| Agency for Health Care Adminis | tration | | | |
|---|---|---|-------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | (X3) DATE SURVEY COMPLETED | |
| | AC13960055 | B. WING | C 05/18/2022 | |

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| ALL WOMEN'S HEALTH CENTER OF ORLANDO, INC. 431 MAITLAND AVENUE | | | | | |
|---|--|----------------------------------|--|--|--|
| (X4) ID PREFIX TAG | ALTAMO SUMMARY STATEMENT OF DEFICIENCIES [EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION] | DNTE SPRINGS, FL ID PREFIX TAG | PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE | |
| A 000 | INITIAL COMMENTS | A 000 | | or and a second | |
| | Unannounced Complaint Investigation #2022007388 was conducted on | | | | |
| A 362 | 390.0111(3)(a), FS Termination/Consents Required | A 362 | | and the second s | |
| | (3) CONSENTS REQUIRED. A termination of may not be performed or except with the voluntary and informed written consent of the woman or, in the case of a mental the voluntary and informed written consent of her court-appointed guardian. (a) Except in the case of a medical emergency, consent to a termination of is voluntary and informed only if. The physician who is to perform the procedure, or the referring physician, has, at a minimum, orally, while physically present in the same room, and at least 24 hours before the procedure, informed the woman of: The nature and risks of undergoing or not undergoing the proposed procedure that a reasonable patient would consider material to making a knowing and willful decision of whether to terminate a, and a special patient would consider material to making a knowing and willful decision of whether to terminate a, and a special patient would consider material to making a knowing and willful decision of whether to terminate a, and a special patient would consider material to making a knowing and willful decision of whether to terminate a, and a special patient would consider material to making a knowing and willful decision of whether to termination of a special patient would consider material to the material to the patient would consider material to the material to the patient would consider material to the patient would be patient would | | | | |
| | (1) The must be performed by the physician who is to perform the or by a person having documented evidence that he or she has completed a course in the operation of | | | | |
| | equipment as prescribed by rule and who is working in conjunction with the physician. (II) The person performing the must offer the woman the opportunity to view the live images and hear an explanation of | | | | |

AHCA Form 3020-0001

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

(X6) DATE

TITLE

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| ALL WOMEN'S HEALTH CENTER OF ORLANDO, INC. 431 MAITLAND AVENUE ALTAMONTE SPRINGS, FL 32701 | | | | | | |
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| (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) | (XS) COMPLETE DATE | | |
| PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | COMPLETE | | |
| | diagnosed as having a condition that, on the basis of a physician's good faith clinical judgment, would create a serious risk of substantial and irreversible of a major bodily function | | | | | |

Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED

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| AC13960055 | B. WING | 05/18/2022 |

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| ALL WOMEN'S HEALTH CENTER OF ORLANDO, INC. 431 MAITLAND AVENUE ALTAMONTE SPRINGS, FL 32701 | | | | | |
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| (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 362 | Continued From page 2 | A 362 | | | |
| | if the woman delayed terminating her , c. The medical risks to the woman and of carrying the , to term. The physician may provide the information required in this subparagraph within 24 hours before the procedure if requested by the woman at the time she schedules or arrives for her , to obtain an and if she presents to the physician a copy of a restraining order, police report, medical record, or other court order or documentation evidencing that she is obtaining the because she is a victim of , incest, domestic violence, or human trafficking. 2. Printed materials prepared and provided by the department have been provided to the , woman, if she chooses to view these materials, including: a . A description of the various stages of development. b. A list of entities that offer alternatives to terminating the , c. Detailed information or the availability of medical assistance benefits for prenatal care, childbirth, and care. 3. The woman acknowledges in writing, before the termination of , , , that the information required to be provided under this subsection has been provided. Nothing in this paragraph is intended to prohibit a physician from providing any additional information which the physician deems material to the woman's informed decision to terminate her . This Statute or Rule is not met as evidenced by. Based on interview and record reviews, the clinic failed to assure that 11 of 179 patients who entered the clinic since for | | | | |
| | termination of , , , received the required | | | 5 | |

PRINTED: 05/25/2022 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B MING AC13960055 05/18/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 431 MAITLAND AVENUE ALL WOMEN'S HEALTH CENTER OF ORLANDO, INC. ALTAMONTE SPRINGS, FL 32701 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A 362 Continued From page 3 A 362 24-hour wait time following the physician visit to the time of the procedure (#2, #3, #7, #14, #15, #16, #17, #22, #23, #25 & #26). The physician visit included information regarding the nature and risks of undergoing or not undergoing the proposed procedure that a reasonable nation! would consider material to making a knowing and willful decision of whether to terminate a , . , , and the probable , . . . age of ., verified by an at the time the termination of , . , can be performed. Findings: A review of the medical records of all patients who had procedures from to was performed. The following discrepancies were discovered. 1. Patient #2 saw the physician for an initial visit to provide information and obtain a consent on at 9:38 AM. The record revealed that a pill to cause an . . . was given on at an unknown time. Since both activities took place on the same day, the 24-hour requirement was not met.

not met.

