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STATEMENT OF DEFICIENCIES

NAME OF PROVIDER OR SUPPLIER

FLORIDA WOMEN'S CENTER. INC.

AND PLAN OF

Agency for Health Care Administration

16:17 9943595954

(X1) PROVIDER/SUPPLIER/CLIA

AC13960062

AHCA FORM APPROVED (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED A DUBLOSHICE B. WING STREET ADDRESS: CITY, STATE, ZIP CODE 3699 UNIVERSITY BLVD & SUITE 1200 JACKSONVILLE, FL 32216 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE m PREFIX TAG DEFICIENCY A 202 All enhancements, changes, and modifications are effective immediately ac of 2014

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR USC IDENTIFYING INFORMATION) (X4) ID PREFIX A 202 Continued From page 1 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. This STANDARD is not met as evidenced by: Based on facility record reviews and staff interviews, the facility failed to ensure staff orientation and annual training including fire safety, other safety measures, medical control, were emergencies, and completed for 2 (Employee B and Employee E) of 5 amployees The findings include: 1). A review of the facility's in-service staff reveals no meeting record dated evidence that Employee B, who has a hire date of 7/29/2008, attended the Annual Regulatory Training/In-service Meeting. 2). A review of the facility's in-service staff neveals no meeting record dated evidence that Employee E attended the Annual Regulatory Training In-service Meeting, Employee E worked in the facility as an intern prior to her A review of the personnel file for Employee E reveals no evidence that the facility's orientation included the required regulatory training. A review of the personnel file for Employee E reveals she reviewed and signed If continuation sheet 2 of 5 AHCA Form 3020-0001 KI VD11 STATE FORM

P.005 PAGE

ΔΗΓΔ 9843596854 FORM APPROVED OW DATE SUBVEY

STATEMEN	or Health Care Adm r of DEFICIENCIES OF CORRECTION	(X1) PROVIDEN/SUPPLIEN/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		AC13960062	B. WING		07/29	/2014
	ROVIDER OR SUPPLIER	3599 UNF	DRESS, CITY, ST VERSITY BLV IVILLE, FL 3	D S SUITE 1200	TION I	(XS)
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)		DATE
A 202	Continued From p		A 202			2014
	verification of und and Procedures N internship.	erstanding of the OSHA Policy Janual on during he	-	Prefix Tag A302: Corrective completed 2014	e action	July30,
	11:27 am reveals	the Administrator on 7/29/14 at that the OSHA Policy Manual the entire office Policy and ual. The Administrator stated the		Category: Medical Screening Trimester. Immediately upon the findin		

he is responsible for all staff training for the Medical Assistants, and can assure the surveyor that all employees have completed the required training. The Administrator was unable to provide written evidence and documentation of the completed training for Employee B and Employee E upon request.

A 302 Medical Screening/eval.-2nd Trimester A 302

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. Emergency med kit containing unopened vet expired medications, a complete set of all medications in the kit were ordered and have been received. All medications identified with any expiration dates close to expiration or beyond manufacturer recommendations were identified and destroyed or for destruction in accordance with proper disposal techniques. The remote Emergency medication kit as a unit has been added as a unique item of inspection with checklist for stocking,

All employees underwent . inforcement of specific and focused management techniques of reinforced monitoring, rotation, and proper handling of medications and supplies.

supply and control of this kit to assure

expiration dates remain current.

The facility medication instituted a new enhanced organizational protocol for enhanced separation of all medications being prepared and continued safe labeling and identification

