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
	AC13960065	A. BUILDING _____ B. WING _____	09/24/2014

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 An unnounced relicensure survey commenced on [redacted] and was concluded on [redacted] at All Women's Clinic. The Provider had a deficiency found at the time of the visit.	A 000	As shown in the enclosed updated PACE maintenance report dated [redacted] the next comprehensive test will be conducted in [redacted] and at least annually, as per the PACE's expert written specifications – or prior to being placed back in service in the event of repairs - to ensure proper operation.	
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 [redacted] 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 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.	A 156	An updated ticket affixed on each piece of inspected equipment will be maintained. Surgical instruments must be sterilized by autoclave before being been used again in any patient. Maintenance of each instrument will be individually recorded. The work described above will include all our patient monitoring equipment, and all [redacted] and surgical equipment, without exceptions. In addition to PACE maintenance work, we are subscribed to monthly autocheck sterilizer monitoring services from Emory Medical Laboratories, as shown in enclosed certificates. Any equipment [redacted] must be immediately corrected prior to further use. Updated List of Dates of Expiration is maintained on the medications in the crash cart, and battery in the automatic defibrillator and are kept current. Our preventative maintenance program is kept at least annually. To avoid missing any required maintenance, our maintenance includes absolutely all our equipment. Patient vital signs are checks using more than one instrument, and discrepancies if any, are immediately checked to detect [redacted] on a daily, ongoing basis.	

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE
Medical Director 10.8.14

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
	AC13980068	A. BUILDING: ____ B. WING ____	09/24/2014

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 156	Continued From page 1	A 156		

This STANDARD is not met as evidenced by:
Based on interview, observation, and record review it was determined that the facility did not ensure that all patient monitoring equipment and surgical equipment is checked and/or tested in accordance with manufacturer's specifications at periodic intervals, not less than annually, to ensure proper operation, and state of good repair.

The findings include:

During a tour of the procedure approximately 11:45 AM on 9/23/14, observation revealed that the inspection/calibration sticker affixed to the machine was dated and was due for another inspection on 9/13/14. Further observation in the procedure approximately 11:45 AM on revealed that the machine attached to the wall had a sticker affixed to the machine dated '09. Interview with Owner/Administrator at approximately 12:30 PM on revealed the machines are utilized; however they had not been inspected or calibrated in the last few years. He stated that the machine "only requires that the battery be checked". The Owner/Administrator provided a copy of a receipt from a medical maintenance company dated 9/21/12 which documented "checked various pieces of equipment for electrical safety, proper operation and calibration--no defects noted".

On 9/24/13 the Owner/Administrator sent additional documentation from the medical maintenance company indicating that the machine "passed" the physical inspection on 9/21/12.

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2014

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

Dear Administrator:

This letter reports the findings of a State Relicensure Survey that was conducted on 24, 2014 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 faxed report. All deficiencies shall be corrected no later than , 2014.**

The plan of correction must include the following:

1. Identify how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
2. Describe how the facility will identify other residents having the potential to be affected by the same deficient practice.
3. Explain measures to be put into place or systemic changes made to ensure that the deficient practice will not recur.
4. Identify how the facility will monitor its corrective action to ensure the deficient practice is being corrected and will not recur; i.e., what program will be put into place to monitor the continued effectiveness of the systemic change.
5. Ensure that no protected or other confidential information (i.e., resident or staff names) are included in the plan.
6. State the completed date; the date that the facility identifies compliance can be achieved, which must be after the exit date.
7. You must sign the bottom of page 1 of the statement of deficiencies; include your title and date.

Delray Beach Field Office
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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,

Arlene Mayo - Davis
Field Office Manager

AMD/jw
Enclosure(s)

TBB2