designated for staff and patients;  (3) Handwashing station(s) equipped with a mixing valve and wrist blades and located in each patient exam/procedure room or area;  (4) Private procedure room(s) with adequate light and ventilation for abortion procedures;  (5) Post procedure recovery room(s) equipped to meet the patient's needs;  (6) Emergency exits wide enough to accommodate a standard stretcher or gurney;  (7) Cleaning and sterilizing area(s) adequate for the cleaning and sterilizing of instruments;  (8) Adequate and secure storage area(s) for the storage of medical records and necessary	A 100	A-100  The sink in the procedure room which contains the handwashing sink with the two round faucets is being upgraded. The faucets will be replaced with <u>Wrist Blade</u> faucet handles, to make them compliant with Chapter 59A-9.022, F.A.C.	4/25/14

AHCA Form 3020-0001

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

*Michelle Amb...*

TITLE

*CEO*

(X6) DATE

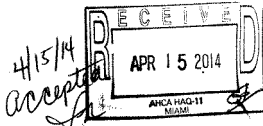
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STATE FORM

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Q8FP-11

Continuation sheet 1 of 10



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NAME OF PROVIDER OR SUPPLIER  A WOMAN'S CHOICE, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 18400 NW 75 PL SUITE #118 HIALEAH, FL 33013			
(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 100	Continued From page 1 equipment and supplies; and  (9) If not otherwise required by the Florida Building Code, at least one general use toilet room equipped with a hand washing station.  Chapter 68A-9.022, F.A.C.  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the handwashing sink utilized in the procedure room is equipped with wrist blade faucet handles.  Findings include:  A tour of the facility was conducted on 3/26/2014 beginning at 12:00 pm. Observation of the handwashing sink identified as being used for the procedure room revealed the sink has two small, round faucet handles (one for hot and one for cold), and not wrist blade faucet handles.  An interview conducted at 1:41 pm with Medical Assistant #1 and the Office Secretary confirmed the procedure room handwashing sink does not have wrist blade faucet handles.	A 100			
A 202	Clinic Personnel-2nd Trimester  Orientation. Each facility shall have and execute a written orientation program to familiarize each new staff member, including volunteers, with the facility and its policies and procedures, to include,	A 202			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  AC19960034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  03/26/2014
NAME OF PROVIDER OR SUPPLIER  A WOMAN'S CHOICE, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 18400 NW 75 PL SUITE #118 MIALEAH, FL 33015		
(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 202	<p>Continued From page 2</p> <p>at a minimum, fire safety and other safety measures, medical emergencies, and infection control.</p> <p>In-service Training. In-service training programs shall be planned and provided for all employees including full time, part time and contract employees, at the beginning of employment and at least annually thereafter and will also apply to all volunteers to insure and maintain their understanding of their duties and responsibilities. Records shall be maintained to reflect program content and individual attendance. The following training shall be provided at least annually, and for surgical assistants and volunteers, must include training in counseling, patient advocacy and specific responsibilities associated with the services they provide:</p> <p>(a) Infection control, to include at a minimum, universal precautions against blood-borne diseases, general sanitation, personal hygiene such as hand washing, use of masks and gloves, and instruction to staff if there is a likelihood of transmitting a disease to patients or other staff members.</p> <p>(b) Fire protection, to include evacuating patients, proper use of fire extinguishers, and procedures for reporting fires;</p> <p>(c) Confidentiality of patient information and records, and protecting patient rights;</p> <p>(d) Licensing regulations; and</p> <p>(e) Incident reporting.</p> <p>Chapter 59A-9.023, (4) and (5), F.A.C.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all employees received yearly in-service training for 1 of 4 facility employees</p>	A 202	<p>A-202</p> <p>Staff member #2, is a part-time employee who had not completed the required In-service training. AS of April 1st, 2014 staff member #2 has been retrained in compliance with Chapter 59A 9.023 (4) and (5), F.A.C.</p> <p>The office manager will be assigned the task of assuring that all employees receive their annual In-Service training, so there is to be no lapse in this area in the future.</p> <p>4/1/14</p>	

