Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
7002447	19840/36774	5/31/17

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Aanchor Health Center LTD	1186 Roosevelt Rd, Glen Ellyn Illinois 60137

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
T000	A licensure survey was conducted on 5/31/17. The Facility was not in compliance with TITLE 77: PUBLIC HEALTH CHAPTER I: DEPARTMENT OF PUBLIC HEALTH SUBCHAPTER b: HOSPITAL AND AMBULATORY CARE FACILITIES PART 205 AMBULATORY SURGICAL TREATMENT CENTER LICENSING REQUIREMENTS, as evidenced by:			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE — TITLE: Chief of Operations — DATE: 6-29-17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
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T076	205.610 a) & b) a) The ASTC shall maintain accurate and complete clinical records for each patient, and all entries in the clinical record shall be made at the time the surgical procedure is performed and when care, treatment, medications, or other medical services are given. The record shall include, but not be limited to, the following: 1) Patient identification; 2) Admitting information including patient history, physical examination findings, diagnosis or need for medical services; 3) Pre-counseling notes; 4) Signed informed consent; 5) Confirmation of a pregnancy (when an abortion is performed); 6) Signed physician orders; 7) Laboratory test reports, pathologist's report of tissue, and radiologist's report of imaging studie;s 8) An anesthesia record; 9) The operative record; 10) Medication and medical treatments; 11) Recovery room progress notes; 12) Physician and nurse progress notes; 13) The patient's condition at time of discharge; 14) Patient instructions; and 15) Post-counseling notes. b) The ASTC shall comply with the Department's rules titled Pregnancy Termination Report Code. This Regulation is not met as evidence by: Based on document review and interview, it was determined that for 4 of 4 records reviewed (Pt. #9, 10, 11, & 12), the Facility failed to ensure all intravenous (IV) fluids administrations were ordered. Findings include:			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE TITLE DATE

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	205.610 a) & b) continued...			
T076	1. The Facility policy titled "Standing Orders" (undated) required, "B. All standing orders shall contain the following information: 1. Type (pre-operative or Post-operative); 2. Application (type <s>, Procedure<s>, Patient profile); 3 Specific, detailed instruction that do not require interpretation... " 2. The Facility policy titled "Preoperative Standing Order for Intravenous Hydration" (undated) reviewed on 5/30/17 required, "A trained RN can initiate intravenous hydration on a patient based on the center's pre-operative standing order...Any medication administration intravenously requires a physicians orders and must be noted in the chart." 3. The clinical record for Pt. #9 was reviewed on 5/30/17. Pt. #9 was a 31 year old female, admitted on 2/11/17, with a diagnosis of intrauterine pregnancy (IUP). The clinical record included documentation of an IV being started and Pt #9 receiving IV fluids. However, the clinical record did not include an order for the IV. 4. The clinical record for Pt. #10 was reviewed on 5/30/17. Pt. #10 was a 32 year old female, admitted on 3/18/17, with a diagnosis of (IUP). The clinical record included documentation of an IV being started and Pt. #10 receiving IV fluids. However, the clinical record did not include an order for the IV. 5. The clinical record for Pt. #11 was reviewed on 5/30/17. Pt. #11 was a 27 year old female, admitted on 3/8/17, with a diagnosis of (IUP). The clinical record included documentation of an IV being started and Pt. #11 receiving IV fluids. However the clinical record did not include an order for the IV. 6. The clinical record for Pt. #12 was reviewed on 5/30/17. Pt. #12 was a 21 year old female, admitted on 1/11/17, with a diagnosis (IUP). The clinical record included			

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T076	205.610 a) & b) continued... Documentation of an IV being started, and Pt. #12 receiving IV fluids. However the clinical record did not include an order for the IV. 7. The above findings were discussed with the Chief of Operations (E #1) and the Assistant Administrator (E #2), during an interview on 5/30/17, at approximately 2:30 PM. E #1 and E #2 stated that all patients receive an IV and fluids on admission. E #1 stated that the IV order should be included in the standing order.	T076	It is in our policy that all patients receive I.V. fluids. In most cases, the anesthesiologist starts the I.V. however on occasion, and the nurse will start the I.V. per the physician's verbal orders. Physician orders will be noted in the chart per our policy (see enclosed). At the end of the surgical day, the Nurse Manager will audit all charts of the day with special attention to the documentation of the physician orders. Any deficiencies will be brought to the attention of the physicians and nurse involved. Any continued deficiencies will be reported to the Administration (see enclosed). Since the survey (May 13, 2017) to date, there have been no orders for the RN to start an I.V; the anesthesiologist has started all the I.V.s. All staff will be reminded to document on the OR/Anesthesiologist record exactly who started the I.V., site, solution, etc. (see enclosed) A memo has been sent out to all of the staff to address this issue (see enclosed). Physicians Orders/ Standing Order documentation audit has also been added to the quarterly Utilization Review/ Peer Review program. The Medical Record Review form has been revised (see enclosed). This report will be reviewed by the Consulting Committee at the next quarterly meeting in September 2017.	July 1, 2017 July 1, 2017

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE

TITLE Chief of Operations

DATE 6/29/17

Illinois Department of Public Health

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AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE

TITLE Chief of Operations

DATE 6/29/17

If continuation sheet Page 4 of 4

Memo

To: **All Staff and Physicians**

From: **Administration**

Date: **06-29-17**

RE: **Documenting I.V Start**

Please be advised that if a RN starts an I.V. per physician's orders, it must be documented in the chart. There is a section of the standing order where this could be noted. We have added "I.V. START (Pre-Op) ___ (Intra-Op) ___" to further clarify (see Enclosure)

Also as a reminder, anyone starting an I. V. (both RNs and Physicians) must note on the OR/Anesthesiologist record exactly who started the I.V., site solution, etc. (See enclosure).

The Nurse Supervisor will audit all charts at the end of the day with special attention to the documentation of physician's orders. Any deficiencies will be addressed with those involved and any continued deficiencies will be reported to the Administration.

Vera Schmidt
Chief of Operations

Americans United for Life

ORDERS

POLICY:

When a physician gives additional orders for a patient they are to be documented in the patient's medical record. Only qualified individuals may give or receive verbal orders for patient care, which are to be recorded in the medical record.

PROCEDURE:

A. The orders will contain the following information:

   a. Type (pre-operative or post-operative).
   b. Patient's Name.
   c. Date.
   d. Specific, detailed instructions that do not require interpretation.
   e. Physicians Signature.

B. Pre-operative orders can be initiated verbally by the physician, in which case they must be signed by the physician the date of surgery. Or, they may be issued and signed by the physician in his office and sent/brought to the Center.

C. Post-operative orders are initialed and signed by the physician on the date of surgery; or delivered to the Center by the physician the day of surgery.

D. All orders will be signed by the registered nurse who receives and administers the orders.

E. Members of the Professional Staff may give verbal orders within the limitations of their privileges at the Center and their licensure.

F. Licensed individuals may accept verbal orders within the limitations of their qualifications and licensure (i.e.: RN's may receive orders for medication or treatment; Laboratory Technologists may receive orders for lab tests; etc.)

G. Verbal orders may be given in person or over the telephone.

H. The receiver will always repeat the order back to the giver to verify that it is understood and correct.

I. The receiver will record the order in the medical record and sign or initial the entry.

J. The giver will counter-sign the order.

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STANDING ORDERS

POLICY:

The Center permits physicians and surgeons to utilize standing orders for the pre-operative and post-operative care and treatment of patients consistent with established protocol and quality of care standard. Standing orders, when properly utilized, serve as a convenient means for the physician/surgeon to completely and accurately communicate and document his orders for patient care and treatment to nursing personnel.

RESPONSIBILITY:

The physician/surgeon is responsible for initiating and documenting standing orders and their utilization in the care and treatment of patients.

PROCEDURES:

A. The center permits physicians/surgeons to use two (2) types of standing orders: Pre-operative and post-operative, including discharge instructions.

B. All Standing Orders shall contain the fallowing information:

1. Type (Pre-operative or Post-operative)
2. Application (Type<s> of Procedure<s>, Patient Profile)
3. Specific, detailed instructions that do not require interpretation
4. Patient's Name
5. Date

C. Pre-operative standing orders can be maintained on file in the Center and initiated verbally by the physician in which case they must be signed by the physician the day of surgery; or, they must be issued and signed by the physician in his office and sent/brought to the Center.

D. Post-operative orders can be maintained on file in the Center and initiated and signed by the physician on the day of surgery; or, delivered to the Center by the physician the day of surgery.

E. All Standing Orders shall be signed by the registered nurse who receives and administers the order.

F. All Standing Orders issued shall be filed in the patient's medical record.

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PATIENT LABEL

D&C / Abortion Standing & Discharge Orders

I.V. START (Pre-Op) ☐ **(Intra-Op)** ☐

TIME	BAG#	TYPE	ADDITIVES	BAG SIZE	SITE	RATE	INITIALS

PRE-OP MEDICATION GIVEN

_____ Cefazolin 500mg I.V. _____ I.M. _____
_____ Clindamycin 300mg 600mg I.V. _____ I.M. _____
_____ Gentamycin 40mg 80mg I.M. _____
_____ Atropine 0.4mg IVP STAT for symptomatic heart rate <50 per minute
_____ Ondansetron 4mg I.V. for nausea
_____ Dexamethasone (Decadron) 4mg I.V. for nausea
_____ Metoclopramide (Reglan) 5mg I.V. for nausea
_____ _____
_____ _____

OR MEDICATIONS

_____ O2 at 1-3 L/M per mask or nasal cannula
_____ Lidocaine _____% ___ with Epinephrine ___ml ___ block
_____ Methylergonovine (Methergine) 0.2mg I.V. _____ I.M. _____
_____ Pitocin I.V. _____ I.M. _____
_____ RH Negative patient Mini-gam (<12 wks) _____ Full dose _____(>12 wks)
_____ D5 w NS 1000ml, 2nd bag to follow
_____ _____
_____ _____

