3055933121 A WOMAN'S CHOICE AHCA

PAGE 02 PAGE 04/13 PRINTED: 04/01/2014 FORM APPROVED

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Agency for Health Care Administration (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CUA STATEMENT OF DEPICIENCIES COMPLETED AND PLAN OF CORRECTION A. BUILDING: B. WING . 03/26/2014 AC13950034 STREET ADDRESS, CITY, STATE, ZIP CODE . NAME OF PROVIDER OR SUPPLIER 18400 NW 75 PL SUITE #118 A WOMAN'S CHOICE, INC. HIA! FAH. FL. 33015 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD SE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE in (X4) ID PREFIX TAG PREFIX DESCRIBNCY A 000 INITIAL COMMENTS A 000 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 sink in the procedure promotions the hardwall grant with the two The following is a description of the non-compliance: A 100 A 100 Physical Plant Reg.-2nd Trimester The following are minimum standards of construction and specified minimum essential physical plant requirements which must be met round fancets is being upgraded. The fancets will be replaced with Weist Black fanat handles, to make them compliant with when providing second trimester abortions. (1) Consultation room(s) with adequate private apace 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; Chapter 59A-9,022, (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 AHCA Form 3020-0001 TORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE TITLE Co



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Agency f	or Health Care Admi	inistration			(X2) DATE SU	e ev
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:		CONSTRUCTION	COMPLE	TED
AND PLAN	JF GUIOREG TION	OCH I PANTON NORDEN	A. BUILDING:_			
		AC13950034	B. WING		03/26/	2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	TATE, ZIP CODE		-
			75 PL SUITE			
A WOMA	N'S CHOICE, INC.	HIALEAH,	FL 33015			1961
(X4) ID	BUMMARY STA	TEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTN (EACH CORRECTIVE ACTION SHOUL	DBE	COMPLETE
PREFIX	REGULATORY OR L	/ MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	TAG	CROSS-REPERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				DETIGRATION,	+	
A 100	Continued From pa	ige 1	A 100			
Į	equipment and sup	plies; and				
-	(9) If not otherwise	required by the Florida			-	
	Building Code, at le	east one general use toilet			1	
	room equipped with	n a hand washing station.			- 1	
	Chapter 69A-9.022	, F.A.C.			ł	
			1			
	This STANDARD	is not met as evidenced by:			-	
	Based on observat	tion and interview, the facility handwashing sink utilized in			-	
	the procedure mon	n is equipped with wrist blade			1	
	faucet handles.	and adult to a second			1	
	Findings include:	,			.	
					Ì	
	A tour of the facility	was conducted on 3/26/2014 pm. Observation of the				
•	handwashing sink	identified as being used for the				
	omcedure room re	vealed the sink has two small,				
	round faucet handl	les (one for hot and one for at blade faucet handles.				
	An interview condu	noted at 1:41 pm with Medical ne Office Secretary confirmed			į	
	the procedure roor	n handwashing sink does not			-	
	have wrist blade fo	aucet handles.			- 1	
A 202	Clinic Personnel-2	nd Trimantor	A 202	-		
A 202						
	Orientation. Each i	facility shall have and execute			1	
	a written orientatio	n program to familiarize each Including volunteers, with the			ĺ	
	facility and its police	ies and procedures, to include,				