AHCA Form 3020-0001 STATE FORM

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PAGE FORM APPROVED

PATRMENT	or Health Care Adm	Inistration (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLET	RVEY TED
ND PLAN C	OF CORRECTION	AC13960062	A. BUILDING		07/29/	2014
AME OF P	ROVIDER OR SUPPLIER	STREET ADI	RESS, CITY, S	TATE, ZIP CODE TO S SUITE 1200		
LORIDA	WOMEN'S CENTER	R, INC. JACKSON	WILLE, FL 3	2216	<u> </u>	
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE APPROPRIATE	COMPLETE DATE
A 302	Continued From p	page 3	A 302	A protocol has been enha established requiring pro-		1433c
	Chapter 59A-9.02	5(3), F.A.C.		medicine type at a time medication a s	in the ingle employee	, ,
	Based on observe	is not met as evidenced by: ations and staff interviews, the sure that all supplies and a not available for patient use afacturer's expiration date.		from start to finish and the monitor leave the m unattended without cor of labeling and proper s	edications npleting the task ecure storing.	_
	The findings incl	ude:		All medications are prep step/one-task/one pers assure continued system	on method to	2014
	Kit on 7/29/2014 the following: 1 vial of date of 201 with an expiration Dexamethason 201 1 vial of expiration date 1 vial of of 2012 40mg with an e 2 vials of Steril	e 20mg with an expiration date of 2; 100mg with an 0,4mg with an expiration date ; 1 wial of Methylprednisolone expiration date of 2012; 2 Water 10co with an expiration	ď	them and place them in designated area specific medications that need the disposed. This disposed administrator's control administrator is to be not there are medications to as being close to expiral expired to assure prophanding, replacement, An additional monthly n	expired disposal in the unit to remove a separate and cally for expired to be properly l area is under th and the ottified each tim hat are identified tion date or er monitoring and safe disposal comporting	
	date of 20	11.		checklist has been impl expiration dates on me medication		k SVO
	at 1 Medication Kit hired, and no	ith the Office Manager on 0:50 am reveals the Emergency has not been used since she we one really looks in the Emergency to see if the medications are ver, the facility will get the expire eplaced.	es Fy	All staff has been re-inst counseled in detail reg- rotation of stock and cl dates to assure system monitoring, compliance	arding diligence necking expiratio ic continued	

P.007

AHCA

PAGE . . FORM APPROVED

STATEMENT	or Health Care Adm or DEFICIENCIES OF CORRECTION	MAIT Care Administration MERICIENCIES (X1) PROVIDER/SUPPLIENCLIA MERCTION (X1) PROVIDER/SUPPLIENCLIA MERCTION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
		AC13960062	B, WING		07/29/2014		
	ROVIDER OR SUPPLIER	STREET AD	ERSITY BLV	TATE, ZIP CODE D S SUITE 1200			
(XA) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SIK CROSS-REFERENCED TO THE APP DEFICIENCY)		(X5) COMPLETE DATE	
A 302	Continued From p	age 4	A 302			Jug 30	
	are 54 pre-filled s on the counter wi of it tableed 75 batch of 62 10cc on the same count on top tableed 25 the counter top counter to counte	syringes filled with clear liquid ther with an orange Post-It Note 6. There is a box on ontaining 21 bottles of 1% expiration date of 2014 f another counter top in the ge the property of an unlabeled a large empty bottle of g sitting on top of that counter set of 30 bottles containing 10 beled medications, with a title of 500mg pills	e wn				



RICK SCOTT

ELIZABETH DUDEK SECRETARY

VIA U.S. Mail & FAX:

2014

Patrick Kelly, M.D., Administrator Florida Women's Center, Inc. 3599 University Boulevard South; Suite 1200 Jacksonville, FL 32216

Dear Dr. Kelly::

Re: RE-LICENSURE SURVEY

This letter reports the findings of an unannounced re-licensure survey completed on 2014 by a representative of this office. It was determined that Florida Women's Center was not in compliance.

Attached is State (3020) Form, indicating the Standard level deficiencies cited.

You must provide the Agency with an acceptable Plan of Correction (PoC) for all deficiencies cited within ten calendar days from receipt of the Form CMS 2567. Please complete a Plan of Correction (PoC) for the deficiencies, including the date corrective action was accomplished or is anticipated to be accomplished. Please indicate correction date(s) in the right-hand column of the State Form, under "Completion Date", for each deficiency. Please sign and date page 1 on the bottom, and return to the Jacksonville Field Office within ten calendar days of receipt. Failure to submit a reply within this time frame may jeopardize your licensure status. All deficiencies must be corrected no later than 2014.

In order for a PoC to be acceptable, it must include the following elements:

Core Elements of PoC:

- How the corrective action will be accomplished for individuals found to have been affected by the deficient practice;
- How the facility will identify other individuals who have the potential to be affected by the same deficient practice, and how the facility will act to protect individuals in similar situations.
- What measures will be put into place or systemic changes made to ensure that the
 deficient practice will not recur:
- How the facility will monitor its corrective actions/performance to ensure that 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 to ensure that
 solutions are permanent; and

Jacksonville Field Office 921 N. Davis St., Bldg. A, Suite 115 Jacksonville, FL 32209 Phone: (904) 798-4201; Fax: (904) 359-6054 AHCA.MyFlorida.com



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Page 2

- What measures will be put into place or what systematic changes you will make to
 ensure that the deficient practice does not recur; and.
- When corrective action will be accomplished. Please refer to above paragraph for instructions on how to complete the State Form.

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 surveyor. If you have questions, please contact us at (904) 798-4201.

Sincerely.

Joan Lynch RNC

Joan M. Lynch, RN, MSN Registered Nurse Consultant Division of Health Quality Assurance

RED/JML/JR/je Enclosure

BNOB