ALERT STICKERS HERE ↓STARTING AT BOTTOM↓ OF THIS↓ BOX

POST-OP

	RX	Dispensed
_____ Ibuprofen 400mg 1 to 2 tabs PO x 1 PRN _____ #6 #6x 2pks (RX only) #20	_____	_____
_____ Tylenol 3 1 PO q 4 to 6hrs PRN _____ #3 #5 #10 #20	_____	
_____ Norco 5/325 1 to 2tabs PO q 6hrs PRN for pain (NO breastfeeding) _____ #10 #15 #20	_____	
_____ Ondansetron (Zofran) 4mg 1 PO q 6 to 8hrs PRN nausea _____ #15 #20	_____	_____
_____ **OR** Compazine 10mg 1 PO q 6 to 8hrs PRN for nausea _____ #10	_____	
_____ **OR** Phenergan 12.5mg 1 PO 6 to 8hrs PRN for nausea _____ #15	_____	
_____ Misoprostol (Cytotec) 200mcg _____ #1 #2 #3 _____ Buccal method		_____
_____ 1 PO in recovery Room _____ 1 PO tonight _____ 1 PO in A.M.		
_____ Take if heavy bleeding _____ Save last pill for F/U exam		
_____ Z-Pack (Azithromycin) Take as directed _____ 1 pack	_____	_____
_____ Metronidazole 500mg 1 BID, after ending other medications **NO ALCOHOL** _____ #14	_____	
_____ Fluconazole (Diflucan) 150mg **(To be taken 24hrs after completion of Ondansetron)** ___#2	_____	
_____ Ovaltine – Nutritional Supplement OTC 1 to 4 Tbsp. 2X daily		
_____ Ciprofloxacin (Cipro) 500mg 1 PO BID _____ #10 #14	_____	_____
_____ Serum Quantitative Beta HCG 1 week and repeat in 2 weeks	_____	
_____ Scant tissue follow up (written instructions given to Patient)		_____
_____ Rest at home for 3 5 7 days		
_____ Notify Physician of any unusual bleeding or change in vital signs		
_____ Liquids and solids, post-nausea, as tolerated		
_____ Ambulate Patient x2 before discontinuing I.V.		
_____ Discontinue I.V. after Patient has been ambulated and is stable		
_____ May be discharged from RR upon meeting approved discharge criteria		
_____ _____		
_____ _____		

May substitute generics for all above meds, unless specified otherwise

Orders noted by: _____ RN Doctor's Signature: _____

Date: Time: Doctor's Name:

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PATIENT INFORMATION

affix label

Patient "TIME OUT" called by:

Time:

Anesth/OR Time IN:

Anesth/OR Time OUT:

Diagnosis

Operation

Surgeon/Anesthesia Provider:

Current Drugs / Medications (incl. aspirin) taken within the last 10 days:

Gestation

OR Staff:

RN

Scrub

Assist

Assist

Patient Position:

- ☐ Lithotomy
  - ☐ Stirrups
  - ☐ Legs
- ☐ Supine
- ☐ Prone
- ☐ Lateral

☐ Twilight/MAC ☐ General ☐ Local

I.V. Meds Start

I.V. Meds Stop

ALLERGY / ALERT STICKER

ALLERGY / ALERT STICKER

Pre-Anesthetic Evaluation: No Change ☐

I.V. Start Pre-Op ☐ OR ☐

Site: Gauge:

Solution: Start By:

								total
O_2 L/M								
DRUGS								
FENTANYL								
VERSED								
PROPOFOL								
Reversal Drugs								
EKG								
$ETCO_2$								
SaO_2								
Ventilation								
SV CV AV								
(Ventilation – Spontaneous, Controlled, Assisted)								
Temp								
Esoph / Skin								

Remarks:

① Patient I.D. Reviewed ☐

② Chart Received ☐

③ Machine Check ☐

④ I.V Established ☐

⑤ Monitors Applied ☐

Comments:

☐ To RR VSS

TIME

MONITORS

EKG

B/P

SAO_2

TEMP

220 200 180 160 140 120 100 80 60 40 20

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ANESTHESIA PROVIDER'S SIGNATURE:

UTILIZATION REVIEW/PEER REVIEW PROGRAM

I. POLICY:

It is the policy of the Center Board of Directors that a Utilization Review Program be functional.

To ensure appropriate and effective utilization of available services, supplies, and equipment in the Center. The plan will establish the methodology used to review and justify the patient's need for surgery and related services and the appropriateness and efficiency of care provided.

II. PURPOSE:

The Utilization Review Program, designed as an organized effort to insure appropriate and effective utilization of the Center, its services, supplies, equipment, and personnel. The Program will also ensure that the procedures performed are: rendered only when medically necessary and in the appropriate setting; correctly coded to ensure proper reimbursement as well as an accurate data base; and representative of professionally recognized standards of care.

III. MEMBERSHIP AND MEETINGS

Membership of the Committee shall consist of at least 2 physicians, the Executive Director, and the Director of Nursing.

The Utilization Review Committee shall meet quarterly. They shall provide a report and copy of their minutes to the Consulting Committee.

IV. FUNCTIONS AND INTERRELATIONSHIPS OF THE COMMITTEE

The administrative staff members involved in the Utilization Review Committee, only review and act on the recommendations made by professional members and coordinate necessary arrangements. The practitioner's report to the administrative staff of the facility all decisions and recommendations. No physician shall have review responsibility for any case in which he was, or is, the attending physician/surgeon.

V. METHODS OF REVIEW

Consistent with the objectives of evaluation the necessity of surgery and the quality of care, the Utilization Review Committee shall utilize a standard methodology in performing its function. This methodology is as follows:

1. Prior to the meeting, thirty medical (30) records are selected on a pro-rata basis by specialty, by physician, for review from the cases performed since the last Utilization Review meeting. In addition, the charts related to Tissue Review that are inconsistent are added to those being reviewed.

2. The committee reviews the elected records' utilizing the worksheet attached and identifies and discusses any inconsistencies noted. The review process includes all information of the medical necessity and appropriateness of care provided including: anesthesia services, nursing services, pathology, complications and completeness of the record. The need of surgery is evaluated based on the criteria for the surgery as described and diagnoses contained in the record.

3. If the committee determines that there is a doubt or lack of substantiation that the patient required the surgery/treatment or that some aspect of care provided was inappropriate, written notice of the committee's questions/determinations is sent to the attending practitioner. The attending practitioner is required to respond within fourteen (14) days. Failure to respond shall be construed as acceptance of the committee's positions and noted in the record of the committee proceedings. The response from the attending practitioner is reviewed by the committee. Such review shall be documented in the minutes of the committee meeting. In the event the committee determines that surgery was unnecessary or some aspect of care was inappropriate, the matter shall be referred for review by the Consulting Committee. In all instances, copies of correspondence are filed in the attending practitioner's Professional Staff file and are subject to the review of privileges by the Credential Committee through its annual review process or on an exception basis if warranted.

4. The Professional Staff of the Center shall develop objective specific criteria or indications for surgery for evaluating the necessity of surgery and appropriateness of care for all applicable approved procedures; e.g. non-cosmetic surgery. The criteria shall be reviewed by the Quality Assurance Committee and approved, modified, or rejected. The criteria shall be submitted to the Utilization Review Committee and if deemed appropriate, serve as the basis for evaluating the medical necessity of surgery.

VI. REPORTS AND RECORDS

The Utilization Review committee is a committee of the Professional Staff with all proceedings, minutes and information gathered considered privilege and confidential.

Minutes of each committee meeting shall include the date of the meeting, the names of the committee members present and absent, confidential identification of each case reviewed, and a summary of cases reviewed. This summary includes the number of cases reviewed, case identification number, and the action taken for each case. Committee action on a case is recorded by case number only. The identities of patients whose records are reviewed are kept confidential.

Reports will be made to the Consulting Committee and the Governing body.

The Committee has the support and assistance of the Center's administrative staff in assembling information, facilitating chart review, conducting studies, exploring ways to improve procedures, maintaining committee records and promoting the most efficient use of available health services and facilities.

MEDICAL RECORD REVIEW

Patient I.D.: _____ Date: _____

Is the following present?		Yes	No	N/A
1. Patient Name on Each Form?		☐	☐	☐
2. Pre-Operative Diagnosis: _____		☐	☐	☐
3. History/Physical Appropriate for Procedure?		☐	☐	☐
4. Lab, X-ray, Ultrasound, EKG, - Complete and Appropriate?		☐	☐	☐
5. Procedure:	Complete Findings?	☐	☐	☐
	Technique Documented?	☐	☐	☐
6. Operative Report?		☐	☐	☐
7. Record Legible?		☐	☐	☐
8. Anesthesia:	Complete?	☐	☐	☐
	Signed by M.D.?	☐	☐	☐
	Type & Method of Anesthesia?	☐	☐	☐
	Vital Signs Regularly Monitored?	☐	☐	☐
9. Post Anesthesia:	Time Based Monitoring of Vitals?	☐	☐	☐
	Level of Awareness?	☐	☐	☐
	Surgical Dressing?	☐	☐	☐
	Discharge Date & Time?	☐	☐	☐
	Signature of M.D.?	☐	☐	☐
NEW 10. Additional Physician's orders documented?		☐	☐	☐
11. Standing Orders documented?		☐	☐	☐
12. Post-Operative Diagnosis: _____		☐	☐	☐
13. Patient Informed Regarding Driving Motor Vehicle?		☐	☐	☐
14. Patient Received Written Discharge Instructions?		☐	☐	☐
15. Patient Discharged by Physician (signed order)?		☐	☐	☐
16. Post - Counseling Progress Note completed?		☐	☐	☐
17. Pathology Report Present?		☐	☐	☐
Type of Tissue: _____		☐	☐	☐
	Reviewed by Physician?	☐	☐	☐
	Pathology Report Justify Surgery?	☐	☐	☐
	Pathology or Cytology Abnormal?	☐	☐	☐
	If yes, Patient Notified?	☐	☐	☐
18. Each Entry in Record Signed, Dated, & Timed?		☐	☐	☐
If no, Departments Incomplete: _____				

Utilization/Peer Review _____
M.D. Signature

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

April 15, 2016

Aimee Dillard, Administrator
Aanchor Health Center, Ltd.
1186 Roosevelt Road
Glen Ellyn, IL 60137-

Re: Aanchor Health Center, Ltd.
Glen Ellyn
Licensure survey

Dear Aimee Dillard:

On April 13, 2016, a life safety code licensure monitoring survey was conducted at the above Ambulatory Surgical Treatment Center to verify completion of your Plan of Correction. All previously cited deficiencies have been corrected; therefore, the facility is no longer under monitoring.

If you have any questions, please do not hesitate to call us at 217/785-4247. The Department's TTY # is 800/547-0466, for use by the hearing impaired.

Sincerely,

[redacted]

Mujeeb Ahmed, Project Designer
Design and Construction Section
Division of Life Safety and Construction

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

March 2, 2016

Ms. Aimee Dillard, Administrator
Aanchor Health Center, Ltd.
1186 Roosevelt Road
Glen Ellyn, IL 60137-

Dear Ms. Dillard:

RE: Aanchor Health Center, Ltd.
Glen Ellyn
Licensure Survey

On February 3, 2016, a life safety code inspection was conducted for the purpose of determining compliance with the requirements of the "Ambulatory Surgical Treatment Center Licensing Requirements" (77 Ill. Adm. Code 205) and the 2000 Edition of NFPA 101, Life Safety Code.

Based on the Facility's Plan of Correction (PoC) dated 02/19/16, we have no further comments. The Facility will receive an unannounced Life Safety Code Monitoring Survey in order to confirm that previously cited deficiencies have been corrected in accordance with your PoC.

If you have any questions about this approval, please contact us at 217-785-4247. The Department's TTY number is 800/547-0466, for use by the hearing impaired.