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A WOMAN'S CHOICE AHCA

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STATEMENT OF DEPICENCIES AC 18950034 NAME OF PROVIDER OR SUPPLIER AC 18950034 STREET ADDRESS, CITY, STATE, ZIP CODE 18400 MW 78 PL SUTTE #18 HALEAR, FL 33015 PROPERLY TAG BUMMANY STATEMENT OF DEPICHENCIES 18400 MW 78 PL SUTTE #18 HALEAR, FL 33015 PROPERLY TAG CONFIDENCY OR IS DENTIFYTING INFORMATION) A 202 Continued From page 2 at a minimum, fire safety and other safety measures, medical emergencies, and infection confrol. In-service Trisining 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 meterather 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 posited at least annually, and for surgical shall be maintained to reflect program content and individual attendance. The following training shall be provided at least annually, and for surgical shall be maintained to reflect program content and individual attendance. The following training shall be provided at least annually, and for surgical shall be maintained to reflect program content and individual attendance. The following training shall be provided at least annually, and for surgical shape to a likelihood of transmitting a disease to patients or other staff members. (a) Infection control, to include at an infilmitum, universal provided to surgical shape to a likelihood of transmitting a decidence to patients or other staff members. (b) Fire prolaction, to Include a shape to the staff members. (c) Fire prolaction, to Include a shape to the staff members. (c) Fire prolaction, to Include a shape to the staff members. (d) Licensing regulations, and procedures for reporting fires, or other staff members. (e) Licensing regulations, and procedures for reporting fires, or other staff members. (d) Licensing regulations, and proce	Agency	for Health Care Adm	(X1) PROVIDER/BUPPLIER/CLIA	(VA) MILL TID:	E CONSTRUCTION	(X3) DATE SURVEY
NAME OF PROVIDER OR SUPPLIER A WOMAN'S CHOICE, INC. 19400 WY 75 PL SUITE #18 HALLEAH, R. 13016 PROCESSOR STREET ADDRESS, CITY, STATE, ZIP CODE 19400 WY 75 PL SUITE #18 HALLEAH, R. 13016 PROCESSOR STREET ADDRESS, CITY, STATE, ZIP CODE 19400 WY 75 PL SUITE #18 HALLEAH, R. 13016 PROCESSOR STREET ADDRESS PLAN OF CORRECTION REQUATORY OR LISC IDENTIFYING INFORMATION) A 202 Continued From page 2 at a minimum, fire safety and other safety measures, medical emergencies, and infection control. 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 refets program content and insidulual attendance. The following training halb be provided at least annually, and for surgical assistants and volunteers, must include raining in counseling, patient advocacy and specific responsibilities associated with the services they provides (a) Infection control, to include at a minimum, universal precautions against tood-tome diseases, general sanitation, personal hygiene diseases, general sanitation, personal hygiene such as hand washing, use of masks and gloves, and instruction to stelf if there is a likelihood of transmitting a disease to patients or other staff members. (a) Fire protection, to include at a minimum, universal precautions against tood-tome diseases, general sanitation, personal hygiene diseases, general sanitation, personal hygiene such as hand washing, use of masks and gloves, and instruction to stelf if there is a likelihood of transmitting a disease to patients or other staff members. (b) Fire protection, to include at a minimum, of the provided of the cathery of the patient information and records, and protecting patient rights; (c) Confidentiality of patient information and records, and protec	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1		COMPLETED	
NAME OF PROVIDER OR SUPPLER AWOMAN'S CHOICE, INC. 1840 MY 75 PL SUITE #18 HALLEAR, R. J. 33015 PROPERLY TAG COntinued From page 2 A 202 Continued From page 2 At a minimum, fife safety and other safety measures, medical emergencies, and infection control. 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 meta-fare 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 able 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: (e) Infection control, to include at a minimum, universal precautions against blood-bome diseases, genoral sanitation, personal hygiene such as hard washing, use of masks and gloves, and instruction to steff if there is a likelihood of transmitting a disease to patients or other staff members. (b) Fire profaction, to include evacuating patients, proper use of fire extinguishers, and procedures for reporting fires; (c) Confidentiality of patient information and records, and protecting, and procedures for reporting fires; (c) Confidentiality of patient rights; (d) Licensing regulations; and (e) Indiction control, to not met as evidenced by; Based on interview and record review, the facility failed to ensure that all employees received yearly inservice training to 16 4 facility persons.			AC13950034	B. WING		03/26/2014
A WOMAN'S CHOICE, INC. 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410 19410	NAME OF	DDONANES OF STIPPINES		DRESS, CITY.	STATE, ZIP CODE	
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ESCH CORRECTIVE ACTION SPOULD BE CONTENT THAN THE PRECEDED BY FILL THAN SPOULD BE CONTENT AND SPOULD BE CONTENT THAN SPOULD BE CONTENT TH	A WOMA			FL 33015		
at aminimum, fire safety and other safety measures, medical emergencies, and infection confrol. In-service Training. In-service training programs shall be planned and provided for all employees including full time, partitime and contract employees, at the beginning of employment and at least annually therefore 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 included attainance. The following training shall be maintained to reflect program content and included attainance and volunteers, must include training in counseling, patient advocacy and specific responsibilities associated with the services they provide. (a) infection control, to include at a minimum, universal precultions against blood-borne such as hard weaking, use of masks and gloves, and institution to stell if there is a likelihood of transmitting a disease to patients or other staff members. (b) Fire protecting patient in galactic, proper use of the exhinguishars, and gloves, and institution to stell if there is a likelihood of transmitting a disease to patients or other staff members. (c) Conflethising perioding patients, proper use of the exhinguishars, and procedures for reporting fires, (c) Londership regulations, and (c) Incident reporting. Chapter 58A-9.023,(4) and (5), F.A.C. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all employees received yearly inservice training for 1 of 4 facility enployees.	PRÉFIX	JEACH DEPICIENC	Y MUST RE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE COMPLETE
failed to ensure that all employees received yearly inservice training for 1 of 4 facility employees	A 202	at a minimum, fire measures, medica control. In-service Training shall be planned a including that be planned an including that be planned at least annually the all volunteers to in understanding of the Records shall be a feast annually the shall be planned as a more shall be a feast annually that including that he prosupped as a post of the shall be s	safety and other safety larmergencies, and infection In-service training programs and provided for all employees part time and contract beginning of employment and reteather and will also apply to sure and maintain their ret duties and responsibilities, naintained to retreat program und attendance. The following ovided at least annually, and may be an expensibilities small times and volunteers, must counseling, patient advocacy natibilities associated with the de: (i), to include at a minimum, nos against blood-borne smalletion, personal hygiene hing, use of masks and gloves, safe if there is a likelinood of asse to patients or other staff to Include evecuating patients, stringulshars, and procedures of patient information and cting patient; alsons; and one, 3,(4) and (5), F.A.C.	A.202	SAAA Member & 15 or part fine employee who had completed the re- Insurice theming, to of Aper 1st Dord star member & this been partial In completore wil Chapter 59A 9,033 (and (5), 17. The office manage will be assigned a took of assuring to all employees feel their annual Insuring, so teen to be no lapa this area in te	most the way
		failed to ensure the	at all employees received yearly		Jujune.	
	AHCA Form		or 1 or 4 recently employees	l	1	

