STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AC13960112	08/21/2018
NAME OF PROVIDER OR SUPPLIER **A WOMAN'S CENTER OF HOLLYWOOD**	STREET ADDRESS, CITY, STATE, ZIP CODE **3829 W HOLLYWOOD BLVD** **HOLLYWOOD, FL 33021**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - INITIAL COMMENTS

An unannounced licensure complaint survey, CCR#2018006919, was commenced , and concluded on at A Woman's Center of Hollywood, License #904. The allegations were substantiated. The facility had a deficiency at the time of the investigation.

0362 - Termination/Consents Required - 390.0111(3)(a), FS

Based on interview and record review, the facility failed to obtain a voluntary and informed written consent for a termination of , prior to the procedure being performed, and the Physician who performed the procedure failed to inform the patient 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 , , orallly or in person, prior to a termination of , for 1 of 3 Patients. (Patient #1).

The findings include:

Review of Patient # 1's record reveals Patient #1 came to the facility to obtain a "medical abortion" (a non-surgical procedure) on , and an " " performed on that day reveals a weeks, 2 days. The Administrator explains, during an interview on at approximately 1:30 PM, that Patient #1 mistakenly received a "surgical abortion procedure", rather than a "pill abortion", (medical abortion), states Patient # 1's medical record "got mixed up" with another patients medical record, and while Patient #1 was in the recovery , the Physician who performed the surgical abortion procedure informed Patient #1 that the wrong procedure had been performed. During an interview on at approximately 1:00 PM with MA (Medical Assistant) #1, she states the "pill abortion" procedure had been discussed with Patient #1 prior to the surgical abortion being performed. Further interview with the Administrator on at approximately 1:30 PM reveals that facility staff requested that Patient #1 sign consent forms for a "surgical abortion" ( ) after the procedure was mistakenly performed.

The Administrator also states that an office staff member was inserting patient information in the facility computer when she realized the consent forms signed by Patient #1 were for a "pill abortion", and a surgical abortion procedure had been performed; therefore she "tore up" the consent forms signed by Patient #1 for a "pill abortion". The Administrator states the " torn pieces" of the consent form for the "pill abortion" were later retrieved from a "trash can" on site. The torn pieces of the consent form signed by Patient #1 for the "pill abortion" on were requested from the Administrator.

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After the Administrator assembled the torn pieces of paper from the consent forms for a "pill abortion", pasted the torn pieces of paper on a blank sheet of paper, and copied the piece of paper with the torn pieces of the consent form for a medical abortion, review of the torn pieces of paper reveals the complete consent forms for a "pill abortion" could not be read; however Patient # 1's initials were visible on various portions of the consent form for a "medical abortion".

The Administrator acknowledged that the facility failed to obtain a voluntary and informed consent for a surgical abortion prior to the procedure being performed..

Class II