Sincerely,

[redacted]

Jody Gudgel, Administrative Assistant
Design and Construction Section
Division of Life Safety and Construction

Cc: Karen Senger, Supervisor
Central Office Operations Section, IDPH

Americans United for Life

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7002447	A. BUILDING: 01 - MAIN BUILDING B. WING _____	02/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AANCHOR HEALTH	1186 ROOSEVLET ROAD GLEN ELLYN, IL 60137

(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
L 000	Initial Comments On 02/03/2016 the life safety code portion of a Pregnancy Termination Center Licensure Survey was conducted. The surveyor was accompanied during the survey walk through by the following provider representatives: Administrator Assistant Administrator Facility Manager The facility is the single tenant in a nonsprinklered 1 story building that was observed to be of Type II unprotected construction. The building is approximately 3,780 sq ft in area. The facility was indicated to have occupied the building since 1992. The facility was surveyed as an Existing Ambulatory Health Care Occupancy under the 2000 Edition of the NFPA 101 Life Safety Code, including Chapter 21, and under Part 205, Ambulatory Surgical Treatment Center Licensing Requirements, as amended by Subpart G, Section 205.710. Unless otherwise noted, those code sections listed herein that do not include a reference to a specific NFPA code and year of issue (such as NFPA 70 1999) are taken from the 2000 Edition of the NFPA 101 Life Safety Code. Unless otherwise noted, all deficiencies cited herein were found through direct observation, staff interview, or document review. The life safety code requirements of licensure are NOT MET as evidenced by the deficiencies cited under the following L-tags:	L 000		

FEB 2 4 2016
LIFE SAFETY & CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7002447	A. BUILDING: 01 - MAIN BUILDING B. WING _____	02/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AANCHOR HEALTH	1186 ROOSEVLET ROAD GLEN ELLYN, IL 60137

(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
L 039	Continued From page 1	L 039		
L 039	Corridors 20.2.3.2, 21.2.3.2 Corridors for exit access are at least 44 inches wide. 20.2.3.2, 21.2.3.2 This Regulation is not met as evidenced by: During the survey walk through it was observed that exit access corridors are not kept free of obstructions and so are not maintained clear for immediate use. This deficiency could affect patients and staff in the event that a building evacuation became necessary. Findings include: On 02/03/2016, accompanied by the Assistant Administrator and Facility Manager, the following exit access corridors were observed to be partially blocked, which is prohibited by 7.1.10.1: A. At 1:12 PM, the corridor leading to the east side exit door was partially blocked by a gurney and a stool. B. At 1:15 PM, the corridor leading to the north east rear exit door was partially blocked by several bags of trash.	L 039	A memo to the staff has been issued and they have been instructed not to leave anything in the exit corridor. 2 signs have been posted in the area to remind staff to keep the exits clear. The manager will be responsible for monitoring these areas.	2/19/2016
L 050	21.7.1.2 FIRE DRILLS Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift, using the fire alarm system, except at night. The staff is familiar with procedures and is aware that drills are part of established routine. 21.7.1.2 This Regulation is not met as evidenced by:	L 050		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7002447	A. BUILDING 01 - MAIN BUILDING B. WING _____	02/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AANCHOR HEALTH	1186 ROOSEVLET ROAD GLEN ELLYN, IL 60137

(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
L 050	Continued From page 2 During the document review it was observed that fire drills are not held at varying times and do not include the transmission of a signal. This deficiency could affect patients and visitors if staff is not fully prepared to respond to an emergency. Findings include: On 02/03/2016 at 2:03 PM, accompanied by the Administrator and Assistant Administrator, during document review and staff interview it was learned that while the facility had a fire drill every quarter, the times did not vary from midday and the intercom was used to announce the fire drills rather than sending a signal with the fire alarm as required by 21.7.1.2. Observed times were as follows: A. 03/18/15, Friday, at 2:35 PM B. 06/17/15, Friday, at 1:19 PM C. 09/09/15, Tuesday, at 11:09 AM D. 12/16/15, Tuesday, at 12:30 PM	L 050	The manager has been educated on how to properly perform a Fire Drill with alarm activation. She has also been instructed to perform these drills at different times of the day. A Fire Drill with alarm activation via pull station took place on February 9, 2016. The alarm monitoring company was called to verify the signal. The administration will be responsible, to ensure that alarm activated drills are performed quarterly at different times.	2/19/2016
L136A	205.1306 a) Examination Room (s) SECTION 205.1360 CLINICAL FACILITIES a) Examination rooms 1) Each examination room shall have a minimum clear floor area of 80 square feet, and a minimum dimension of 8 feet, exclusive of vestibule, toilet, closet, and work counter (whether fixed or movable). A minimum clear dimension of 2'6" on each side and at both ends of the examination table shall be provided.	L136A		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7002447	A. BUILDING 01 - MAIN BUILDING B. WING _____	02/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AANCHOR HEALTH	1186 ROOSEVLET ROAD GLEN ELLYN, IL 60137

(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
L136A	Continued From page 3 2) A lavatory or sink equipped for handwashing with electronic or knee or foot control shall be provided. 3) A counter or shelf space for writing shall be provided. (Source: Amended at 24 Ill. Reg. 2691, effective February 18, 2000) This Regulation is not met as evidenced by: During the survey walk through it was observed that the facility is not equipped with hand washing features as required. This deficiency could affect patients if the care givers ' hands are not thoroughly clean. Findings include: On 02/03/2016 at 1:20 PM, accompanied by the Assistant Administrator and Facility Manager, the exam room was observed to not be provided with a hand washing sink that is equipped for hands free operation as required by 205.1360a)2).	L136A	We have ordered an electronic hands-free faucet. It will be installed within the next two weeks.	3/4/2016

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

☐ ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

NAME AND ADDRESS OF FACILITY: Access Health Center, 1700 75th Street, Downers Grove, IL 60516

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.710 (cont'd)	Findings include: 1. The facility's licensure renewal application submitted to the Department dated 11/1/14 was reviewed on 4/16/15 and included the following list of approved procedures: Dilation and Curretage, Diagnostic and/or therapeutic, Dilation and Curretage, Dilation and Evacuation, Dilation and Extraction, and Endocervical Curretage. 2. The facility's list of "Procedures Currently Being Performed" (approved 3/28/14) was reviewed on 4/16/15 and included, "…Vasectomy"	① this information is correct. ② The PTSC performs pregnancy terminations. The center also provides exam and vasectomy procedures during non-PTSC times. The staff have been informed → 5/18/15 to keep exam and vasectomy information separate from the PTSC documents.	

DATE OF SURVEY 4/16/15 BY 30195 (Surveyor) (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

Americans United for Life

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

☐ ASTC X PREGNANCY TERMINATION CENTER ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

NAME AND ADDRESS OF FACILITY: Access Health Center
1700 75th Street, Downers Grove, IL 60516

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
000 Section 205.710	An investigation survey was conducted on 4/16/15 for complaint #152203. The facility was not in compliance with Rules and Regulations for Pregnancy Termination Centers for this survey as evidenced by: **Pregnancy Termination Specialty Centers** a) A facility will be considered a pregnancy termination specialty center if it meets each of the following conditions: 1) Procedures performed at the facility are limited to procedures to terminate pregnancy…and other gynecologic procedures related to the termination of pregnancy… This requirement was not met as evidenced by: Based on document review and interview, it was determined for 1 of 2 (SP #1) surgical procedures performed at the facility, the facility failed to ensure all procedures performed were related to pregnancy termination.		

DATE OF SURVEY 4/16/15 BY 30195 (Surveyor) (Provider's Representative)

NOTE: IF REV, INDICATE DATE OF PRIOR SURVEY

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

☐ ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

NAME AND ADDRESS OF FACILITY: Access Health Center, 1700 75th Street, Downers Grove, IL 60516

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.710 (cont'd)	3. The facility's quarterly clinical statistical data was reviewed from 4/1/14-3/31/15 and included 24 vasectomies were performed at the facility. 4. During an interview with the Chief of Operations (E #2) on 4/16/15 at approximately 2:00 pm, E #2 stated that due to the low percentage of vasectomy cases performed at the facility, it was allowed. The Chief of Operations stated that I did not provide requested clarification of the breakdown of % of the services provided and we submitted that < 1% were vasectomies. We believed that we can perform vasectomies in physician office as long as they were not more than "50% of the activities at that location." (42 CFR 416)	(3.) The vasectomies are considered physician office procedures and should not have been listed on the quarterly clinical statistical data form of the PTSC. Staff will be informed to keep exam and vasectomy data separate from PTSC data. → 5/18/15 (4) This statement has been misunderstood.	

DATE OF SURVEY 4/16/15 BY 30195 (Surveyor)

(Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

Americans United for Life

Access Health Center, Ltd.
Administrative Office
1640 N. Arlington Heights Rd. #110
Arlington Heights, IL 60004
Tel: 847-255-7400
Fax: 847-398-4585

May 19, 2015

Karen Senger, R.N., Supervisor
Division of Health Care Facilities and Programs
Illinois Department of Public Health
525 West Jefferson St. 4TH Floor
Springfield, IL 62761-0001

Sent Via First Class Mail

Re: Access Health Center, Ltd.
1700 75th St. Downers Grove, IL 60516

Dear Karen,

On May 18, 2015 we received your response letter dated May 15, 2015.

We have immediately discontinued vasectomy services at Access Health Center, Ltd. We will remove it from the services we offer.

Sincerely,

[redacted]

Vera Schmidt
Chief of Operations
Access Health Center, Ltd.

Americans United for Life

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street · Springfield, Illinois 62761-0001 · www.dph.illinois.gov

May 15, 2015

Vera Schmidt, Administrator
Access Health Center Ltd.
1700 75th Street
Downers Grove, IL 60516

Re: Complaint and licensure renewal survey

Dear Ms. Schmidt:

The Department received your plan of correction and letter dated May 11, 2015. In response to your question, as we stated in the May 7, 2015, it is a violation of a licensed pregnancy termination center facility to perform other surgical procedures (vasectomies) at the facility that is only licensed to perform abortions.

The Ambulatory Surgical Treatment Center Licensing Requirements Code states that procedures performed at a PTSC are "limited to procedures to terminate pregnancy performed within 18 weeks assessed gestational age… and other gynecologic procedures related to the termination of pregnancy." Ill. Admin. Code title 77, § 205.710(a) (1) (2008).

Please respond in writing to this office no later than 10 days after receipt of this letter with the agency's revised Plan of Correction (POC). The Department's acceptance of a POC does not constitute a waiver of any enforcement actions its entitled to take including, but not limited to, adverse licensure action and fine assessment.

If you have any questions regarding this request, please address your concerns to the Illinois Dept. of Public Health, Division of Health Care Facilities and Programs, 525 West Jefferson Street, 4th Floor, Springfield, Illinois 62761-0001, or feel free to call myself at 217/782-0381. The Department's TTY number is 800/547-0466, for use by the hearing impaired.