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And PLAN of CORRECTION

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18400 NW 75 PL SUITE #118 A WOMAN'S CHOICE INC. HIALEAH, PL 33015 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE GROSS-REPERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES in (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGILL ATORY OR LSC (DENTIFYING INFORMATION) TAG TAG DECIMENCY A 202 A 202 Continued From page 3 reviewed (Staff #2) Findings include: A review of the facility's Employee Hendbook 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. 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. 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. A 302 A 302 Medical Screening/eval.-2nd Trimester Laboratory Equipment and Supplies. (a) All equipment and supplies for the collection,

AHCA Form 3020-0001

storage, and testing of specimens shall meet the

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If continuation sheet 4 of 10

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3855933121 84/81/2014 14:58 PRINTED: 04/01/2014 FORM APPROVED Agency for Health Care Administration (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING: B. WING 03/26/2014 AC13950034 STREET ADDRESS. CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 18400 NW 75 PL SUITE #118 A WOMAN'S CHOICE, INC. HIALEAH, FL 33015 SUMMARY SYATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR USC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE DATE 10 (X4) ID REFIX TAG DESIGNATION A.302 A 302 A 302 Continued From page 4 Laboratory Egyiptment provisions of Rule 59A-7 F.A.C., and shall be maintained according to manufacturer 's and supplies that Were expired were discarded as stated instructions and in a manner that ensures accurate test results. (b) Temperature controlled spaces for the storage of specimens or testing supplies shall be monitored and recorded to ensure that the proper in the survey storage temperature is maintained. The office manager (c) All dated supplies and materials shall not be will begin insporting used beyond their expiration date. Here Supplies on (d) Adequate facilities and supplies for the a monthly bass to crowned that expred supplies have been discarded and replaced collection, storage and transportation of laboratory specimens shall be available on site. Chapter 59A-9.025(3), F.A.C. This STANDARD is not met as evidenced by: Based on observation and interview, the facility With rea Supplies. failed to ensure expired supplies and medications were removed as appropriate relating to 2 of 6 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. Findings include: A tour of the facility was conducted at 12:00 pm with Medical Assistant #1 and the Office Secretary. An observation of the facility's BD Vacutainer

the other package was observed with an AHCA Form 3020-0001

supplies revealed a total of 6 packages of small viels 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

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STATEMEN	or Health Care Adm T of DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE &	ETED
		AC13950034	B. WING		03/20	3/2014
NAME OF F	ROVIDER OR SUPPLIER			TATE, ZIP COOE		
A WOMA	N'S CHOICE, INC.		/ 75 PL SUITE , FL 33015	E#118,		,
(XA) ID BUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO OBFICIENCY)	.DBE	COMPLETE DATE	
A 302	confirmed with exp both packages from A tour of the proces Diphenhydramine is 50mg/ml with an ei 2013 was in a sma the wall. The Office expiration date of 5 the bottle. A tour of the proces opened bottle of H	/2014. The Office Secretary iration dates and removed	A 302			,
A 400	trimester abortions	c which is providing second shall comply with the following ndards when providing second	A 400	·		
	recovery rooms wi meet the patient's assistant, a license practical nurse or a practitioner who is the recovery area the patient in the rr is discharged. The basic cardiopulmo the rost-operative	rocedure, post procedure if he supervised and staffed or length, Alphysician or physician content of the supervised and staffed or another process of the supervised and subsequent of the supervised staffed in the management of shall be available to monitor socyety room until the patient in another supervised supervise				

