PRINTED: 01/14/2009
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
	AC13960108	A. BUILDING _____ B. WING _____	01/06/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF GREATER ORLANDO	726 SOUTH TAMPA AVENUE ORLANDO, FL 32805

(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 Expansion survey for 1st trimester to 2nd trimester abortions and Relicensure survey was performed on 01/06/09. Deficient practices were identified and cited at A 100, A 151, A 156, A 201, A 202, A 250, A 300, A 302, A 400 and A 9999, Class III.	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 equipment and supplies; and	A 100	(1) Cardboard boxes were removed from the recovery room and properly stored. The Center Manager review ed policies and procedures with clinical staff on how to store clinical supplies on. Corrective action was reviewed and documented by clinical staff, and items in A 100 will be monitored daily by designated staff on a daily/weekly basis.The corrected will be audited daily and included in the daily "Start-UP/Shut-Down" Log (as part of our QA calendar) (2) The intravenous poles were removed from the recovery room and placed in their proper location. (3) The six boxes of disposable suction catheters have been removed from the recovery room and stored in their proper location. (4) The various boxes of supplies located around and near the crash cart have been stored appropriately and placed in the proper storage location. The Center Manger reviewed with clinical staff the necessity of keeping a clear path to the emergency exit door	1/20/09

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A 100	Continued From Page 1	A 100		

(9) If not otherwise required by the Florida Building Code, at least one general use toilet room equipped with a hand washing station.

Chapter 59A-9.022, F.A.C.

This Standard is not met as evidenced by:
Based on observation and interview, the facility failed to ensure medical supplies were stored in an appropriate storage area.

Findings:

During the tour of the facility on 01/06/09 commencing at 11:46 a.m., the following was observed.

1. Two elongated carton boxes were observed stored in the recovery room against the wall behind a patient's recliner.

2. The carton labels identified the contents to be intravenous poles.

3. In the patient examination room #4 against the wall approximately 6 large carton boxes of medical supplies were stored. On top of these boxes numerous sealed/sterile disposable suction catheters were observed.

The nurse accompanying on the tour was interviewed on 01/06/09 at 12:25 p.m., stated the contents in the large boxes in examination room #4 were disposable gowns and confirmed the findings.

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A 100	Continued From Page 2 4. The crash cart was observed in the hallway close to the exit door against the wall outside of the recovery room. Various boxes of medical supplies were observed on the floor around the crash cart obstructing easy access to the emergency exit door. The Director of Patient Services was interviewed on 01/06/09 at approximately 12:35 p.m. and observed the supplies stored on the floor around the crash cart. She confirmed the emergency exit door was the access used to transfer a patient via a stretcher to an ambulance in the event of an emergency. She confirmed the findings. Class III Correction Date: 01/28/09	A 100		
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 facility	A 151	Emergency suctioning equipment has been purchased for the facility. A training was conducted with clinical staff on the proper usage and maintenance of the equipment. The equipment will be checked weekly to insure its proper operation. An abortion equipment maintenance log was created to monitor this task.	1/21/09

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A 151	Continued From Page 3 failed to ensure suctioning emergency equipment was available for immediate patient use. Findings: During the tour of the facility on 01/06/09 commencing at 11:46 a.m., no emergency suctioning equipment was observed. The Director of Patient Services was interviewed on 01/06/09 at approximately 12:15 p.m. and confirmed no emergency suctioning equipment was available in the facility for patient use. Class III Correction Date: 01/28/09	A 151		
A 156	Clinic Supplies/equip. Stand.-2nd Trimester Equipment Maintenance. (a) When patient monitoring equipment is utilized, a written preventive maintenance program shall be developed and implemented. This equipment shall be checked and/or tested in accordance with manufacturer's specifications at periodic intervals, not less than annually, to insure proper operation, and a state of good repair. After repairs and/or alterations are made to any equipment, the equipment shall be thoroughly tested for proper calibration before returning it to service. Records shall be maintained on each piece of equipment to indicate its history of testing and maintenance. (b) All anesthesia and surgical equipment shall have a written preventive maintenance program developed and implemented. Equipment shall be checked and tested in accordance with the manufacturer ' s specifications at designated	A 156	A manual was written and completedfor the patient equipment maintenance program (EMP), including patient monitoring equipment, anesthesia and surgical equipment. The manual creates a QA committee to oversee the Equipment Management Program headed by MD and PSD. Components are selection and acquisition of equipment, evaluation of equipment for inclusion into the EMP, incoming inspections for PPGO/PPSGO owned equipment, incoming inspections for rented equipment, incoming inspections for other equipment, preventative maintenance inspections, repairs, review of hazards, alerts and product recalls, incident inspections,	1/17/09