Sincerely,

[redacted]

Karen Senger, RN
Supervisor, Central Office Operations Section
Division of Health Care Facilities and Programs
Illinois Department of Public Health

Access Health Center, Ltd.
Administrative Office
1640 N. Arlington Heights Rd. #110
Arlington Heights, IL 60004
Tel: 847-255-7400
Fax: 847-398-4585

May 11, 2015

Karen Senger, R.N., Supervisor
Division of Health Care Facilities and Programs
Illinois Department of Public Health
525 West Jefferson St. 4TH Floor
Springfield, IL 62761-0001

Sent Via Overnight Delivery

Re: Letter dated 5-7-2015
Access Health Center, Ltd. 1700 75th St. Downers Grove, IL 60516

Dear Karen,

On May 11, 2015 we received your letter dated May 7, 2015.

As we have previously discussed our center performs reproductive health services such as, legal abortions, exams and < 1% vasectomies. Since vasectomies can be performed in non-ASTC clinics and physicians' offices we felt that this was not an issue and your department was aware of this service.

Please advise us on how to proceed. If physicians' office vasectomies are not allowed in the PTSC we will discontinue this service immediately.

We await your response.

Thank You,

[redacted]

Vera Schmidt
Chief of Operations
Access Health Center, Ltd.

Americans United for Life

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

May 7, 2015

Vera Schmidt, Administrator
Access Health Center Ltd.
1700 75th Street
Downers Grove, IL 60516

Re: Complaint and licensure renewal survey

Dear Ms. Schmidt:

The Department conducted a complaint investigation and licensure renewal survey on April 16, 2015. The allegation related to the list of services being offered on the building advertisement. The signage on the door implies that this is a physician office practice that provides Gynecology, Internal Medicine, Urology, Family Practice, Gastroenterology, and Outpatient Surgical Center. During the survey interviews your staff stated the facility performs 1st and 2nd trimester abortions, medical abortions and vasectomies and offers the following services: gynecological exams, sexually transmitted disease testing, pregnancy testing, gestational ultrasound, wellness physicals, vitamin B-12 injections, and Depo-Provera injections.

The Department had similar concerns back in 2011 and needed to determine if your office required an Ambulatory Surgical Treatment Center (ASTC) license. The information, your facility provided indicated you were a physician's office that also provides abortions. Your October 19, 2011, stated the clinic performs 53% abortions, 46% exams and 1% vasectomies.

Based on the observations made during the April 16, 2015 survey, this location was only operating as a Pregnancy Termination Specialty Center (PTSC) and not a physician office. Access Health Center, LTD. obtained a PTSC license on January of 1992. The Ambulatory Surgical Treatment Center Licensing Requirements Code states that procedures performed at a PTSC are "limited to procedures to terminate pregnancy performed within 18 weeks assessed gestational age… and other gynecologic procedures related to the termination of pregnancy." Ill. Admin. Code title 77, § 205.710(a) (1) (2008).

In reviewing the survey findings attached, the Department has determined that your facility is in violation of its license by performing other surgical procedures (vasectomies) at the facility that is only licensed to perform abortions.

Please respond in writing to this office no later than 10 days after receipt of this letter with the agency's Plan of Correction (POC). The Department's acceptance of a POC does not constitute a waiver of any enforcement actions its entitled to take including, but not limited to, adverse licensure action and fine assessment.

If you have any questions regarding this request, please address your concerns to the Illinois Dept. of Public Health, Division of Health Care Facilities and Programs, 525 West Jefferson Street, 4th Floor,

Springfield, Illinois 62761-0001, or feel free to call myself at 217/782-0381. The Department's TTY number is 800/547-0466, for use by the hearing impaired.

Sincerely,

Karen Senger, RN
Supervisor, Central Office Operations Section
Division of Health Care Facilities and Programs
Illinois Department of Public Health

Americans United for Life

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 7001613 Y1	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING B. Wing Y2	DATE OF REVISIT 4/5/2018 Y3
NAME OF FACILITY ACCESS HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1700 - 75TH STREET DOWNERS GROVE, IL 60516	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix L0115 Reg. # 20.3.7.2/21.3.7.2 LSC	Correction Completed 04/05/2018	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 1/28/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7001613	A. BUILDING: 01 - MAIN BUILDING B. WING _____	R 04/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESS HEALTH	1700 - 75TH STREET DOWNERS GROVE, IL 60516

(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
{L 000}	Initial Comments On January 28, 2016, the physical plant portion of a Licensure Survey was conducted at the above facility. The surveyors were accompanied during the survey walk-through by the following provider representatives: The Chief of Operations (COO) The Assistant Administrator (AA) The facility was observed to be the sole tenant in a one story building of (apparent) Type V (000) construction. The building was observed to be neither fully covered by an automatic sprinkler system nor fully covered by an automatic smoke detection system. The facility was surveyed as an existing ambulatory health care occupancy under the 2000 Edition of the NFPA 101 Life Safety Code, including Chapter 21, and as an existing Ambulatory Surgical Treatment Center under 77 Illinois Administrative Code 205, as amended by Section 205.710. Unless otherwise noted, those code sections listed herein that do not include a reference to a specific NFPA code and year of issue (such as NFPA 70 1999) are taken from the 2000 Edition of the NFPA 101 Life Safety Code. Unless otherwise noted, all deficiencies cited herein were found through observation during the survey walk-through, staff interview, or document review. The requirements of 77 Illinois Administrative Code 205 are NOT MET as evidenced by the deficiencies cited under the following L-Tags.	{L 000}		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7001613	A. BUILDING: 01 - MAIN BUILDING B. WING _____	R 04/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESS HEALTH	1700 - 75TH STREET DOWNERS GROVE, IL 60516

(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
{L 000}	Continued From page 1 On February 22, 2018, follow-up on-site was conducted. The requirements of 77 Illinois Administrative Code 205 are NOT MET as evidenced by the deficiencies cited under the following L-Tags. On March 5, 2018, certification package was reviewed and found acceptable in response to our on-site survey conducted on February 22, 2018. The requirements of 77 Illinois Administrative Code 205 are NOW MET.	{L 000}		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
7001613 Y1	A. Building 01 - MAIN BUILDING B. Wing Y2	2/22/2018 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESS HEALTH	1700 - 75TH STREET DOWNERS GROVE, IL 60516

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix L0029	Correction	ID Prefix L0032	Correction	ID Prefix L0050	Correction
Reg. # 38.2.1/39.3.2	Completed	Reg. # 20.2.4/21.2.4	Completed	Reg. # 21.7.1.2	Completed
LSC	02/22/2018	LSC	02/22/2018	LSC	02/22/2018
ID Prefix L0051	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 20.3.4/21.3.2	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/22/2018	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
1/28/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7001613	A. BUILDING 01 - MAIN BUILDING B. WING _____	R 02/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESS HEALTH	1700 - 75TH STREET DOWNERS GROVE, IL 60516

(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
{L 000}	Initial Comments On January 28, 2016, the physical plant portion of a Licensure Survey was conducted at the above facility. The surveyors were accompanied during the survey walk-through by the following provider representatives: The Chief of Operations (COO) The Assistant Administrator (AA) The facility was observed to be the sole tenant in a one story building of (apparent) Type V (000) construction. The building was observed to be neither fully covered by an automatic sprinkler system nor fully covered by an automatic smoke detection system. The facility was surveyed as an existing ambulatory health care occupancy under the 2000 Edition of the NFPA 101 Life Safety Code, including Chapter 21, and as an existing Ambulatory Surgical Treatment Center under 77 Illinois Administrative Code 205, as amended by Section 205.710. Unless otherwise noted, those code sections listed herein that do not include a reference to a specific NFPA code and year of issue (such as NFPA 70 1999) are taken from the 2000 Edition of the NFPA 101 Life Safety Code. Unless otherwise noted, all deficiencies cited herein were found through observation during the survey walk-through, staff interview, or document review. The requirements of 77 Illinois Administrative Code 205 are NOT MET as evidenced by the deficiencies cited under the following L-Tags.	{L 000}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7001613	A. BUILDING 01 - MAIN BUILDING B. WING _____	R 02/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESS HEALTH	1700 - 75TH STREET DOWNERS GROVE, IL 60516

(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
{L 000}	Continued From page 1 On February 22, 2018, follow-up on-site was conducted. The requirements of 77 Illinois Administrative Code 205 are NOT MET as evidenced by the deficiencies cited under the following L-Tags.	{L 000}	ASCs that are < 5,000 sq. ft. do not require a subdivided smoke compartment if they are protected with an approved smoke detection system. Our facility is 3,178 sq. ft. and has an approved smoke detection system. Therefore, all smoke compartment deficiencies have been resolved (A, B, C, D). In February 2016 we installed an approved smoke detection system. Attached, please find correspondence from your department and the installer "Affiliated".	3/9/18
{L 115}	20.3.7.2/21.3.7.2 SMOKE COMPARTMENTATION Ambulatory health care facilities are divided into at least two smoke compartments with smoke barriers having at least a one-hour fire resistance rating. Doors in smoke barriers be at least 1 3/4 inch solid core and are equipped with closing devices (latch not required). Vision panels are provided and are of fixed wired glass limited to 1,296 sq in. per panel. (21.3.7.2) (see codes sections for exceptions for size, smoke detection and sprinkler protection) This Regulation is not met as evidenced by: Based on observation during the survey walk-through and document review, smoke barriers are not constructed and maintained as required. Findings include: A. On January 28, 2016 at 9:30 AM, while accompanied by the COO and the AA, the surveyors observed that the smoke barrier wall identified on facility life safety plans could not be determined as being complete to the underside of the roof deck above, as required by 21.3.7.2 and 8.3.2, because there is no access to the attic space through the layer of drywall attached to the underside of the roof trusses.	{L 115}		

RECEIVED-OFFICE
MAR 12 2018
LIFE SAFETY & CONSTRUCTION

Chief of Operations 3/9/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7001613	A. BUILDING 01 - MAIN BUILDING B. WING _____	R 02/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESS HEALTH	1700 - 75TH STREET DOWNERS GROVE, IL 60516

(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
(L 115)	Continued From page 2 B. On January 28, 2016 at 9:35 AM, while accompanied by the COO and the AA, the surveyors observed that at least two ducts which penetrate the smoke barrier wall identified on facility life safety plans lack smoke dampers required by 21.3.7.3 and 8.3.5.1. The two ducts observed were in the wall between the Staff Lounge and the Laboratory. C. On January 28, 2016 at 9:55 AM, while accompanied by the COO and the AA, the surveyors observed multiple pipe or other penetrations, through the smoke barrier wall identified on facility life safety plans, which are not sealed against the passage of smoke as required by 8.3.6.1. Locations observed include: 1. 9:55 AM, Cashier's Office, 1 penetration. 2. 10:05 AM, Copy Room, 3 penetrations. D. On January 28, 2016, while accompanied by the COO and the AA, the surveyors observed pass-through windows, in the smoke barrier wall identified on the facility life safety plans, which are not fixed fire window assemblies as required by 21.3.7.4 and 8.2.3.2.2. Locations observed include: 1. 9:55 AM, Cashier's Office. 2. 10:05 AM, PoC Room.	(L 115)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7001613	A. BUILDING: 01 - MAIN BUILDING B. WING _____	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESS HEALTH	1700 - 75TH STREET DOWNERS GROVE, IL 60516