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04/15/2014 13:26 3058289974 A WOMAN'S CHOICE PAGE 10/13 PRINTED: 04/01/2014 FORM APPROVED 04/01/2014 14:59 3055933121 AHCA

Agency	or Health Care Adm	inistration			(X3) DATE S	URVEY
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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		1	I	
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			B. WING		03/26	3/2014
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	COLUMN CO CLICCI VAN	STREET AM	RESS, CITY, S	STATE, ZIP CODE		1
NAME OF	PROVIDER OR SUPPLIER		76 PL SUIT			
A MICHA	N'S CHOICE, INC.			E 7 (19		
Y MONN	NO OHOIDE, HAVE	HIALEAH.	PL, 33015			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	DN D	(X5) COMPLETE
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	O		A 400	Allm-	1	
A 400		-		A-400-		1
	(2) The clinic shall	arrange hospitalization if any		Expective immedi	askle	
	complication hours	nd the medical capability of the		ENECTIVE IMPLU	7	
	etaff occurs or in a	uspected. The clinic shall		1 1 10	,, 0	/
	Stall Coudin Ul 18 8	ropriate equipment and		all medial Record	er	UI_
	ensure mar an app	Objecte administration				47/15
	services are readily	y accessible to provide		will be upgraded	.fv	ו דיזי ז
1	appropriate emerg	ency resuscitative and life				
	support procedure	s pending the transfer of the	i	include a Space to	n-	
1	patient or a viable	fetus to the hospital. A		,		
l	physician shall sign	n the discharge order and be		the physcian signal	hul.	
1	readily accessible	and available until the last				
1	natient is dischard	ed to facilitate the transfer of		d. d	7.0	
	emergency cases	if hospitalization of the patient	1	the physican will Sid	n	
	or vishle fetus is n	ecessary. The clinic medical	1	next to per Dactors		
i	records document	ing care provided shall	I	next to the Doctor		
1	TECOLOG OCCUMENT	tient. These records will	i	Assistant on the F	atient	
l	accompany use pa	Contraction for the physician	l	HS stant. or 1		!
l	lucinae me course	t information for the physician	ŀ	D Do 1.		
1	who performed the	procedure at the clinic.		Recovery Page. The		
1			1	11		1
l	(3) A physician sha	all discuss Rho (D) immune	1	physian will be reg	wire.	1
	globulin with each	patient for whom it is indicated	1	0 0-		
i	and will ensure the	at it is offered to the patient in		to Sign of on each		l
l	the immediate pos	toperative period or that it will	1	70 00	,	i
i	he available to the	patient within 72 hours	Į.	discharge for Ventica	ADM.	Į.
1	following completing	on of the abortion procedure. If	1	and the		
	the nation refuses	the Rho (D) immune globulin.	1	Alaki I Amil oto Ha	WI II	
	refusal Form 3130	-1002, January 2006, " Refusal	1	Medical Assistants		
	to Permit Administ	ration of Rh(D) Immunoglobulin	1	be required to re	red	1
1	" harein incorpore	ted by reference, shall be	1	be required to	L.	i
i	nigend by the natio	ent and a witness, and shall be	1	each individual Ch	art	1
1		ient and a withess, and shall be	1	Lan Inches		1
	incinded to the bat	ent a medicar record.	ł	for the physicians &	Buchane	t
		Community assessed to somet	1	17 1 1	- 6	1
i	(4) whiten instruc	tions with regard to post	l	PRIOR to each patie	シェン)	1
1	abortion coltus, sig	ns of possible medical	1			į.
1	complications, and	i general aftercare shall be	1	discharge.		1
	given to each patis	ent. Each patient shall have	1	ALL medical record	is.	1
1		tructions regarding access to	1	Will be reviewed	bu	1
1		omplications, including a	1	Will be reviewed	~ /	į
1	telephone number	to call for medical	1	1 1 1 1 1 possibar	L	1
1	emergencies. The	physician will ensure that	}	he medical assistant	7	ł
1	1		1	ı	-/	l

