PRINTED: 04/15/2008 FORM APPROVED

Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING 04/10/2008 AC13960109 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1103 LUCERNE TERRACE CENTER OF ORLANDO FOR WOMEN/ORLANDO W ORLANDO, FL 32806 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** PRFFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) A 000 A 000 INITIAL COMMENTS A Relicensure survey attempt was made at the facility on 04/10/08. The Executive Administrator validated that the facility is not opened for services as of that date and a tentative date for open operation was indicated to be on 04/27/08 (Sunday) which will be the only day of the week for services. During this visit, there were no patients and records for review. A deficiency was cited at A 0650 Chapter 59A-9.034 FAC Pursuant to Chapters 382 and 390, FS. A 650 A 650 Reports Pursuant to Chapters 382 and 390, F.S., an abortion clinic must submit a report each month to the Office of Vital Statistics of the Department of Health, regardless of the number of terminations of pregnancy. Monthly reports must be received by the department within 30 days following the preceding month. Chapter 59A-9.034, F.A.C. This Standard is not met as evidenced by: Based on interview, the facility failed to submit monthly reports to the Office of Vital Statistics of the Department of Health within 30 days from 06/10/07 through 4/10/08, regardless of the number of patients seen. Findings: Based on interview with the Executive Administrator of the facility on 04/10/08 on or

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for	<u>or Health Care Admi</u>	nistration					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING		(X3) DATE SURVEY COMPLETED	
	AC13960109		0/2008				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
CENTER OF ORLANDO FOR WOMEN/ORLANDO W 1103 LUCERNE TERRACE ORLANDO, FL 32806							
(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 650	Continued From Page 1			A 650			
A 030	about 10:15 a.m. ir opened for service were no patients and rec with the Executive or about 12:42 p.m submit monthly rep days from 06/10/0	ndicated that the facil s as of that date and cords for review. Inte Administrator on 04/ n. validated that she foorts each month with 7 through current dat fice Of Vital Statistics alth.	there erview 10/08 on ailed to nin 30 e of				

AHCA Form 3020-0001

Agency for Health Care Administration

4/28/08/0

PRINTED: 04/15/2008 FORM APPROVED

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING 04/10/2008 AC13960109 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1103 LUCERNE TERRACE CENTER OF ORLANDO FOR WOMEN/ORLANDO W ORLANDO, FL 32806 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) A 000 **INITIAL COMMENTS** A 000 A Relicensure survey attempt was made at the facility on 04/10/08. The Executive Administrator validated that the facility is not opened for services as of that date and a tentative date for open operation was indicated to be on 04/27/08 (Sunday) which will be the only day of the week for services. During this visit, there were no patients and records for review. A deficiency was cited at A 0650 Chapter 59A-9.034 FAC Pursuant to Chapters 382 and 390, FS. A 650 A 650 Reports Pursuant to Chapters 382 and 390, F.S., an abortion clinic must submit a report each month to the Office of Vital Statistics of the Department of Health, regardless of the number of terminations of pregnancy. Monthly reports must be received by the department within 30 days following the preceding month. Chapter 59A-9.034, F.A.C. This Standard is not met as evidenced by: Based on interview, the facility failed to submit monthly reports to the Office of Vital Statistics of the Department of Health within 30 days from 06/10/07 through 4/10/08, regardless of the number of patients seen. Findings: Based on interview with the Executive Administrator of the facility on 04/10/08 on or AHCA Form 3020-0001 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PRINTED: 04/15/2008 FORM APPROVED

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING 04/10/2008 AC13960109 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1103 LUCERNE TERRACE CENTER OF ORLANDO FOR WOMEN/ORLANDO W ORLANDO, FL 32806 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PRÉFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) All Reports were sent to Department of Health 4.15-08 4-16-08 From 3/07 to 3/08 4-16-08 From 3/07 to 3/08 4-16-08 From 3/07 to 3/08 Endicating Zero patients were seerl. Department of health has been updated and the reports will be and the reports will be sent monthly from 4/08 sent monthly from 4/08 on regardless of Number of patients seen as pursuant to Chapters 382 and 390. A 650 A 650 Continued From Page 1 about 10:15 a.m. indicated that the facility is not opened for services as of that date and there were no patients and records for review. Interview with the Executive Administrator on 04/10/08 on or about 12:42 p.m. validated that she failed to submit monthly reports each month within 30 days from 06/10/07 through current date of 04/10/08 to the Office Of Vital Statistics of the Department of Health. Correction Date: 05/02/08

Agency for Health Care Administration



CHARLIE CRIST GOVERNOR HOLLY BENSON SECRETARY

April 15, 2008

Administrator Center of Orlando For Women 1103 Lucerne Terrace Orlando, FL 32806

RE: Annual Licensure Survey

Dear Administrator:

This letter confirms the findings of an annual licensure survey conducted at your agency on 04/10/08 by Jane Woodson, Registered Nurse Specialist of this office.

Enclosed is a copy of the Statement of Deficiencies and Plan of Correction State Form, which indicates the deficiency that was discussed with you upon completion of the survey. Please provide a plan of correction, sign, date and return to this office within ten (10) calendar days of receipt.

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 webbased 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.

Please call this office at 407-316-4859, if we may be of any further assistance.

Sincerely,

Joel M. Libby

Field Office Manager

Division of Health Quality Assurance

Reresa De più Fu

JML/cid

Enclosure: State Form

Instructions for Plan of Correction