(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
L 000	Initial Comments On January 28, 2016, the physical plant portion of a Licensure Survey was conducted at the above facility. The surveyors were accompanied during the survey walk-through by the following provider representatives: The Chief of Operations (COO) The Assistant Administrator (AA) The facility was observed to be the sole tenant in a one story building of (apparent) Type V (000) construction. The building was observed to be neither fully covered by an automatic sprinkler system nor fully covered by an automatic smoke detection system. The facility was surveyed as an existing ambulatory health care occupancy under the 2000 Edition of the NFPA 101 Life Safety Code, including Chapter 21, and as an existing Ambulatory Surgical Treatment Center under 77 Illinois Administrative Code 205, as amended by Section 205.710. Unless otherwise noted, those code sections listed herein that do not include a reference to a specific NFPA code and year of issue (such as NFPA 70 1999) are taken from the 2000 Edition of the NFPA 101 Life Safety Code. Unless otherwise noted, all deficiencies cited herein were found through observation during the survey walk-through, staff interview, or document review. The requirements of 77 Illinois Administrative Code 205 are NOT MET as evidenced by the deficiencies cited under the following L-Tags.	L 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7001613	A. BUILDING: 01 - MAIN BUILDING B. WING _____	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESS HEALTH	1700 - 75TH STREET DOWNERS GROVE, IL 60516

(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
L 029	Continued From page 1	L 029		
L 029	38.2.1/39.3.2 HAZARDOUS AREAS 39.3.2.1 Hazardous Areas: Hazardous areas that include, but are not limited to general storage, boiler or furnace rooms, and maintenance shops shall be protected in accordance with Section 8.4. High hazard areas shall comply with 39.3.2.2. This Regulation is not met as evidenced by: Based on observation during the survey walk-through, not all hazardous areas are protected as required. Findings include: On January 28, 2016 at 10:45 AM, while accompanied by the COO and the AA, the surveyors observed that the File Room is not separated from the remainder of the building by minimum 1 hour fire rated construction as required by 21.3.2, 39.3.2.1, and 8.4.1.1(1).	L 029		
L 032	20.2.4/21.2.4 TWO REMOTE EXITS At least two exits, located remote from each other are provided for each floor or fire section of the building. 20.2.4.1,20.2.4.2,20.2.4.3/21.2.4.1, 21.2.4.2 21.2.4.3 This Regulation is not met as evidenced by: Based on observation during the survey walk-through, not all exit paths are constructed or maintained to provide at least 2 remote exits from	L 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7001613	A. BUILDING: 01 - MAIN BUILDING B. WING _____	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESS HEALTH	1700 - 75TH STREET DOWNERS GROVE, IL 60516

(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
L 032	Continued From page 2 each floor or fire section. These deficiencies could affect any patients, staff, or visitors in the building because they could be prevented from exiting the building under emergency conditions. Findings include: On January 28, 2016, while accompanied by the COO and the AA, the surveyors observed exterior egress doors which are equipped with both a latchset and a separate thumbturn deadbolt, thus requiring two operations to exit the building as prohibited by 7.2.1.5.4. Locations observed include: A. 9:40 AM, exterior exit door from the Recovery Room. B. 10:50 AM, exterior exit door from Surgery Corridor.	L 032		
L 050	21.7.1.2 FIRE DRILLS Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift, using the fire alarm system, except at night. The staff is familiar with procedures and is aware that drills are part of established routine. 21.7.1.2 This Regulation is not met as evidenced by: Based on document review and staff interview, fire drills are not held at varying times and varying conditions in accordance with 21.7.1.2. Findings include: A. Based on document review conducted on	L 050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7001613	A. BUILDING: 01 - MAIN BUILDING B. WING _____	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESS HEALTH	1700 - 75TH STREET DOWNERS GROVE, IL 60516

(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
L 050	Continued From page 3 January 28, 2016 at 10:30 AM, fire drills are not conducted at varying times as required by 21.7.1.2. During the calendar years 2015 and 2016, fire drills did not list the times at which fire drills were conducted. B. During an interview held in the Staff lounge on January 28, 2016 at 10:30 AM, the COO confirmed that fire drills do not include the transmission of a fire alarm signal as required by 21.7.1.2.	L 050		
L 051	20.3.4/21.3.2 FIRE ALARM SYSTEM A manual fire alarm system, not a pre-signal type, is provided to automatically warn the building occupants. The fire alarm system is arranged to automatically transmit an alarm to summon the fire department. 20.3.4 and 21.3.4 This Regulation is not met as evidenced by: Based on observation during the survey walk-through, the facility failed to provide and maintain a compliant fire alarm system. These deficiencies could affect any patients, staff, or visitors in the building because the fire alarm system could fail to operate properly under emergency conditions. Findings include: On January 28, 2016, at 9:55 AM, while accompanied by the COO and the AA, the surveyors observed a smoke detector, in the Surgical Corridor, that is located within 3'-0" of supply air diffusers as prohibited by NFPA 72 1999 2-3.5.1.	L 051		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7001613	A. BUILDING: 01 - MAIN BUILDING B. WING _____	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESS HEALTH	1700 - 75TH STREET DOWNERS GROVE, IL 60516

(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
L 115	Continued From page 4	L 115		
L 115	20.3.7.2/21.3.7.2 SMOKE COMPARTMENTATION Ambulatory health care facilities are divided into at least two smoke compartments with smoke barriers having at least a one-hour fire resistance rating. Doors in smoke barriers be at least 1 3/4 inch solid core and are equipped with closing devices (latch not required). Vision panels are provided and are of fixed wired glass limited to 1,296 sq. in. per panel. (21.3.7.2) (see codes sections for exceptions for size, smoke detection and sprinkler protection) This Regulation is not met as evidenced by: Based on observation during the survey walk-through and document review, smoke barriers are not constructed and maintained as required. Findings include: A. On January 28, 2016 at 9:30 AM, while accompanied by the COO and the AA, the surveyors observed that the smoke barrier wall identified on facility life safety plans could not be determined as being complete to the underside of the roof deck above, as required by 21.3.7.2 and 8.3.2, because there is no access to the attic space through the layer of drywall attached to the underside of the roof trusses. B. On January 28, 2016 at 9:35 AM, while accompanied by the COO and the AA, the surveyors observed that at least two ducts which penetrate the smoke barrier wall identified on facility life safety plans lack smoke dampers required by 21.3.7.3 and 8.3.5.1. The two ducts	L 115		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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L 115	Continued From page 5 observed were in the wall between the Staff Lounge and the Laboratory. C. On January 28, 2016 at 9:55 AM, while accompanied by the COO and the AA, the surveyors observed multiple pipe or other penetrations, through the smoke barrier wall identified on facility life safety plans, which are not sealed against the passage of smoke as required by 8.3.6.1. Locations observed include: 1. 9:55 AM, Cashier's Office, 1 penetration. 2. 10:05 AM, Copy Room, 3 penetrations. D. On January 28, 2016, while accompanied by the COO and the AA, the surveyors observed pass-through windows, in the smoke barrier wall identified on the facility life safety plans, which are not fixed fire window assemblies as required by 21.3.7.4 and 8.2.3.2.2. Locations observed include: 1. 9:55 AM, Cashier's Office. 2. 10:05 AM, PoC Room.	L 115		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
7001613	30195	8/13/18

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Access Health	1700 75th St., Downers Grove, IL 60516

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
000	A post certification visit (PCV) was conducted on 8/13/18, to determine compliance with TITLE 77: PUBLIC HEALTH CHAPTER I: DEPARTMENT OF PUBLIC HEALTH SUBCHAPTER b: HOSPITAL AND AMBULATORY CARE FACILITIES PART 205 AMBULATORY SURGICAL TREATMENT CENTER LICENSING REQUIREMENTS SECTION 205.710 PREGNANCY TERMINATION SPECIALTY CENTERS, 205.410 b) 1-3., cited during the licensure survey on 05/25/2018. The Facility was back in compliance based on the following: 1. On 8/13/18 at approximately 9:00 AM, the sterilization logs for sterilizer #1 and sterilizer #2 were reviewed from 6/4/18 through 8/11/18. The logs indicated that a Biological Spore Test was completed weekly as required. The logs also indicated that a chemical indicator was present in every load as required. The instruments in each load were documented on the logs as they appeared on the instrument inventory list. 2. On 8/13/18 at approximately 9:15 AM, the In-Service Training Record for New Sterilization Procedures and New Patient Form (dated 5/25/18) was reviewed and included completion of the in-service by all staff that perform sterilization at the Facility. 3. The sterile processing and storage room was observed on 8/13/18 at 10:30 AM. Every pack was labeled with the load number, the sterilizer number, the date, and the operator's initials.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7001613	30195	8/13/18

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Access Health	1700 75th St., Downers Grove, IL 60516

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
000	4. On 8/13/18 at approximately 9:45 AM, the clinical records were reviewed for 10 patients who underwent surgery at the Facility between 6/1/18 and 8/11/18. The 10 records included every sterile instrument used on the patient, along with the date of sterilization, sterilizer number, and load number. 5. On 8/13/18 at approximately 10:15 AM, the sterilizer cycle tapes were reviewed for sterilizer #1 and sterilizer #2. The cycle tapes included the sterilizer operator's initials daily (indicating review of the tapes daily), and the Facility Manager's initials weekly (indicating review of the tapes weekly). 6. The Quality Assurance/Quality Improvement Quarterly Meeting Minutes, dated 7/26/18, were reviewed on 8/13/18 at approximately 10:30 AM and included the review of the quarterly Infection Control Surveillance Report (completed by the Chief of Operations/Infection Control Officer (E #1) on 7/6/18). 7. On 8/13/18 at approximately 10:35 AM, an interview was conducted with the Chief of Operations/Infection Control Officer (E #1). E #1 stated that all of the Facility's staff who perform sterilization were in-serviced on the new sterilization policies and procedures. E #1 stated that E #1 had conducted a review of the sterilization logs on 7/6/18, and the logs were completed as required.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
7001613	30195	8/13/18

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Access Health	1700 75th St., Downers Grove, IL 60516

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A001				

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE

#86

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH, STATE OF ILLINOIS, Complainant, v. ACCESS HEALTH CENTER, LTD. *License Number 7001613, expires 1/12/19,* Respondent.	)	Docket No. **ASTC 18-002**

CONSENT AGREEMENT
AND REQUEST FOR FINAL ORDER

NOW COME the Complainant and the Respondent and request the Director of the Illinois Department of Public Health to issue a Final Order in the above-captioned matter consistent with the following:

RECITALS

1. The Illinois Department of Public Health ("Department") is designated as the State Agency to administer the provisions of the Ambulatory Surgical Treatment Center Act ("Act") (210 Ill. Comp. Stat. 5/1 *et seq.*)

2. Access Health Center, LTD. ("Respondent") is located at 1700 W. 75th Street, Downers Grove, Illinois 60516.

3. The Department issued a Notice of Violations, Notice of Fine Assessment, Notice of Opportunity for Hearing and Notice of Plan of Correction Required ("Notice") for Respondent's failure to comply with Section 10(d) and 10(e) of the Act and Sections 205.410(b)(1), 205.410(b)(2), 205.410(b)(3), 205.410(d), 205.420(a), 205.540(a), 205.550(a), 205.550(h)(1), 205.550(h)(2), 205.550(h)(3), 205.550(h)(4) and 205.550(h)(5) of the Ambulatory Surgical Treatment Center Licensing Requirement Code (77 Ill. Adm. Code 245) as more fully set forth in Attachment "A," incorporated herein.

