PRINTED: 12/01/2009
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
	AC13950034	A. BUILDING _____ B. WING _____	11/17/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A WOMAN'S CHOICE, INC	6406 NW 186TH STREET MIAMI, 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 000	INITIAL COMMENTS An unannounced visit was made to A Woman's Choice, Inc. November 17, 2009, in order to conduct a State Licensure Renewal 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	RECEIVED [illegible] AHCA HAQ-11 MIAMI	
A 150	Clinic Supplies/Equip. Stand.-2nd Trimester Each abortion clinic providing second trimester abortions shall provide the following essential clinic supplies and equipment: (a) A surgical or gynecological examination table(s); (b) A bed or recliner(s) suitable for recovery; (c) Oxygen with flow meters and masks or equivalent; (d) Mechanical suction; (e) Resuscitation equipment to include, at a minimum, resuscitation bags and oral airways; (f) Emergency medications, intravenous fluids, and related supplies and equipment; (g) Sterile suturing equipment and supplies; (h) Adjustable examination light; (i) Containers for soiled linen and waste materials with covers; and (j) Appropriate equipment for the administering of general anesthesia, if applicable.	A 150	Was told by Ric Garcia that this was just a reference to the Standards/ regulations and not a deficiency found per our conversation on 12/2/09.	

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: President (X6) DATE: 12/14/09

STATE FORM 021189 RNGU11 If continuation sheet 1 of 2

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	AC13960034	A. BUILDING _____ B. WING _____	11/17/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A WOMAN'S CHOICE, INC	6406 NW 186TH STREET MIAMI, FL 33015

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A 150	Continued From Page 1 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 crash cart, which includes emergency medications. Findings include: During a tour of the facility conducted on 11-17-2009 at approximately 11:25 am, the surveyor observed the facility's crash cart. The box contained expired medications. Atropine sulfate expired 1/1/09, Dextrose 8/1/09, and Sodium Bicarbonate expired 5/1/09. The director of the facility advised he/she already ordered the new medications, but they are on back order. Correction date: 12-17-2009	A 150	OK All MDS CHECK IN CRASH CART NO EXPIRED MEDS NOTED JMC 1/4/10 Clinic will maintain an updated crash cart box w/ updated medications at all times. Clinic will be sure to order replacements in a timely manner so as to avoid any complications (i.e. backordered medications). Clinic has enrolled in an automatic renewal Contract w/ crash cart Provider to ensure Compliance.	

AHCA Form 3020-0001
STATE FORM 021110 RNGU11 If continuation sheet 2 of 2

Khristy Smith 12/14/09

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

CHARLIE CRIST
GOVERNOR

Better Health Care for all Floridians

THOMAS W. ARNOLD
SECRETARY

December 1, 2009

Administrator
A Woman's Choice, Inc
6406 NW 186th Street
Miami, FL 33015

Dear Administrator:

This letter reports the findings of a state licensure renewal survey that was conducted on November 17, 2009 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 (10) 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 December 17, 2009.**

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 Ric Garcia, RNC and Supervisor Hospital/HHA Unit at (305) 499-2165.

Sincerely,

R. Steve Emling
Field Office Manager, Area 11

Enclosures: State Form 3020 and POC Guidelines.

Headquarters
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Tallahassee, FL 32308
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Miami Field Office
8355 N.W. 53rd Street, First Floor
Miami, FL 33166
Phone (305) 499-2165; Fax (305) 499-2190