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NAME OF PROVIDER OR SUPPLIER  A WOMAN'S CHOICE, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 18400 NW 75 PL SUITE #118 HALEAH, FL 33015		
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A 202	<p>Continued From page 3</p> <p>reviewed (Staff #2).</p> <p>Findings include:</p> <p>A review of the facility's Employee Handbook was conducted on 3/26/2014. Review of page 18 titled "Employee Handbook Log" revealed that on 2/4/2014 three of four facility employees (Staff #1, Staff #3, and Staff #4) signed the signature page attesting that they reviewed the Employee Handbook since their previous inservice training on 2/12/2013. Staff #2 was noted to have last signed the Employee Handbook Log on 2/12/2013 with no signature found for 2014.</p> <p>Further review revealed separate pages titled "Training Log" for Staff #1, Staff #3, and Staff #4 which listed training topics, an inservice date of 2/4/2014, and total hours of training. A Training Log sheet was not found for Staff #2 for 2/4/2014 or for any later date. No other documentation for Staff #2 relating to 2014 inservice training was found in the Employee Handbook binder or in Staff #2's personnel file.</p> <p>An interview conducted with the Office Secretary at 11:15 am revealed she believes Staff #2 was out the day of the training and therefore she did not attend on 2/4/2014 with the other staff members. The Office Secretary was unable at this time to locate any documentation that Staff #2 received this training at a later date.</p>	A 202			
A 302	<p>Medical Screening/eval-2nd Trimester</p> <p>Laboratory Equipment and Supplies.</p> <p>(a) All equipment and supplies for the collection, storage, and testing of specimens shall meet the</p>	A 302			

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NAME OF PROVIDER OR SUPPLIER  A WOMAN'S CHOICE, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 18400 NW 75 PL SUITE #118 HIALEAH, FL 33015		
(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 302	<p>Continued From page 4</p> <p>provisions of Rule 59A-7 F.A.C., and shall be maintained according to manufacturer's instructions and in a manner that ensures accurate test results.</p> <p>(b) Temperature controlled spaces for the storage of specimens or testing supplies shall be monitored and recorded to ensure that the proper storage temperature is maintained.</p> <p>(c) All dated supplies and materials shall not be used beyond their expiration date.</p> <p>(d) Adequate facilities and supplies for the collection, storage and transportation of laboratory specimens shall be available on site.</p> <p>Chapter 59A-9.025(3), F.A.C.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure expired supplies and medications were removed as appropriate relating to 2 of 8 packages of BD Vacutainers observed, an expired bottle of medication found in the procedure room, and an expired bottle of hydrogen peroxide found in the procedure room.</p> <p>Findings include:</p> <p>A tour of the facility was conducted at 12:00 pm with Medical Assistant #1 and the Office Secretary.</p> <p>An observation of the facility's BD Vacutainer supplies revealed a total of 6 packages of small vials used to collect blood for blood tests. Two of the six packages were opened, one package was observed with an expiration date of 10/2013 and the other package was observed with an</p>	A 302	<p>A-302</p> <p>Laboratory Equipment and Supplies that were expired were discarded as stated in the survey.</p> <p>The office manager will begin inspecting these supplies on a monthly basis to ensure that expired supplies have been discarded and replaced with new supplies.</p>	4/1/14