4. Respondent timely requested a hearing to contest the Notice.

5. The Department and Respondent have agreed, in order to resolve this matter, that Respondent be permitted to enter into this Consent Agreement and Request for Final Order ("Consent Agreement") with the Department, providing for the imposition of certain provisions that are consistent with the best interests of the People of the State of Illinois, subject to the entering of a Final Order dismissing this consolidated matter.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH, STATE OF ILLINOIS, Complainant, v. ACCESS HEALTH CENTER, LTD. *License Number 7001613, expires 1/12/19,* Respondent.	)	Docket No. **ASTC 18-002**

PROOF OF SERVICE

The undersigned certifies that she caused a true and correct copy of the attached Final Order to be served by certified mail in a sealed envelope, postage prepaid, to:

Vera Schmidt
c/o Access Health Center, Ltd.
1700 W. 75th Street
Downers Grove, IL 60516

That said document was deposited in the United States Post Office at Chicago, Illinois, on the 1st day of August, 2018.

[redacted]
Rebecca Gold
Assistant General Counsel
Illinois Department of Public Health

cc:
Karen Senger [IDPH]
Lisa Reynolds [Springfield Final Order File]

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH, STATE OF ILLINOIS, Complainant, v. ACCESS HEALTH CENTER, LTD. *License Number 7001613, expires 1/12/19,* Respondent.	)	Docket No. **ASTC 18-002**

FINAL ORDER

The foregoing Consent Agreement of the parties is adopted and approved, and IT IS HEREBY ORDERED that this matter is dismissed pursuant to the terms contained herein.

The Department's rules do not require any motion or request for reconsideration.

Attorney for Complainant
Rebecca Gold
122 S. Michigan, 7dt Floor
Chicago, IL 60603

Agent for Respondent
Vera Schmidt
Access Health Center, Ltd.
1700 W. 75th St.
Downers Grove, IL 60516

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

[redacted]

By: Nirav D. Shah, M.D., J.D.
Director

7/27/18
Date

Americans United for Life

6. This Consent Agreement is a compromise and settlement of violations alleged in Docket Number ASTC 18-002. This Consent Agreement shall not be used in determining liability in any action brought by a third party not a signatory to this Consent Agreement against Respondent. Nothing herein shall be considered an admission of fault of any kind by Respondent as to any action brought by a third party, nor shall anything herein be considered a reflection of any weakness of proof by the Department. The parties agree that this Consent Agreement is entered into solely for the purpose of settlement and, except for future actions between the Department and Respondent, does not constitute an admission of any liability or wrongdoing by the Respondent, its parent, subsidiaries or other related entities, or each of its directors, officers, employees, agents, successors, assigns and attorneys. Nothing in this paragraph shall prevent the Department from using violations imposed herein in any other matter before the Department.

NOW, THEREFORE, in consideration of the aforesaid Recitals and representations, the mutual covenants and provisions hereinafter set forth, and for other good and valuable consideration, the receipt and sufficiency of which are mutually acknowledged by the parties, the parties hereby agree as follows:

ARTICLE I
Respondent's Consideration

1.1 Respondent hereby withdraws its request for a hearing in this matter, thereby expressly waiving its right to contest the Notice, as described in paragraph 3 of the Recitals, as amended by this Consent Agreement.

1.2 The Respondent will submit payment for the $2,000 fine amount ("Fine Amount") within 60 days of receipt of the Final Order issued in relation to this Consent Agreement.

1.3 Check(s) for the Fine Amount will be submitted to the Department at the following address:

Illinois Department of Public Health
P.O. Box 4263
Springfield, Illinois 62708

1.4 If Respondent fails to comply with any of the terms of this Consent Agreement, or with any provisions of the Act or Code, as determined by the Department, the Notice will be automatically reinstated at the end of the 60 day period referenced in paragraph 1.2.

ARTICLE II
Department's Consideration

2.1 The Department agrees to automatically dismiss the Notice if Respondent complies with all of the terms of the Consent Agreement and all rules in furtherance of the Act, as determined by the Department, upon receipt of payment of the Fine Amount.

ARTICLE III
General Provisions

3.1 This Consent Agreement shall become binding on, and shall inure to the benefit of, the parties hereto, their successors, or assignees immediately upon the execution of this Consent Agreement by the Director of Public Health, or his designee, dismissing the above-captioned matter with prejudice.

3.2 The provisions of this Consent Agreement shall apply notwithstanding any transfer of Agency ownership or interest. Should Respondent fail to comply with any provisions of this Consent Agreement, the Department may reinstate this action against Respondent, and if Respondent no longer exists as a legal entity, said action shall proceed against any person having five percent (5%) or more interest in Respondent.

3.3 In the event that any of the provisions of Article I are not complied with within the times specified therein, this Agreement will be held for naught, except for the provisions referred to in Paragraph 1.1 wherein Respondent has withdrawn its request for hearing to contest this matter.

3.4 It is hereby agreed that this matter be dismissed with prejudice, all matters in controversy for which this matter was brought having been fully settled, compromised, and adjourned.

3.5 This Consent Agreement constitutes the entire agreement of the parties, and no other understandings, agreements, or representations, oral or otherwise, exist or have been made by or among the parties. The parties hereto acknowledge that they, and each of them, have read and understood this Consent Agreement in all respects.

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

[redacted] 7/16/18

By: Rebecca Gold
Assistant General Counsel
Illinois Department of Public Health

Date

ACCESS HEALTH CENTER, LTD.

[redacted] 7/12/18

By: Vera Schmidt
Agent on behalf of Respondent

Date

Attachment H
pg. 1

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH, STATE OF ILLINOIS, Complainant vs. ACCESS HEALTH CENTER, LTD., *License Number 7001613, expires 1/12/2019* Respondent	)	Docket No. ASTC 18-002

NOTICE OF VIOLATIONS; NOTICE OF FINE ASSESSMENT; NOTICE OF OPPORTUNITY FOR HEARING AND NOTICE OF PLAN OF CORRECTION REQUIRED

Pursuant to the authority granted by the Ambulatory Surgical Treatment Center Act (210 ILCS 5/1) ("Act"), and in accordance with Sections 205.820 and 205.850 of the Ambulatory Surgical Treatment Center Licensing Requirements Code (77 Ill. Adm. Code 205) ("Code"), the Illinois Department of Public Health ("Department") hereby notifies Respondent of the following:

NOTICE OF VIOLATIONS

Pursuant to Section 10b of the Act, and subsequent to an annual licensure survey and complaint investigation conducted by the Department on or about May 21-24, 2018, at Access Health Center, Ltd., 1700 75th St., Downers Grove, IL 60516, the Illinois Department of Public Health ("Department") hereby notifies Respondent that it has violated the following sections of the Code: 205.410(b)(1), 205.410(b)(2), 205.410(b)(3), 205.410(d), 205.420(a), 205.540(a), 205.550(a), 205.550(h)(1), 205.550(h)(2), 205.550(h)(3), 205.550(h)(4), and 205.550(h)(5).

The allegations relating to the Code violations are further described in the three Statements of Deficiencies attached hereto and incorporated herein as Exhibit A, Exhibit B, and Exhibit C.

NOTICE OF FINE ASSESSMENT

Pursuant to Sections 10d and 10e of the Act, and in accordance with Section 205.850 of the Code, the Department hereby imposes a fine assessment of **$2,000** in relation to the Code violations stated in the above Notice of Violations.

All penalties shall be paid to the Department within ten (10) days of receipt of the Notice of Fine Assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Illinois Department of Public Health
P.O. Box 4263
Springfield, Illinois 62708

NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Section 10g of the Act and Section 205.860 of the Code, the Respondent shall have a right to hearing to appeal the Notice of Violation and Notice of Fine Assessment herein.

In order to obtain a hearing, the licensee must file a written request for hearing no later than ten (10) days after the receipt of this Notice.

The request for hearing must be sent to:

Illinois Department of Public Health
Attn: Rebecca Gold
Assistant General Counsel
122 S. Michigan, 7th Floor
Chicago, Illinois 60603

FAILURE TO REQUEST A HEARING WITHIN TEN (10) DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING

NOTICE OF PLAN OF CORRECTION REQUIRED

Pursuant to Section 10c of the Act and Section 205.830 of the Code, Respondent shall submit to the Department a written plan of correction within ten (10) days of receipt of this Notice of Violation. Such plan of correction shall include the following:

1) A statement of the specific actions the facility intends to take, or has taken, to correct each violation stated in the above Notice of Violations; and

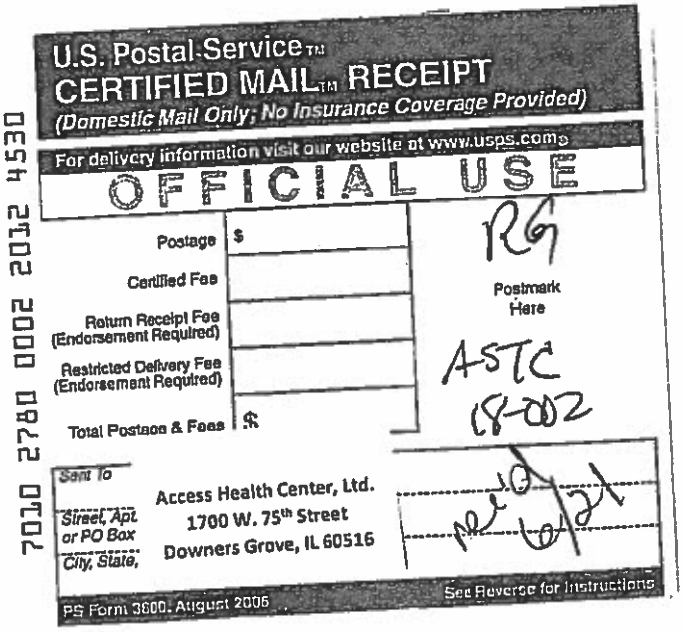
2) The specific date by which each violation will be corrected, or has been corrected.

