

Amended 6/11/13

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AC13960088	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/24/2013
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ALL WOMEN'S CLINIC

2100 E COMMERCIAL BLVD
FORT LAUDERDALE, FL 33308

(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 Licensure Survey conducted on . All Women's Clinic had deficiencies found at the time of the visit.	A 000		
A 400	Recovery I-2nd Trimester Each abortion clinic which is providing second trimester abortions shall comply with the following recovery when providing second trimester abortions: (1) Following the procedure, post procedure recovery will be supervised and staffed to meet the patient's needs. A physician or physician assistant, a licensed registered nurse, 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 the patient is discharged. The individual must be certified in basic A patient in the post-op or recovery I 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 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 is necessary. The clinic medical records documenting care provided shall	A 400		

AHCA Form 3020-0001

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

Allison Barker

TITLE

RJ BSN

(X6) DATE

6/11/13

STATE FORM

6899

08SE11

If continuation sheet 1 of 4

Office Manager

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AC13960068	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/24/2013
NAME OF PROVIDER OR SUPPLIER ALL WOMEN'S CLINIC		STREET ADDRESS, CITY, STATE, ZIP CODE 2100 E COMMERCIAL BLVD FORT LAUDERDALE, FL 33308		
(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 400	Continued From page 1 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) with each patient for whom it is indicated and will ensure that it is offered to the patient in the immediate 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) refusal Form 3130-1002, 2006, "Refusal to Permit Administration of (D)", herein incorporated by reference, shall be signed by the patient and a witness, and shall be included in the patient's medical record. (4) Written instructions with regard to post abortion coltus, 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-op 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 period. Chapter 59A-9.027, F.A.C.	A 400		

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NAME OF PROVIDER OR SUPPLIER ALL WOMEN'S CLINIC			STREET ADDRESS, CITY, STATE, ZIP CODE 2100 E COMMERCIAL BLVD FORT LAUDERDALE, FL 33308	
(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 400	<p>Continued From page 3</p> <p>Further review of Patient #10's record revealed that telephone contact was not made with Patient #10 by the Physician or Registered Nurse, in an attempt to assess her recovery within 24 hours of the procedure. There was also no evidence that "Patient consent to receive a telephone call from the Clinic within 24 hours after the procedure was performed" was obtained.</p> <p>Interview with the Office Manager, who is also a Registered Nurse, at approximately 2 PM on _____ revealed that "the Medical Director does not allow telephone contact to be made with Patients, following Abortion Procedures, in an attempt to maintain the Patient's confidentiality". During the interview, she also stated that "Patient consent to receive a telephone call following abortion procedures is not requested".</p> <p>During an interview with the Medical Director on _____ at approximately 3 PM, he confirmed that telephone contact was not made with Patients after abortion procedures, to ensure Patient's confidentiality. He also stated that "Patient consent to receive a telephone call following Abortion Procedures" was not being requested by the Clinic.</p>	A 400	<p>In addition, we modified our _____ note to document our 24- hour follow up phone call to patient.</p> <p>I hope the above is satisfactory.</p> <p>Thank you.</p> <p>Sincerely,</p> <p><i>Theodor Lehrer</i></p> <p>Theodor Lehrer, M.D., FACOG Medical Director All Women's Clinic, LLC</p> <p>Attached, please find a copy of our new form titled, AUTHORIZATION FOR 24-HOUR FOLLOW UP CALL, INSTRUCTIONS AND COUNSELING CHECK LIST that the patient will sign.</p> <p>In addition, we modified our _____ note to document when we make the 24- follow up call.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AC13960058	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/24/2013
NAME OF PROVIDER OR SUPPLIER ALL WOMEN'S CLINIC			STREET ADDRESS, CITY, STATE, ZIP CODE 2100 E COMMERCIAL BLVD FORT LAUDERDALE, FL 33308	
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A 400	Continued From page 2 This STANDARD is not met as evidenced by: Based on record review and interview, the Physician failed to ensure that 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 for 2 of 3 2nd Trimester sampled Patients (Patient #9, and #10). The findings include: Interview with the Office Manager at approximately 10:00 AM on _____ revealed that both 1st and 2nd Trimester Abortions are performed at this location. Review of Patient #9's record revealed that age was 14 weeks, and a 2nd Trimester abortion procedure was performed on _____ Further review of Patient #9's record revealed that telephone contact was not made with Patient #9 by the Physician or Registered Nurse, in an attempt to assess her recovery within 24 hours of the procedure. There was also no evidence that "Patient consent to receive a telephone call from the Clinic within 24 hours after the procedure was performed" was obtained. Review of Patient #10's record revealed that age was 13.5 weeks, and a 2nd Trimester abortion procedure was performed on _____ and _____	A 400	AHCA Health Quality Assurance 5150 Linton Blvd, Suite 500 Delray Beach, Florida 33484 Dear _____ Mayo-Davis Thank you for the inspection on _____ 2013 that was conducted by Joanna Walker, ACHA Field Officer. The inspection was extremely thorough and lasted over six hours. I appreciate it, as we strive to not only comply but to exceed all of ACHA requirements. I like the idea of the doctor or the registered nurse making a 24-hour follow up call after a termination of _____. This will help reinforce _____ instructions provided to the patient and enhance patient's satisfaction. We will be glad to comply. Attached please find copy of our new form titled, AUTHORIZATION FOR 24-HOUR FOLLOW UP CALL, INSTRUCTIONS AND COUNSELING CHECK LIST that the patient signs in the office.	



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
All Women's Clinic
2100 E Commercial Blvd
Fort Lauderdale, FL 33308

Dear Administrator:

This letter reports the findings of a State Licensure Survey that was conducted on _____, 2013 by a representative from 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 calendar days of receipt of this report. All deficiencies shall be corrected no later than** _____, 2013.

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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

A handwritten signature in black ink that reads "Arlene Mayo-Davis".

Arlene Mayo - Davis
Field Office Manager

AMD/jw
Enclosure(s)

TBB2

