

Agency For Health Care Administration		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AC13950034		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/03/2008	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		STREET ADDRESS, CITY, STATE, ZIP CODE 6406 NW 186TH STREET MIAMI, FL 33015					
NAME OF PROVIDER OR SUPPLIER A WOMAN'S CHOICE, INC							
(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 the facility on September 3, 2008, in order to conduct a state licensure survey. The following deficiencies were identified at the time of the licensure survey	A 000					
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 (e) Maintenance of patient airway Chapter 59A-9.0225(2), F.A.C. This Standard is not met as evidenced by: Based on observation and interview, the abortion clinic's emergency equipment did not include defibrillation, therefore, was not capable of providing it at the time of the survey. Findings include: During a tour of the facility conducted on 9-3-2008 at 1:30 PM. The surveyor toured the procedure room. The surveyor requested to see the facility's defibrillation device as a part of their emergency equipment. The administrator advised he/she did not have one, and was unaware of the requirement to have a	A 151	The emergency equipment is available for immediate use. A defibrillator has been purchased and is available. Cardiac monitoring, suctioning, and maintenance of patient airway is also available for emergency purposes.				

AHCA Form 3020-0001

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

Melita Aub...

TITLE

President/CEO

(X5) DATE

10/7/08

STATE FORM

021198

79BK11

If continuation sheet 1 of 6

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 09/03/2008
NAME OF PROVIDER OR SUPPLIER A WOMAN'S CHOICE, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 151	Continued From Page 1 defibrillation device at the clinic. The surveyor advised the administrator as the abortion clinic is licensed to perform 1st and 2nd trimester terminations, the abortion clinic is required to have the capability of providing defibrillation services. The administrator advised he/she will start calling around immediately to obtain the defibrillation device. The surveyor was unable to determine the abortion clinic's lack of defibrillation services poses actual harm to patients. The surveyor did observe Inhalation therapy, Cardiac monitoring, Suctioning, and Maintenance of patient airway (bags) at the time of the survey. Correction date: 10-3-2008	A 151			
A 201	Clinic Personnel-2nd Trimester Each abortion clinic providing second trimester abortions shall have a staff that is adequately trained and capable of providing appropriate service and supervision to the patients. The clinic will have a position description for each position delineating duties and responsibilities and maintain personnel records for all employees performing or monitoring patients receiving a second trimester abortion. The clinical staff requirements are as follows: Physicians. The clinic shall designate a licensed physician to serve as a medical director. Nursing Personnel. Nursing personnel in the clinic shall be governed by written policies and procedures relating to patient care, establishment of standards for nursing care and mechanisms for evaluating such care, and	A 201	Personnel files have been implemented and employee duties are outlined in the Employee Manual. Dr. David S. Brown is the designated Medical Director and conducts the yearly Medical in service training to the proper employees within their duties.		

PRINTED: 09/08/2008
FORM APPROVED

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 09/03/2008
NAME OF PROVIDER OR SUPPLIER A WOMAN'S CHOICE, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6406 NW 186TH STREET MIAMI, FL 33016		
(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 201	Continued From Page 2 nursing services. Allied health professionals, working under appropriate direction and supervision, may be employed to work only within areas where their competency has been established. Chapter 59A-9.023(1),(2),and (3), F.A.C. This Standard is not met as evidenced by: Based on record review and interview, the abortion clinic failed to maintain personnel records for all employees performing or monitoring patients receiving a second trimester abortion. Findings include: During personnel record review conducted on 9-3-2008, the administrator advised he/she cannot locate the personnel records for his/her medical director or medical assistants who assist the medical director. The administrator advised receiving a second trimester abortion. The administrator was unable to provide documentation demonstrating the medical director's designation. Correction date: 10-3-2008	A 201			
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	A 202	The Employee Handbook has been updated to cover our policies and procedures. Fire Safety		

AHCA Form 3020-0001

STATE FORM

021199

79BK11

If continuation sheet 3 of 6

PRINTED: 09/08/2008
FORM APPROVED

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 09/03/2008
NAME OF PROVIDER OR SUPPLIER A WOMAN'S CHOICE, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 202	<p>Continued From Page 3</p> <p>facility and its policies and procedures, to include, 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> <ul style="list-style-type: none"> (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. (b) Fire protection, to include evacuating patients, proper use of fire extinguishers, and procedures for reporting fires; (c) Confidentiality of patient information and records, and protecting patient rights; (d) Licensing regulations; and (e) Incident reporting. <p>Chapter 59A-9.023,(4) and (5), F.A.C.</p> <p>This Standard is not met as evidenced by: Based on record review and interview, the facility failed to provide annual in-service training for all employees.</p>	A 202	<p>Medical emergencies, and infection control. The Handbook also covers our Bio-Medical Waste Protocols, Patient Protocols, Emergency Protocols, Incident Reporting, and other pertinent information concerning the safety of our patients. All employees have signed out this book and has signed at the end of the book that the information read was understood.</p>		