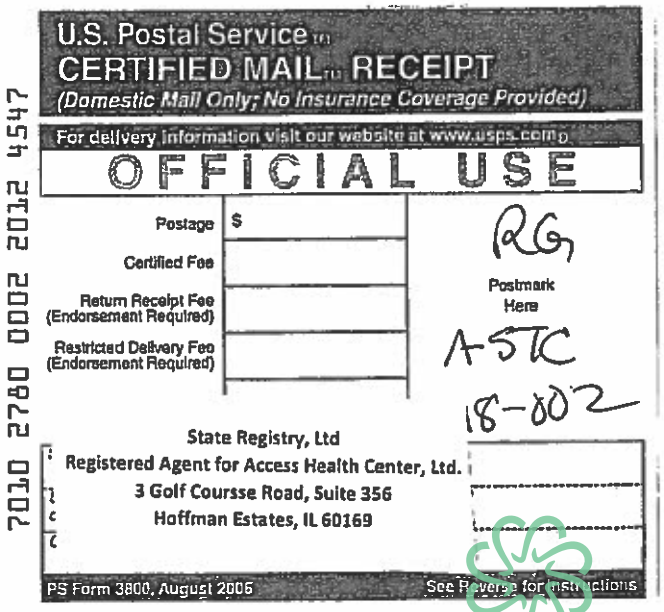
Attachment #1
Pg. 3

Respondent may submit any additional information in response to the notice of violation which it believes will clarify the condition or alleged violation. The Department will consider the information in reviewing the facility's response and the plan of correction.

[redacted]
Debra D. Bryars, MSN, RN
Deputy Director, Office of Health Care Regulation
Illinois Department of Public Health

Dated this 11th day of June, 2018.





Americans United for Life

Petitioner's Exhibit PE-4
Copy

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH, STATE OF ILLINOIS,	)	
Complainant	)	
vs.	)	Docket No. ASTC 18-002
ACCESS HEALTH CENTER, LTD. *License Number 7001613, expires 1/12/2019*	)	
Respondent	)	

PROOF OF SERVICE

The undersigned certifies that a true and correct copy of the attached NOTICE OF VIOLATIONS; NOTICE OF FINE ASSESSMENT; NOTICE OF OPPORTUNITY FOR HEARING AND NOTICE OF PLAN OF CORRECTION REQUIRED was sent by certified and mail in a sealed envelope, postage prepaid to:

Access Health Center, Ltd.
1700 W. 75th Street
Downers Grove, IL 60516

State Registry, Ltd
Registered Agent for Access Health Center, Ltd.
3 Golf Course Road, suite 356
Hoffman Estates, IL 60169

The said document was deposited in the United States Post Office at Chicago, Illinois on the 6 day of June, 2018.

[redacted]

Rebecca Gold
Assistant General Counsel
Illinois Department of Public Health
122 S. Michigan Ave., 7th Floor
Chicago, IL 60603

cc: Karen Senger, Division of Health Care Facilities & Programs
Springfield Legal File

Americans United for Life

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH, STATE OF ILLINOIS, Complainant vs. ACCESS HEALTH CENTER, LTD., *License Number 7001613, expires 1/12/2019* Respondent	)	Docket No. ASTC 18-002

NOTICE OF VIOLATIONS; NOTICE OF FINE ASSESSMENT; NOTICE OF OPPORTUNITY FOR HEARING AND NOTICE OF PLAN OF CORRECTION REQUIRED

Pursuant to the authority granted by the Ambulatory Surgical Treatment Center Act (210 ILCS 5/1) ("Act"), and in accordance with Sections 205.820 and 205.850 of the Ambulatory Surgical Treatment Center Licensing Requirements Code (77 Ill. Adm. Code 205) ("Code"), the Illinois Department of Public Health ("Department") hereby notifies Respondent of the following:

NOTICE OF VIOLATIONS

Pursuant to Section 10b of the Act, and subsequent to an annual licensure survey and complaint investigation conducted by the Department on or about May 21-24, 2018, at Access Health Center, Ltd., 1700 75th St., Downers Grove, IL 60516, the Illinois Department of Public Health ("Department") hereby notifies Respondent that it has violated the following sections of the Code: 205.410(b)(1), 205.410(b)(2), 205.410(b)(3), 205.410(d), 205.420(a), 205.540(a), 205.550(a), 205.550(h)(1), 205.550(h)(2), 205.550(h)(3), 205.550(h)(4), and 205.550(h)(5).

The allegations relating to the Code violations are further described in the three Statements of Deficiencies attached hereto and incorporated herein as Attachment A, Attachment B, and Attachment C.

NOTICE OF FINE ASSESSMENT

Pursuant to Sections 10d and 10e of the Act, and in accordance with Section 205.850 of the Code, the Department hereby imposes a fine assessment of **$2,000** in relation to the Code violations stated in the above Notice of Violations.

All penalties shall be paid to the Department within ten (10) days of receipt of the Notice of Fine Assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Illinois Department of Public Health
P.O. Box 4263
Springfield, Illinois 62708

NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Section 10g of the Act and Section 205.860 of the Code, the Respondent shall have a right to hearing to appeal the Notice of Violation and Notice of Fine Assessment, herein.

In order to obtain a hearing, the licensee must file a written request for hearing no later than ten (10) days after the receipt of this Notice.

The request for hearing must be sent to:

Illinois Department of Public Health
Attn: Rebecca Gold
Assistant General Counsel
122 S. Michigan, 7th Floor
Chicago, Illinois 60603

FAILURE TO REQUEST A HEARING WITHIN TEN (10) DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING

NOTICE OF PLAN OF CORRECTION REQUIRED

Pursuant to Section 10c of the Act and Section 205.830 of the Code, Respondent shall submit to the Department a written plan of correction within ten (10) days of receipt of this Notice of Violation. Such plan of correction shall include the following:

1) A statement of the specific actions the facility intends to take, or has taken, to correct **each violation** stated in the above Notice of Violations; and

2) The **specific date** by which each violation will be corrected, or has been corrected.

Respondent may submit any additional information in response to the notice of violation which it believes will clarify the condition or alleged violation. The Department will consider the information in reviewing the facility's response and the plan of correction.

[redacted]
Debra D. Bryars, MSN, RN
Deputy Director, Office of Health Care
RegulationIllinois Department of Public Health

Dated this 11th day of June, 2018.

Americans United for Life

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH, STATE OF ILLINOIS,	)	
Complainant	)	
vs.	)	Docket No. ASTC 18-002
ACCESS HEALTH CENTER, LTD. *License Number 7001613, expires 1/12/2019*	)	
Respondent	)	

PROOF OF SERVICE

The undersigned certifies that a true and correct copy of the attached NOTICE OF VIOLATIONS; NOTICE OF FINE ASSESSMENT; NOTICE OF OPPORTUNITY FOR HEARING AND NOTICE OF PLAN OF CORRECTION REQUIRED was sent by certified and mail in a sealed envelope, postage prepaid to:

Access Health Center, Ltd.
1700 W. 75th Street
Downers Grove, IL 60516

State Registry, Ltd
Registered Agent for Access Health Center, Ltd.
3 Golf Course Road, suite 356
Hoffman Estates, IL 60169

The said document was deposited in the United States Post Office at Chicago, Illinois on the _____day of _____, 2018.

Rebecca Gold
Assistant General Counsel
Illinois Department of Public Health
122 S. Michigan Ave., 7th Floor
Chicago, IL 60603

cc: Karen Senger, Division of Health Care Facilities & Programs
Springfield Legal File

Access Health Care, Ltd.
Administration Office
1640 N. Arlington Heights Rd, Ste 110
Arlington Heights, IL 60004
Phone: (847) 255-7400
Fax: (847) 398-4585

Rebecca L. Gold
Assistant General Counsel
Illinois Department of Public Health
122 S. Michigan, 7th Floor
Chicago, Illinois 60603

Enclosed please find our Plan of Correction in response to the Statement of Deficiencies we received on 6/21/2018.

I will await the fine payment agreement.

Sincerely,

[redacted]

Vera Schmidt
Chief of Operations
Access Health Center, Ltd.

Americans United for Life

EXHIBIT A

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
7001613	30195	5/24/18

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Access Health	1700 75th St., Downers Grove, IL 60516

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
000	A licensure survey was conducted on 5/21/18 through 5/24/18. An Immediate Jeopardy (IJ) began on 5/22/18 due to the Facility's failure to ensure a chemical indicator was included in each sterilized pack to ensure successful sterilization; failure to ensure biological indicator tests were performed weekly; failure to maintain sterilizer logs which included the load number, contents, chemical indicator, and operator identification; and failure to ensure surveillance of the sterilization process, and was identified on 5/23/18, at TITLE 77: PUBLIC HEALTH CHAPTER I: DEPARTMENT OF PUBLIC HEALTH SUBCHAPTER b: HOSPITAL AND AMBULATORY CARE FACILITIES PART 205 AMBULATORY SURGICAL TREATMENT CENTER LICENSING REQUIREMENTS SECTION 205.710 PREGNANCY TERMINATION SPECIALTY CENTERS, 205.410 b) 1-3. The IJ was announced on 5/23/18 at 9:00 AM to the Chief of Operations (E #5) and the Assistant Administrator (E #1). The IJ was removed by the survey exit date of 5/24/18 based on observation, document review, and interview as follows: 1. The sterile processing and storage room was observed on 5/24/18 at 4:30 PM. Every surgical instrument had been re-sterilized, and every pack was labeled with the load number, the sterilizer number, the date, and the operator's initials. 2. The "Autoclave Sterilization In-Service Training Record" (dated 5/24/18) was reviewed on 5/24/18 and included that 5 of the employees responsible for performing sterile processing had completed the training. 3. The Staff Schedule for 5/25/18-6/1/18 was reviewed on 5/24/18 at 10:45 AM. One of the employees who had been trained in sterilization on 5/24/18 was on the schedule every day to perform sterilization.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE

Infection Control Coordinator

TITLE

DATE 7/9/18

Access Health Center, Ltd.
Administration Office
1640 North Arlington Heights Road Suite #110
Arlington Heights, IL 60004
(847) 255-7400

Annette Hodge
Illinois Department of Public Health
122 South Michigan Avenue, 20th Floor
Chicago, IL 60603

Dear Ms. Hodge,

Per our conversation on 7/6/18, I am submitting the additional information you have requested to complete our P.O.C.:

T026 1. Training records regarding autoclave sterilization (was previously given to surveyors during the inspection).
2. Documentation showing weekly monitoring by Infection Control Coordinator; initials are circled.
3. Surveillance report to be submitted and reviewed at the Quarterly Consulting Committee Meeting.

T028 1. End of Day O.R. Checklist.
2. Daily Nursing Checklist.
Nurse Supervisor will be checking both logs daily.

T056 1. Discharge criteria.
2. New entry on Recovery Room Record documenting RN discharge. Nurse Supervisor will be auditing all charts to make sure that RN discharges patients.

Please contact me if you have any other questions.

Sincerely,

[redacted]

Vera Schmidt
Infection Control Coordinator
Access Health Center, Ltd.