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A WOMAN'S CHOICE AHCA

AHCA PAGE 09 PAGE 11/13 PRINTED: 04/01/2014 FORM APPROVED

Agency for Health Care Administration		CONSTRUCTION	(X3) DATE SURVEY
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X		COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A	. BUILDING: _		
1.			03/26/2014
AC13950034 B	. WING		03/26/2014
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NAME OF PROVIDER OR SUPPLIER STREET ADDRES 18400 NW 75			1
		5#110	1
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(X4) ID SUMMARY STATEMENT OF DEPICIENCIES	PREFIX		
PREFIX (EACH DEFICIENCY MUST BE PREVENED BY FOLK	TAG	OROSS-REFERENCED TO THE APPRO	PRIATE DATE
TAG REGULATORY OR CSC ILLEN IS THE BET OF SET		DEFICIENCY	
	A 400		/
A 400 Continued From page /	1,100	leaving he facili	Jan 1471 1
either a registered nurse, licensed practical	1	1 - 1 - 6	. MIN
nume advanced registered murse practitioner, or	1	leaving the Facili	7
nhysician assistant from the abortion clinic makes			·
a nood faith effort to contact the patient by	1		
telephone, with the patient's consent, within 24	-		
hours after surgery to assess the patient's	1		
recovery. A contact for post-operative care from		•	
the facility shall be available to the patient on a			
24-hour basis.			
(5) Facility procedures must specify the minimum			!
length of time for recovery as warranted by the			
procedure type and gestation period.			
procedure type and governor party			
Chapter 59A-9.027, F.A.C.			
Chapter services			i
			1
This STANDARD is not met as avidenced by:			•
Resert on interview and record review, the facility		1	
failed to demonstrate appropriate staff monitored			Į.
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.		ĺ	1
Codings include:		1	-
Findings include:		1	
A review was conducted on 3/26/2014 of patient		ł	
files for individuals who underwent second		1	
trimpeter procedures. The review revealed the		1	
same form is used for each patient with the first			
hage for history and the second page for		1	
physician related services including data		1	
regarding the physical exam,		1	}
medication/anesthesia administered,		1	1
observations during the procedure, and the plan			1
for discharge. The physicien was noted to sign the bottom of the second page. A separate page		1	i
is used to record data related to monitoring of			
individuals in the recovery room post-procedure.			i
AHCA Form 3020-9001			if continuation sheet 8 of 1

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A WOMAN'S CHOICE AHCA

AHCA PAGE 10 PAGE 12/13 PRINTED: 04/01/2014 FORM APPROVED

Agency fo	or Health Care Adm	nistration			(X3) DATE S	I IDLATY
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED		
1144# OF B	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, 2IP CODE		
		18400 NW	75 PL SUITE	#118		,
A WOMA	N'S CHOICE, INC.	HIALEAH,	FL 33015		net ;	OXID.
(X4) ID PREFIX TAG	JEACH DEGICIENC	TEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE AFPRO DEFICIENCY)	DBE i	COMPLETE
A 400	Continued From pa	ige 8	A 400			
A 400	The information on includes data, time signs recorded, co instructions to patil signs recorded, co instructions to patil signature line dend recovery from for entries. The individual recovery room for entries. The individual recovery room for on the line next to match the physicial revealed individual transater procedual recovery room for entries. The individual recovery room for entries the individual recovery room for entries.	the top half of this page in the receivery room, vital sittlion on discharge, and int. Below his information is a tect as "Dectors Assistant". all if is closed patient file if underwent a second e and was seated in the standard in the st				
	on the line next to match the physici	Doctors Assistant but did not				
	Medical Assistant procedures for me a second trimeste the facility has two monitor vital stone	conducted at 1:11 pm with #1 (MA#1) regarding initioning the recovery room after procedure. MA#1 stated that in medical assistants who in the recovery room after all confirmed the initials on the				

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PAGE 11

(X1) PROVIDENDUM TO			(X2) MULTIPLE CONSTRUCTION		COMPI	ETED .
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		1	
		AC13950034	B. WING		03/2	6/2014
		AC13950039	DRESS, CITY, ST	ATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER	1840D NV	75 PL SUITE	#118		1
AWOMA	N'S CHOICE, INC.	HIALEAH	, FL 33015	TO THE OWNER OF THE OWNER.	CODRECTION	(pxs)
(X4) ED PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL USC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETE DATE
TAG	REGULATORY OR	COCHOLOTT	1			
A 400	recovery room she assistants and that the sheets. She st nurse on staff and monitoring of pati- further stated that	aets are from the medical at the physician does not co-signated the facility does not have a that the physician overseas ents in the recovery room. She the physician sees all patients scharged but does not go back a to sign off on the recovery				
AHCA	orm 3020-0001		280	O9FP11	if conf	inuation sheet 10 o



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:

- 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.
- 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 Page 2

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.my/lorida.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,

Hmdolpane Arlene Mayo-Davis (Fr)

Field Office Manager, Area 11

Enclosure: State (3020) Form