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NAME OF PROVIDER OR SUPPLIER  A WOMAN'S CHOICE, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 18400 NW 75 PL SUITE #118 HIALEAH, FL 33015			
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A 302	Continued From page 5  expiration date of 2/2014. The Office Secretary confirmed with expiration dates and removed both packages from the supply area.  A tour of the procedure room revealed a bottle of Diphenhydramine Hydrochloride Injection USP 50mg/ml with an expiration date of September 2013 was in a small medicine cabinet affixed to the wall. The Office Secretary confirmed the expiration date of September 2013 and removed the bottle.  A tour of the procedure room also revealed the opened bottle of Hydrogren Peroxide had an expiration date of 2/2014. The Office Secretary confirmed the expiration date and disposed of the bottle.	A 302			
A 400	Recovery Rm Stand.-2nd Trimester  Each abortion clinic which is providing second trimester abortions shall comply with the following recovery room standards when providing second trimester abortions:  (1) Following the procedure, post procedure recovery rooms will be supervised and staffed to meet the patient's needs. A physician or physician assistant, a licensed registered nurse, a licensed practical nurse or an advanced registered nurse practitioner who is trained in the management of the recovery area shall be available to monitor the patient in the recovery room until the patient is discharged. The individual must be certified in basic cardiopulmonary resuscitation. A patient in the post-operative or recovery room shall be observed for as long as the patient's condition warrants.	A 400			

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NAME OF PROVIDER OR SUPPLIER  A WOMAN'S CHOICE, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 19400 NW 75 PL SUITE #119 HALEAH, FL 33015		
(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 400	<p>Continued From page 8</p> <p>(2) The clinic shall arrange hospitalization if any complication beyond the medical capability of the staff occurs or is suspected. The clinic shall ensure that all appropriate equipment and services are readily accessible to provide appropriate emergency resuscitative and life support procedures pending the transfer of the patient or a viable fetus to the hospital. A physician shall sign the discharge order and be readily accessible and available until the last patient is discharged to facilitate the transfer of emergency cases if hospitalization of the patient or viable fetus is necessary. The clinic medical records documenting care provided shall accompany the patient. These records will include the contact information for the physician who performed the procedure at the clinic.</p> <p>(3) A physician shall discuss Rho (D) immune globulin with each patient for whom it is indicated and will ensure that it is offered to the patient in the immediate postoperative period or that it will be available to the patient within 72 hours following completion of the abortion procedure. If the patient refuses the Rho (D) immune globulin, refusal Form 3130-1002, January 2006, "Refusal to Permit Administration of Rh(D) Immunoglobulin", herein incorporated by reference, shall be signed by the patient and a witness, and shall be included in the patient's medical record.</p> <p>(4) Written instructions with regard to post abortion coitus, signs of possible medical complications, and general aftercare shall be given to each patient. Each patient shall have specific written instructions regarding access to medical care for complications, including a telephone number to call for medical emergencies. The physician will ensure that</p>	A 400	<p>A-400 - Effective immediately all medical Records will be upgraded to include a space for the physician signature. The physician will sign next to the Doctors Assistant on the Patient Recovery Page. The physician will be required to sign off on each discharge for verification. Medical Assistants will be required to review each individual chart for the physician signature prior to each patient's discharge. All medical records will be reviewed by the medical assistant</p>	4/7/14	

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NAME OF PROVIDER OR SUPPLIER  A WOMAN'S CHOICE, INC.				
STREET ADDRESS, CITY, STATE, ZIP CODE 18400 NW 75 PL SUITE #118 HIALEAH, FL 33016				
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A 400	<p>Continued From page 7</p> <p>either a registered nurse, licensed practical nurse, advanced registered nurse practitioner, or physician assistant from the abortion clinic makes a good faith effort to contact the patient by telephone, with the patient's consent, within 24 hours after surgery to assess the patient's recovery. A contact for post-operative care from the facility shall be available to the patient on a 24-hour basis.</p> <p>(5) Facility procedures must specify the minimum length of time for recovery as warranted by the procedure type and gestation period.</p> <p>Chapter 59A-9.027, F.A.C.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to demonstrate appropriate staff monitored the recovery room after second trimester procedures were completed for 3 of 3 patient files (Individual #1, Individual #2, and Individual #3) reviewed for second trimester procedures.</p> <p>Findings include:</p> <p>A review was conducted on 3/26/2014 of patient files for individuals who underwent second trimester procedures. The review revealed the same form is used for each patient with the first page for history and the second page for physician related services including data regarding the physical exam, medication/anesthesia administered, observations during the procedure, and the plan for discharge. The physician was noted to sign the bottom of the second page. A separate page is used to record data related to monitoring of individuals in the recovery room post-procedure.</p>	A 400	<p>Phone to the physician leaving the facility.</p>	4/1/14