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A 156	Continued From Page 4 intervals, not less than annually, to ensure proper operation and a state of good repair. (c) All surgical instruments shall have a written preventive maintenance program developed and implemented. Surgical instruments shall be cleaned and checked for function after use to ensure proper operation and a state of good repair. Chapter 59A-9.0225(7), F.A.C. This Standard is not met as evidenced by: Based on interview, the facility failed to develop, implement a written preventative maintenance program for patient monitoring equipment, anesthesia, surgical equipment and surgical instruments and failed to ensure patient monitoring equipment, anesthesia and surgical equipment was checked and tested in accordance with the manufacturers' specifications. Findings: The Director of Patient Services (DPS) was interviewed on 01/06/09 at 9:39 a.m. and asked to present the facility's written preventative patient equipment maintenance programs. The DPS confirmed the facility failed to develop and implement a written preventative maintenance program for patient monitoring equipment, anesthesia equipment, surgical equipment and for surgical instruments. The DPS was asked if the patient equipment was tested and checked in accordance with each manufacturers' specifications and stated she did not know what the manufacturers' specifications were for the checking and testing of the patient equipment.	A 156	reviewed and approved by the affiliate medical director orientation and continuing education and monitoring of overall EMP. The monitoring tool is included in the affiliate QA calendar. The manual was reviewed and approved by the affiliate medical director	

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A 156	Continued From Page 5 Class III Correction Date: 01/28/09	A 156		
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 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 personnel record review and interview, the facility failed to ensure that 5 of 8 employees (#1, 2, 3, 5 & 6) had position descriptions, failed to have a mechanism to evaluate 7 of 8	A 201	(1) The affiliate HR policies and procedures for clinical staff were reviewed and updated, including revision of job descriptions. Performance appraisals were conducted, and clinician privileges were reviewed and approved by the affiliate's medical director. Job descriptions have been signed by clinical staff and providers and included in employee files. (2) Performance evaluations were completed on all clinical staff and providers and will be done so annually. The respective supervisor (Center Manager, Patient Services Director, Medical Director) conducted the reviews. (3) For allied health professional employees, competency and proficiency reviews were conducted for the areas procedure room assistance, patient counseling, laboratory competency and recovery room responsibilities.	

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A 201	Continued From Page 6 employees (#1, 2, 3, 4, 5, 7 & 8) regarding nursing care and nursing services, and 5 of 5 allied health professionals (#1, 2, 4, 5 & 6) failed to have documented evidence that they had established competencies to work in their assigned clinic areas. Findings: 1. The personnel files for employees #1, #2, #3, #5 and #6 were reviewed. Position descriptions were not found to indicate the duties and responsibilities of these employees. 2. The personnel files for employees #1, #2, #3, #4, #5, #7 and #8 assigned to work in the procedure and/or recovery rooms were reviewed and performance evaluations were not found. 3. The personnel files for the allied health professional employees/medical assistants #1, #2, #4, #5 and #6 assigned to work in the procedure rooms were reviewed. Documented evidence was not found to indicate these employees had been evaluated to have established competencies to work in this assigned area. Medical assistants #1, #2, #4 and #5 were assigned to provide counseling to patients and documented evidence was not found to indicate these employees had been evaluated to have established competencies to work in this assigned area. The Director of Patient Services was interviewed on 01/06/09 at approximately 2:25 p.m. and confirmed the findings. Class III Correction Date: 01/28/09	A 201		

