PRINTED: 01/19/2017
FORM APPROVED

AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AC13810029	01/06/2017
NAME OF PROVIDER OR SUPPLIER **WOMEN'S OB-GYN CENTER OF COUNTRYSIDE, INC.**	STREET ADDRESS, CITY, STATE, ZIP CODE **28960 HWY 19 NORTH, SUITE 110 CLEARWATER, FL 33761**	

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

accepted 1/24/17

0000 - INITIAL COMMENTS

An unannounced Licensure survey was conducted at Women's OB-GYN Center of Countryside, Inc., an abortion clinic located in Clearwater, Fl. on 1/06/17. License #753.

The provider had deficiencies at the time of the visit.

0153 - Clinic Suppl/eqt-2d Trimes-Resuscitative Meds - 59A-9.0225(4), FAC

Based on observation and interview it was determined the facility failed to ensure all medications in the emergency box were within manufacturer's safe doe use date.

Findings included:

On at 9:30 a.m. a tour of the facility revealed four of four 2 milliliter vials of with expiration dates of 01/2016.

An interview with the facility administrator confirmed the findings and stated the medications should not be used.

0250 - Clinic Policies/Procedures-2nd Trimester - 59A-9.024, FAC

Based on observation, review of facility records and interview it was determined the facility failed to review policy and procedures annually.

Findings included:

On at 11:00 a.m. a review of the facility policy and procedure manual revealed policies and procedures were last reviewed by the facility medical director

An interview with the facility administrator confirmed the findings

0302 - Medical Screening/eval.-2nd Tri-Lab Eq/Suppl - 59A-9.025(3), FAC

Based on observation and interview it was determined the facility failed to ensure all supplies were within the manufacturer's direction for safe use.

Findings included:

On at 9:30 a.m. a tour of the operating one of one 4-0 sterile synthetic suture

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	AC13910029	01/06/2017
NAME OF PROVIDER OR SUPPLIER **WOMEN'S OB-GYN CENTER OF COUNTRYSIDE, INC.**	STREET ADDRESS, CITY, STATE, ZIP CODE **28960 HWY 19 NORTH, SUITE 110 CLEARWATER, FL 33761**	

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with an expiration date of 07/1996.

On at 9:40 a.m. a tour of exam # revealed one of one thin prep test expired on

On at 10:00 a.m. a tour of the equipment sterilization/medication medications stored within a locked cabinet. Observation of the medications stored revealed three of three clear plastic 30 milliliter medication cups each with a white caplet shaped medication. There were no labels on the cups and no identifying information as to what the caplet was. Also noted was one of one opened multi dose vial of with no date on the vial for when it was opened. There were two of two multi dose vials of with no date on the vials for when it was opened.

On at 10:30 a.m. an interview with the facility administrator confirmed the above findings.

0400 - Recovery -2nd Trimester - 59A-9.027, FAC

Based on interview and personnel file review it was determined the facility did not have a registered nurse on staff for recovering patients post procedures.

Findings included:

On at 11:00 a.m. a review of the personnel files did not reveal any registered nurses employed at the facility.

On at 11:00 and interview with the facility administrator confirmed the above findings.

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

, 2017

Administrator
Women's OB-GYN Center of Countryside, Inc.
28960 Hwy 19 North, Suite 110
Clearwater, FL 33761

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2017 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2017.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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(s). Should you have any questions please call Nila Perrone at 727-552-2000.

Sincerely,

Patricia Reid Caufman
Field Office Manager

PRC/eah
Enclosure

XG90

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