2. Patient #3 saw the physician for an initial visit to provide information and obtain a consent on at 10:55 AM. The record revealed that a pill to cause an was given on at an unknown time. Since both activities took place on the same day, the 24-hour requirement was

3. Patient #7 saw the physician for an initial visit to provide information and obtain a consent on at an unknown time. The record revealed

at an unknown time.

that a surgical procedure to cause an was performed on

05/18/2022

Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С

NAME OF PROVIDER OR SUPPLIER

B. WING ____ STREET ADDRESS, CITY, STATE, ZIP CODE

AC13960055

| REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED.) | | | NTE SPRINGS, FL | | |
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| Since both activities took place on the same day, the 24-hour requirement was not met. 4. Patient #14 saw the physician for an initial visit to provide information and obtain a consent on at 12:30 PM. The record revealed that a pill to cause an was given on at an unknown time. Since there was no time indicated on for the pill administration, there was no way to confirm that the 24-hour requirement had been met. 5. Patient #15 saw the physician for an initial visit to provide information and obtain a consent on at 12:00 PM. The record revealed that a pill to cause an was given on at an unknown time. Since there was no time indicated on for the pill administration, there was no way to confirm that the 24-hour requirement had been met. 6. Patient #16 saw the physician for an initial visit to provide information and obtain a consent on at an unknown time. Since there was no some to confirm that the 24-hour requirement had been met. 7. Patient #16 saw the physician for an initial visit to provide information and obtain a consent on at an unknown time. Since there was no time indicated on for the pill administration, there was no way to confirm that the 24-hour requirement had been met. 7. Patient #17 saw the physician for an initial visit to provide information and obtain a consent on at 12:00 PM. The record revealed that a pill to cause an was given on at an unknown time. Since there was no time indicated on for the pill administration, there was no way to confirm that the 24-hour equirement had been met. | X4) ID REFIX TAG | | PREFIX | CROSS-REFERENCED TO THE APPROPRIATE | COMPLETE |
| at 12:40 PM. The record revealed that a pill to cause an was given on at an unknown time. Since there was no time indicated on for the pill administration, there was no way to confirm that the 24-hour requirement had been met. 7. Patient #17 saw the physician for an initial visit to provide information and obtain a consent on at 12:00 PM. The record revealed that a pill to cause an was given on at an unknown time. Since there was no time indicated on for the pill administration, there was no way to confirm that the 24-hour | TAG | Continued From page 4 Since both activities took place on the same day, the 24-hour requirement was not met. 4. Patient #14 saw the physician for an initial visit to provide information and obtain a consent on at 12:30 PM. The record revealed that a pill to cause an was given on at an unknown time. Since there was no time indicated on for the pill administration, there was no way to confirm that the 24-hour requirement had been met. 5. Patient #15 saw the physician for an initial visit to provide information and obtain a consent on at 12:00 PM. The record revealed that a pill to cause an was given on at an unknown time. Since there was no time indicated on for the pill administration, there was no way to confirm that the 24-hour requirement had been met. 6. Patient #16 saw the physician for an initial visit | TAG | | DATE |
| | | pill to cause an was given on at an unknown time. Since there was no time indicated on for the pill administration, there was no way to confirm that the 24-hour requirement had been met. 7. Patient #17 saw the physician for an initial visit to provide information and obtain a consent on at 12:00 PM. The record revealed that a pill to cause an was given on at an unknown time. Since there was no time | | | |
| | | there was no way to confirm that the 24-hour | | | nonement of the second |

| NAME OF PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
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| ALL WOMEN'S HEALTH CENTER OF ORLANDO INC. | | | AND AVENUE E SPRINGS, I | FL 32701 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATI | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| A 362 | Continued From page 5 to provide information and obtain a consent at 9:00 AM. The record revealed tha pill to cause an was given on | t a a t a a t a a t a a t a a t a a t a a t a a t a a t a a t a a t a a t a t a a t a t a t a t a t a t a t a t a t a t a t a a t a t a t a t a t a t a t a t a t a t a t a a t a t a a t | A 362 | DEHILIENCY) | |
| | hours between the time they counsel the pat and perform the procedure, and to documen | | | | T- |

| Agency f | or Health Care Adminis | stration | | | | : 05/25/2022 I APPROVED |
|--------------------------|---|--|---------------------------------|---|----------------------|----------------------------|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE C A. BUILDING: | CONSTRUCTION | (X3) DATE S COMPL | |
| | | AC13960055 | B. WING | | 05/1 | 8/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STATE | E, ZIP CODE | | |
| ALL WOM | IEN'S HEALTH CENTER | OF ORLANDO INC. | LAND AVENUE TE SPRINGS, FL | . 32701 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETE DATE |
| A 362 | Continued From page | 6 | A 362 | | | |
| | She stated that in the | first few days of the new | | | | |
| | requirement of in ensuring compliant | , they experienced difficulty | | | | |
| | , | Je. | | | | |
| | Unclassified | | | | | |
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