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A 202	Continued From Page 7	A 202		
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, 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 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: (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. Chapter 59A-9.023,(4) and (5), F.A.C.	A 202	(1) The affiliate HR policies for new hires were revised to include a new orientation checklist, which includes a review of medical policies and procedures, emergencies and infection control. A checklist was created to insure that all employees understood and were competent and efficient in carrying out their clinical responsibilities. (2) An in-service training program was created based on standards and guidelines of the Planned Parenthood Federation of America, Inc. Elements include training modules provided by CAPS, proficiency checklists, and corrective action recommendations based on the medical standards implemented and approved by the affiliate medical director. The evaluative tools will be used after a 90 day probationary period, and then annually. Corrective actions will be taken, however, when an employee is deemed to be operating outside of policies and protocols of the affiliate. (3) Staff participated in the CAPS (Consortium of Abortion Providers) counseling video "Talking About Abortion". Documented and placed in employee's personnel files. 1/23/09 (4) The Infection Control Manual was updated in 9/08, and staff had an in-service at that time. Staff had an in-service, documented 1/27/09	

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A 202	Continued From Page 8 This Standard is not met as evidenced by: Based on interview, the facility failed to have a written orientation program regarding review of the facility's policies and procedures, medical emergencies and infection control, failed to have a planned in-service training program for employees at the beginning of employment and annually, failed to provide documented evidence that 4 of 4 employees (#1, 2, 4 & 5) assigned to patient counseling received any counseling training or annual counseling training, 5 of 8 employees (#2, 3, 5, 7 & 8) failed to receive annual infection control in-services, 4 of 8 employees (#1, 3, 4 & 7) failed to receive annual fire protection in-service including patient evacuation, proper use of fire extinguishers and procedure for reporting fires, 3 of 8 employees (#1, 3 & 7) failed to receive annual in-service regarding patient confidentiality and protecting patient rights, 7 of 8 (#1, 2, 3, 4, 5, 7 & 8) failed to receive annual licensing regulation in-service, and 4 of 8 employees (#1, 3, 4 & 7) failed to receive annual incident reporting in-service. Findings: 1. The Director of Patient Services (DPS) was interviewed on 01/06/09 at approximately 1 p.m. and asked to present the facility's written staff orientation program for review. She stated new employees upon hire and annually received the Planned Parenthood of Greater Orlando Security Manual (PPGO) to review and sign. The PPGO was reviewed with the DPS. The PPGO failed to include and identify that the new employees reviewed the facility's policies and procedures, medical emergencies and infection control. The DPS confirmed the findings.	A 202	(5) The annual fire protection in-service was that included patient evacuation, properuse of fire extinguishers, and procedure for reporting fires was held, and documentation was placed in employee files. (6) Staff had annual HIPAA in-service, and annual confirmation was signed and documentation was placed in employee files. (7) Annual licensing regulation in service was conducted for clinicians and documentation was placed in employee files. (8) Incident report in-service was held, and documentation was placed in employee files.	1/27/09 1/26/09 1/17/09 1/27/09

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A 202	Continued From Page 9	A 202		

2. The DPS was interviewed on 01/06/09 at approximately 1 p.m. and asked to present the facility's planned in-service training program provided to newly hired staff and annually for review. She stated the facility did not have a planned staff in-service training program developed for new hired staff or annually thereafter. She confirmed the findings.

3. The DPS was interviewed on 01/06/09 at approximately 1:15 p.m. and asked which employees provided patient counseling and stated employees #1, #2, #4 and #5. The personnel records for these employees #1, #2, #4 and #5 assigned to patient counseling were reviewed with the DPS. Documented evidence was not found to indicate any counseling training was provided to these employees. The DPS confirmed the findings.

4. The personnel files for employees #2, #3, #5, #7 and #8 were reviewed with the DPS on 01/06/09 at approximately 1:30 p.m. Documented evidence was not found to indicate these employees received annual infection control in-service. The DPS confirmed the findings.