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NAME OF PROVIDER OR SUPPLIER  A WOMAN'S CHOICE, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 18400 NW 75 PL SUITE #118 HALEAH, FL 33015		
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A 400	<p>Continued From page 8</p> <p>The information on the top half of this page includes date, time in the recovery room, vital signs recorded, condition on discharge, and instructions to patient. Below this information is a signature line denoted as "Doctors Assistant".</p> <p>Review of Individual #1's closed patient file revealed Individual #1 underwent a second trimester procedure and was seated in the recovery room for 35 minutes with 3 vital sign entries. The individual's condition at discharge was noted to be "stable". Initials were observed on the line next to Doctors Assistant but did not match the physician's signature.</p> <p>Review of Individual #2's closed patient file revealed Individual #2 underwent a second trimester procedure and was seated in the recovery room for 50 minutes with 4 vital sign entries. The individual's condition at discharge was noted to be "stable". Initials were observed on the line next to Doctors Assistant but did not match the physician's signature.</p> <p>Review of Individual #3's closed patient file revealed Individual #3 underwent a second trimester procedure and was seated in the recovery room for 95 minutes with 2 vital sign entries. The individual's condition at discharge was noted to be "stable". Initials were observed on the line next to Doctors Assistant but did not match the physician's signature.</p> <p>An interview was conducted at 1:11 pm with Medical Assistant #1 (MA #1) regarding procedures for monitoring the recovery room after a second trimester procedure. MA #1 stated that the facility has two medical assistants who monitor vital signs in the recovery room after all procedures. She confirmed the initials on the</p>	A 400			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  AC13950034		
NAME OF PROVIDER OR SUPPLIER  A WOMAN'S CHOICE, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 18400 NW 75 PL SUITE #118 HIALEAH, FL 33015		
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A 400	Continued From page 9  recovery room sheets are from the medical assistants and that the physician does not co-sign the sheets. She stated the facility does not have a nurse on staff and that the physician oversees monitoring of patients in the recovery room. She further stated that the physician sees all patients before they are discharged but does not go back into the patient file to sign off on the recovery room sheet for verification.	A 400		



RICK SCOTT  
GOVERNOR

ELIZABETH DUDEK  
SECRETARY

April 2, 2014

Administrator  
A Woman's Choice, Inc.  
18400 Nw 75 PL. Suite #118  
Hialeah, FL 33015

Dear Administrator:

This letter reports the findings of a state re-licensure survey that was conducted on March 26, 2014 by a representative of this office.

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

Please provide a plan of correction to this Field Office, in accordance with enclosed instructions, for the identified deficiencies **within ten calendar 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 April 25, 2014.**

**The plan of correction must include the following:**

1. Identify how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
2. Describe how the facility will identify other residents having the potential to be affected by the same deficient practice.
3. Explain measures to be put into place or systemic changes made to ensure that the deficient practice will not recur.
4. Identify how the facility will monitor its corrective action to ensure the deficient practice is being corrected and will not recur; i.e., what program will be put into place to monitor the continued effectiveness of the systemic change.
5. Ensure that no protected or other confidential information (i.e., resident or staff names) are included in the plan.
6. State the completed date; the date that the facility identifies compliance can be achieved, which must be after the exit date.
7. You must sign the bottom of page 1 of the statement of deficiencies; include your title and date.



A Woman's Choice, Inc.

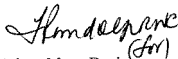
March 28, 2014

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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,

A handwritten signature in dark ink, appearing to read 'Arlene Mayo-Davis', with a stylized flourish underneath.

Arlene Mayo-Davis  
Field Office Manager, Area 11

Enclosure: State (3020) Form