PRINTED: 09/08/2008
FORM APPROVED

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 09/03/2008
NAME OF PROVIDER OR SUPPLIER A WOMAN'S CHOICE, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 202	Continued From Page 4 Findings include: Personnel record review conducted on 9-3-2008, revealed the facility's failure to maintain personnel records. The surveyor requested to review the facility's in-service material, which is provided annually. The administrator provided Bio-Medical Waste handling training documentation, which he/she explained the proof of those staff who attended had been left at his/her home. The administrator was unable to provide in-service training materials for infection control, fire protection, confidentiality of patient information and records, licensing regulations, and incident reporting. Correction date: 10-3-2008	A 202		
A 250	Clinic Policies/Procedures-2nd Trimester An abortion clinic providing second trimester abortions shall have written policies and procedures to implement policies and to assure that quality patient care shall relate specifically to the functional activities of clinic services. These written procedures shall apply to second trimester abortions and shall be available and accessible to clinic personnel and shall be reviewed and approved annually by the clinic's medical director. These clinic policies and procedures shall include but not be limited to the following: (1) Patient admission; (2) Pre- and post-operative care; (3) Physician's orders; (4) Standing orders with required signatures; (5) Medications, storage and administration; (6) Treatments; (7) Surgical asepsis; (8) Medial asepsis;	A 250	Attached you will find our Employee Handbook, it has since been revised. Upon completion of the Employee Handbook being read and understood, each employee will log in the day of the review accordingly. The on-the-job training is given to all employees in their areas of expertise, by our Medical director, Dr. David S. Brown on a yearly basis. Written policies/procedures concerning 2nd trimester abortions are now a part of our Employee Handbook. As previously	

AHCA Form 3020-0001

STATE FORM

021190

79BK11

If continuation sheet 5 of 8

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 09/03/2008
NAME OF PROVIDER OR SUPPLIER A WOMAN'S CHOICE, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 250	<p>Continued From Page 5</p> <p>(9) Sterilization and disinfection; (10) Documentation: Medical records and facility records; (11) Patient discharge; (12) Patient transfer; (13) Emergency measures; (14) Incident reports; (15) Personnel orientation; (16) Inservice education record; (17) Anesthesia; (18) Equipment and supplies: availability and maintenance; (19) Volunteers; and (20) Visitors.</p> <p>Chapter 59A-9.024, F.A.C.</p> <p>This Standard is not met as evidenced by: Based on record review, the facility failed to have their written policies and procedures reviewed and approved annually by the clinic's medical director.</p> <p>Findings include:</p> <p>A review of the facility's license conducted on 9-3-2008, revealed the clinic is licensed to perform first and second trimester abortions only. The surveyor reviewed the facility's policies and procedures. The last date of revision/review was January 1996. The facility was unable to provide documentation demonstrating their policies and procedures had been reviewed and approved by the facility's medical director on an annual basis.</p> <p>Correction date: 10-3-2008</p>	A 250	<p>Stated, when the current Employee Handbook is completed and has been reviewed by all employees at this location, they will be filed at the last pages of the handbook.</p>		



CHARLIE CRIST
GOVERNOR

HOLLY BENSON,
SECRETARY

September 6th, 2008

Mitta Turbides, Administrator
A Woman's Choice
6406 N.W. 186th Street
Hialeah, Florida 33015

Dear Ms. Turbides:

This letter is to report the findings of the annual Licensure survey, which was completed on September 3rd, 2008 by Kim Ody, Health Facility Evaluator II, of this office.

Enclosed, please find State Form 3020, Statement of Deficiencies and Plan of Correction, which enumerate the deficiency that was found during the survey and discussed with you and your staff during the survey and at the exit conference.

Please provide an acceptable Plan of Correction for each deficiency on the State Form 3020 in accordance with the enclosed instructions (Guidelines for Development of Plans of Correction). You must include on your Plan of Correction who, when and how the deficiency is to be corrected as well as how the requirement will be monitored for future compliance. You must sign, date, and return the Statement of Deficiencies/Plan of Correction, State Form 3020, to this office within ten (10) calendar days of receipt. All citations must be corrected within 30 days of survey date.

Sign and return the original State Form 3020 with the Plan of Correction to:

**R. Steve Emling
Field Office Manager, Area 11
Agency for Health Care Administration, HQA Area 11
Manchester Bldg, 1st floor
8355 N.W 53rd Street
Miami, FL 33166
(305) 499-2165
FAX: (305) 499-2190**

Any deficiencies, which were repeated from previous surveys, or deficiencies that are not corrected within the established time frames may be subjected to administrative actions or fines by the department.

Certain documents may be made available for public disclosure as required by law.

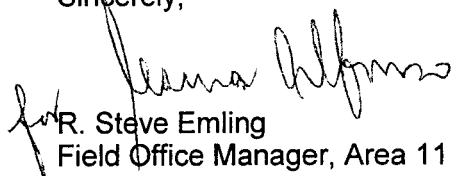
The *Quality Assurance Questionnaire* has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at www.fdhc.state.fl.us/Publications/, as a first step in providing a web-based interactive consumer



satisfaction survey system. You may access the questionnaire through the link under **Forms** 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 every assistance provided during this survey process. If you have any questions regarding this report, please call Ric Garcia, RNC and Supervisor of the HHA/Hospital Unit of this office at (305) 499-2165.

Sincerely,


for R. Steve Emling

Field Office Manager, Area 11
Division of Health Quality Assurance

Enclosure: State Form 3020, and Instructions
Copies to: Hospital and Outpatient Services