5. The personnel files for employees #1, #3, #4 and #7 were reviewed with the DPS on 01/06/09 at approximately 1:40 a.m. Documented evidence was not found to indicate these employees received annual fire protection in-service including patient evacuation, proper use of fire extinguishers and procedure for reporting fires. The DPS confirmed the findings.

6. The personnel files for employees #1, #3 and #7 were reviewed with the DPS on 01/06/09 at approximately 2 p.m. Documented evidence

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A 202	Continued From Page 10 was not found to indicate these employees received annual in-service regarding patient confidentiality and protecting patient rights. The DPS confirmed the findings. 7. The personnel files for employees #1, #2, #3, #4, #5, #7 and #8 were reviewed with the DPS on 01/06/09 at approximately 2:15 p.m. Documented evidence was not found to indicate these employees received annual licensing regulation in-service. The DPS confirmed the findings. 8. The personnel files for employees #1, #3, #4 and #7 were reviewed with the DPS on 01/06/09 at approximately 2:30 p.m. Documented evidence was not found to indicate these employees received annual incident reporting in-service. The DPS confirmed the findings. Class III Correction Date: 01/28/09	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;	A 250	Documentation that the policies and procedures concerning the provision of second trimester abortion have been reviewed and approved by the affiliate's Medical Director, Philip waterman, II, MD	1/29/09

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A 250	Continued From Page 11	A 250		

(4) Standing orders with required signatures;
(5) Medications, storage and administration;
(6) Treatments;
(7) Surgical asepsis;
(8) Medial asepsis;
(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.

Chapter 59A-9.024, F.A.C.

This Standard is not met as evidenced by:
Based on review of written policies and procedures (P&Ps) for second trimester procedures and interview, the facility failed to ensure the clinic medical director reviewed and approved the facility's second trimester P&Ps.

Findings:

The facility's written policies and procedures for second trimester procedures were reviewed.

The Director of Patient Services was interviewed on 01/06/09 at approximately 10:20 a.m. and asked if she could present documented evidence that the medical director reviewed and approved the second trimester P&Ps and stated no. She stated the medical director did not review and

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A 250	Continued From Page 12 approve the P&Ps and did not know the medical director had to review and approve them. Class III Correction Date: 01/28/09	A 250		
A 300	Medical Screening/Eval.-2nd Trimester Each abortion clinic that provides second trimester abortions shall formulate and adhere to written patient care policies and procedures designed to ensure professional and safe care for patients undergoing second trimester abortions and shall maintain a medical record for each such patient that records history, care and services. These patient care policies and procedures, for patients undergoing second trimester abortions, shall include but not be limited to the following: (a) Admission criteria and procedures; (b) Identification in the medical record of physician(s) and nurse(s) involved in providing the services offered for patients undergoing second trimester abortions; (c) Specific details regarding the pre-operative procedures performed, to include: 1. History and physical examination, to include verification of pregnancy, estimation of gestational age, identification of any preexisting conditions or complications; including allergies to medications, antiseptic solutions, or latex; and a complete obstetric and gynecological history. 2. Special examinations, lab procedures, and/or consultations required, to include ultrasonography to confirm gestational age and a physical examination including a bimanual examination estimating uterine size and	A 300	The Medication and Surgical abortion medical history has been revised to include questions concerning patient a llergies to latex or antiseptic solutions.	1/20/09

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	AC13960108	A. BUILDING _____ B. WING _____	01/06/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF GREATER ORLANDO	726 SOUTH TAMPA AVENUE ORLANDO, FL 32805

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A 300	Continued From Page 13 palpation of the adnexa. The physician shall keep original prints of each ultrasound examination of a patient in the patient's medical history file. For an abortion in which an ultrasound examination is not performed before the abortion procedure, urine or blood tests for pregnancy shall be performed before the abortion procedure. Chapter 59A-9.025(1), F.A.C. This Standard is not met as evidenced by: Based on review of a sampled patient clinical record and interview, the facility failed to ensure that patient's allergy to latex or antiseptic solutions would be identified and documented in the clinical record. Findings: A sampled patient clinical record was reviewed with the Director of Patient Services (DPS)on 01/06/09 at approximately 10:40 a.m. The page entitled Medical and Surgical History had a section entitled Allergies which identified if the patient had an allergy to shellfish (Iodine), allergy to local anesthesia or had a severe reaction to sedative medications (meds). No section was found to indicate if the patient had an allergy to latex or antiseptic solutions. The DPS stated it was the patient's responsibility to document if they had an allergy to latex or antiseptic solutions. The DPS was asked if the staff questioned patient's regarding any allergy to latex or antiseptic solutions and stated she did not know. She stated the Medical and Surgical History form would be changed to reflect a	A 300		

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A 300	Continued From Page 14 section to identify and document if a patient had an allergy to latex or antiseptic solution. Class III Correction Date: 01/28/09	A 300		
A 302	Medical Screening/eval.-2nd Trimester Laboratory Equipment and Supplies. (a) All equipment and supplies for the collection, storage, and testing of specimens shall meet the 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. (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. (c) All dated supplies and materials shall not be used beyond their expiration date. (d) Adequate facilities and supplies for the 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 failed to ensure laboratory specimens were stored appropriately and failed to ensure expired sterile water was discarded. Findings: During the facility tour on 01/06/09 at	A 302	In order to resolve the issue of patient specimens and medications being stored on the same shelf in the refrigerator in the lab, a second refrigerator has been purchased to store these items. This addition has been added to our lab manual.	1/17/09

PRINTED: 01/14/2009
FORM APPROVED

Agency for Health Care Administration

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A 302	Continued From Page 15 approximately 11:46 a.m., the following was observed inside the laboratory refrigerator. 1. Inside the laboratory refrigerator various medications and testing solutions were observed on each shelf. 2. On the top shelf medications were stored along with 4 patients' vials of blood. 3. On the door of the refrigerator an opened 500 milliliter bottle of sterile water was observed with a label indicating the bottle was opened on 12/29/07. The opened sterile water bottle had an expiration date of 04/08. The Director of Patient Services accompanying on the tour was interviewed. She confirmed the findings. She stated the staff knew one shelf in the refrigerator was designated only for laboratory specimens and specimens were not to be stored on shelves with medications. She stated the facility was in the process of purchasing another refrigerator designated only for storing laboratory specimens. Class III Correction Date: 01/28/09	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 400	(1) As part of the EMP (A156) the AED will be checked weekly by designated personnel as per manufacturer's recommendation	2/4/09

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A 400	Continued From Page 16 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. (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. (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	A 400	(2) All licensed nursing staff have documentation of current CPR certification in their respective employee files. CPR status is included in the QA calendar for training updates (3) All abortion physicians were notified of their responsibility to discuss Rh status with applicable patient. Documentation that the doctor has discussed this with the client will be included in the client's operative note. (4) A policy and procedure was created to document that the on-call nurse would contact all second trimester patients within 24 hours to assess the patient's status. A good faith effort will be done with each woman, and the respective on-call nurse will follow the approved medical guidelines of the affiliate.	

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A 400	Continued From Page 17 medical record. (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 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. (5) Facility procedures must specify the minimum length of time for recovery as warranted by the procedure type and gestation period. Chapter 59A-9.027, F.A.C. This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure the automatic external defibrillator (AED) emergency resuscitative equipment was checked, tested and operable, failed to ensure 1 of 3 licensed nurses (#3) received current cardiopulmonary resuscitation (CRP) training, failed to ensure a physician would discussed Rho (D) immune globulin with	A 400		

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A 400	Continued From Page 18	A 400		

patients needing the medication, and failed to ensure a good faith effort would be made by the facility to contact a patient within 24 hours post-operatively with their permission to assess the patient's recovery.

Findings:

1. During the facility tour on 01/06/09 an AED was observed on the emergency crash cart. The nurse was interviewed on 01/06/09 at 12:25 p.m. and stated she was assigned to the recovery room. She was asked how often the AED was checked, tested, was the machine functioning and what was the manufacturer's specification for checking and testing the AED. She stated she did not know. She stated to her knowledge the AED was never tested and checked to see if it was operable. The Director of Patient Services (DPS) was interviewed on 01/06/09 at 12:30 p.m. and was asked the same question and stated she did not know.

2. The personnel file for licensed nurse #3 was reviewed with the DPS on 01/06/09 at 2:25 p.m. No documented evidence was found to indicate the nurse received current CPR training. The DPS confirmed the findings.

3. The DPS was interviewed on 01/06/09 at approximately 10:40 a.m. and asked if she was aware the physician was responsible to discuss Rho (D) immune globulin medication with each patient if indicated and stated no. She stated she did not know the physician had to do that.

4. The DPS was interviewed on 01/06/09 at approximately 10:41 a.m. and asked when the nurse would contact a patient post-operatively. She stated the nurse would call the patient post-operatively only if the patient contacted the

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A 400	Continued From Page 19 facility with questions or concerns. The DPS was asked if she was aware a licensed nurse or licensed physician assistant was required to make a good faith effort to contact a patient, with their permission, within 24 hours post-operatively to assess the patient's recovery. She stated no she was not aware of this and confirmed the findings. Class III Correction Date: 01/28/09	A 400		
A9999	Final Observations Based on observation and interview, the facility failed to ensure injectable medications were prepared when needed by a patient and a multidose vial of medication was dated when opened, and failed to ensure medications were properly stored and dated when opened. Findings: 1. During the initial facility tour on 01/06/09 at 9:58 a.m. the following was observed. In the bottom drawer of the crash cart 3 prefilled 20 cubic centimeter (cc.) syringes were observed and the word "Lido" was written on each syringe with a black marker. A 50 milliliter (ml.) multidose vial of Lidocaine was observed opened, used and was not dated to indicate when the vial was opened. The Director of Patient Services (DPS) accompanying on the tour confirmed the syringes were prefilled by the staff, were undated and did not know when the syringes were prefilled with medication. At approximately 12:25 p.m., a nurse and writer checked the crash cart and the 3 prefilled	A9999	(1) Licensed nursing staff will draw appropriate medicationsfor each client prior to the individual procedure, and not have pre-filled syringes for patient use.The Medical Director directed staff to comply with this policy. Multi-dose vials must be labeled the date opened and labeled the date of expiration. (2) Medication cabinets will be locked at all times, as per affiliate's long standing policy.	1/17/09

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A9999	Continued From Page 20	A9999		

syringes were observed back in the bottom drawer along with the opened multidose Lidocaine vial. The nurse confirmed the findings and stated these items would be discarded.

The nurse opened the locked narcotic cabinet on 01/06/09 at approximately 12:15 p.m. An undated prefilled 6 cc. syringe with the words "Versed 2 milligrams (mgs.) and Fentanyl 50 micrograms (mcg.)" were written with a black marker. The nurse stated she did not know the date the syringe was prefilled and confirmed the findings. The nurse confirmed injectable medications should be prepared at the time a patient would need the medication and syringes should not be prefilled.

2. The medication cabinets in the laboratory were found to be unlocked and no staff member was present in the room. Inside the cabinets were various medications and injectable medications. A bottle of Benadryl Allergy medication was stored in the cabinet, was opened and undated. The DPS confirmed the findings and stated the medication cabinets should be locked.

Class III
Correction Date: 01/28/09

CHARLIE CRIST
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION
Better Health Care for all Floridians

HOLLY BENSON
SECRETARY

January 14, 2009

Administrator
Planned Parenthood of Greater Orlando
726 South Tampa Avenue
Orlando,FL 32805

RE: Relicensure Survey

Dear Administrator:

This letter confirms the findings of a relicensure survey conducted at your agency on 01/06/09 by Donna Barton, Registered Nurse Specialist of this office.

Enclosed is the provider copy of the Statement of Deficiencies and Plan of Correction, State Form , which lists the deficiencies observed and discussed with you or your representative 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 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.

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

JML/cid

Enclosure: State Form

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