Americans United for Life

IN-SERVICE TRAINING RECORD

T026 #1

DATE: 5/24/18 TIME: 11:00am

PRESENTOR: Vera Schmidt, Infection Control Coordinator

TOPIC: Autoclave Sterilization

OUTLINE:

Discussion of IDPH findings
Review of Biological Spore Indicator policy
Discussion of new Autoclave Log and how to properly document log: Date, Autoclave Code #, Cycle/Run #, Contents & Initials
How to label each set with above information
Review of Chemical Internal Indicator in each set.

ATTENDEES: [signatures]

2 Managers, 2 assistant managers trained

VERIFIED BY: [signature]

Americans United for Life

T026

IN-SERVICE TRAINING RECORD

DATE: 5/25/18 TIME: 11:30am

PRESENTOR: Vera Schmidt, Infection Control Coordinator

TOPIC: New Sterilization Procedures, New Patient Form, Hand Washing Policy Review

OUTLINE:

Discussion of IDPH Survey findings:

1. Discussed need of Chemical Indicator in each set/packet
2. Discussed new autoclave log and proper documentation
3. Discussed review/Initial of autoclave tapes
4. Reviewed protocol for weekly Spore Testing and documentation
5. Discussion of new "Operative Note" form in patient record and how to properly document Sterile Instruments used on the form.
6. Hand washing Policy:

Reviewed need to wash/hand sanitize hands between patients, after removal of gloves, before donning gloves, after touching surfaces.

ATTENDEES:

K. Olson
[illegible]
J. Muncz
V. Gromelek
[illegible]
[illegible] Buddie
K. Kaminski
[illegible]

VERIFIED BY: [signature]

Infection Control Coordinator

Autoclave Quality Control Log – Biological Spore Testing

T026 # 2

Center ACC

Month June/July

6723/ 9/2019
lot # / expiration date

(+) Growth (yellow color) (-) No Growth (purple color)

Read test results before the start of surgery

			Day 1 - reading				Day 2 - reading				
I.D. #	Autoclave Date	Tech	Test	Control	Tech	Date	Test	Control	Tech	Date	Notes
I	06/07/18	AK	–	+	AK	06/08/18					
II	06/07/18	AK	–	+	AK	06/08/18					6/8
I	6/14	MV	–	+	PS	06-15-18					
II	6/14	MV	–	+	PS	06-15-18					6-18
I	6/21	MV	–	+	PS	6-22-18					
II	6/21	MV	–	+	PS	6-22-18					6/25/18
I	6-28	MV	–	+	MV	6-29-18					
II	6-28	MV	–	+	MV	6-29-18					7/2
I	7-5-18	MV	–	+	MV	7-6-18					
II	7-5-18	MV	–	+	MV	7-6-18					7/6/18
											OLD FORM USED START USING NEW FORM for 24 hour reading only.
								NA			

Report any positive test Results immediately to supervisor

Americans United for Life

T026 #2

Autoclave Log

Autoclave # I

Date	Cycle	Contents	Int. Chem indicator	Tapes	Comment	Intials
7/2	3	29/31 Dilator (3)	✓	✓		
		#5 curette (4)	✓	✓	✓	
7-3-18	1	33/35 Dilator (3)	✓	✓		
		49/51 Dilator (1)	✓	✓		
7/5	1	1st tri set (2)	✓	✓		
		1st tri curette (2)	✓	✓		
		29/31 (3)	✓	✓		
7/6	1	1st tri set (2)	✓	✓		
		1st tri Curette (4)	✓	✓		
		29/31 Dilator (2)	✓	✓		
	2	2nd tri Curette (1)	✓	✓		
		1st tri set (4)	✓	✓		
		1st tri curette (3)	✓	✓		
		29/31 Dilator (4)	✓	✓		
						7/6/18

Weekly Biologicial Spore Test
Date Autoclaved 7/5/18 Date Passed 7/6/18 Intials

Americans United for Life

Autoclave Log

Autoclave # I

T026 #2

Date	Cycle	Contents	Int. Chem indicator	Tapes	Comment	Intials
6/27	1	1ST TR SET (2)	✓	✓		
		Medium Pederson 1	✓	✓		
		1ST TR connectors (4)	✓	✓		
		29/31 Dialator (1)	✓	✓		
6/28	(1)	1ST TR SET (1)	✓	✓		
		1st TR connector (1)	✓	✓		
		29/31 Dialator (1)	✓	✓		
		37/39 Dialator	✓	✓		
6/29	(1)	1ST TR SET (3)	✓	✓		
		29/31 Dialator (4)	✓	✓		
		37/39 dialator (1)	✓	✓		
		33/35 dialator (1)	✓	✓		
		2nd TR connector (1)	✓	✓		
6/30	(1)	#5 curettes	✓	✓		
		1ST TR HOSE END (5)	✓	✓		
		2nd TR Hose (5)	✓	✓		
7/2	(1)	4 29/31 dialators	✓	✓		
		1 41/43 dialators	✓	✓		
		1 #5 curette	✓	✓		
		5 37/39 Dialators	✓	✓		
		2 33/35 Dialators				
		1 7/8 Dialater				
	2	1ST TR SET (5)	✓	✓		

7/2/18

Weekly Biologicial Spore Test
Date Autoclaved 6/28/18 Date Passed 6/29/18 Intials

Americans United for Life

T026 #2

Autoclave Log

Autoclave # I

Date	Cycle	Contents	Int. Chem indicator	Tapes	Comment	Intials
6/18	1	145/47 dialator	✓	✓		PS
6/18	1	141/43 dialator	✓	✓		PS
6/18	1	133/35 dialator	✓	✓		PS
6/18	1	137/39 dialator	✓	✓		PS
6/18	1	129/31 dialator	✓	✓		PS 6/18
6/21	1	IUD SET (1)	✓	✓		MV
		1st tri SET (1)	✓	✓		MV
		IUD Hook (1)	✓	✓		MV
		1st tri connectors (1)	✓	✓		MV
	2	1st tri Set (1)	✓	✓		MV
		1st tri Connector (1)	✓	✓		MV
		29/31 Dialator (1)	✓	✓		MV
6/22	1	1st tri set (2)	✓	✓		MV
		1st tri set connect (2)	✓	✓		MV
		29/31 Dialator (2)	✓	✓		MV
		33/35 Dialator (1)	✓	✓		MV
		37/39 Dialator (1)	✓	✓		MV
		41/43 Dialator (1)	✓	✓		MV
		#5 Curette (1)	✓	✓		MV
6/25	1	1st tri Set (3)	✓	✓		MV
		29/31 Dialator (3)	✓	✓		MV
		1st tri connect (3)	✓	✓		MV
		33/35 dialator (1)	✓	✓		MV
						MV 6/25/18

Weekly Biologicial Spore Test
Date Autoclaved 6/21/18 Date Passed 6/25/18 Intials

Americans United for Life

T026 #2

Autoclave Log

Autoclave # II

Date	Cycle	Contents	Int. Chem indicator	Tapes	Comment	Intials
6/29	2	29/31 Dilator (2)	✓	✓		
6/30		1ST TRI connector (2)	✓	✓		
6/29	1	1st+tri -3	✓	✓		
6/30	2	1st+tri -3				
		Back Bottle hose ends				
7/2	1	1st+tri connector (1)	✓	✓		
	2	1st+tri set (4)	✓	✓		
	3	1st+tri connectors (10)	✓	✓		
						7/2
7/3/18	1	29/31 Dilators (3)	✓	✓		
		37/39 Dilators (2)	✓	✓		
	2	41/43 Dailators (3)	✓	✓		
7/5/18	1	1ST TRI set (4)	✓	✓		
		1st+tri Connect (4)	✓	✓		
		2nd tri connect (1)	✓	✓		
	2	29/31 Dilators (4)	✓	✓		
7/6	1	1st+tri set (3)	✓	✓		
		1st tri connect (3)	✓	✓		
		29/31 Dilator (3)	✓	✓		
						7/6

Weekly Biologicial Spore Test
Date Autoclaved 7/5/18 Date Passed 7/6/18 Intials

Americans United for Life

Autoclave Log

Autoclave # II

T 026 #2

Date	Cycle	Contents	Int. Chem indicator	Tapes	Comment	Intials
6/22	1	29/31 Dialator (1)	✓	✓		AV
		41/43 Dialator (1)	✓	✓		AV
		37/39 Dialator (1)	✓	✓		AV
		33/35 Dialator (1)	✓	✓		AV
	2	1ST+TRI SET (2)	✓	✓		AV
		1ST+TRI connector (2)	✓	✓		AV
		29/31 Dialator (2)	✓	✓		AV
6/25	1	1ST+TRI connector (3)	✓	✓		AV
		1ST+TRI SET (3)	✓	✓		AV
		29/31 Dialator (3)	✓	✓		AV
		33/35 Dialator (1)	✓	✓		AV
		37/39 Dialator (1)	✓	✓		AV
		#5 currette (1)	✓	✓		AV
6/27	1	1ST+TRI SET (3)	✓	✓		AV
		29/31 Dialator (3)	✓	✓		AV
		33/35 Dialator (1)	✓	✓		AV
		37/39 Dialator (1)	✓	✓		AV
		41/43 Dialator (1)	✓	✓		AV
		#5 currette	✓	✓		AV
6/28	1	1ST+TRI set (1)	✓	✓		AV
		1ST+TRI Set connector (1)	✓	✓		AV
		29/31 Dialator (1)	✓	✓		AV
6/29	1	1ST+TRI set (3)	✓	✓		AV
		1ST+TRI Connector (4)	✓	✓		AV

6/25

Weekly Biologicial Spore Test

Date Autoclaved	Date Passed	Intials
6.28.18 AV	6.29.18	AV

Americans United for Life

Infection Control Instrument Cleaning/Sterilization Surveillance Report

T026 #3

Quarterly Audit From 5/28 – 7/6/18

	Date	Reviewed	Comments
General			
1. Proper Attire	7/6/18	✓	
2. Proper cleaning/disinfection			
• Bottles		✓	
• Instruments		✓	
• Hoses		✓	
3. Transport of Instruments			
• From dirty environment (POC Lab)		✓	
• To clean environment (Sterile Lab)		✓	
Sterile Lab			
1. General Cleaning	7/6/18	✓	
2. Autoclaves			
• Cleaning		✓	
• Maintaining		✓	
• Spore Testing (weekly)		✓	Performed 5/31, 6/7, 6/14, 6/21, 6/28, 7/5
• Wrapped Instruments Integrity		✓	
• Labeling of Sets		✓	
• Chemical Internal Indicators		✓	
• Sterilization of Items		✓	
• Autoclave Tapes			
❖ Documentation		✓	Staff initialing tape
❖ Error Codes		✓	No Error Codes
❖ Storage		✓	
• Logs			
❖ Autoclave Log		✓	
❖ Maintenance (daily cleaning)		✓	
❖ Biological Spore Testing		✓	old form used; advised staff to use new 24hr form instead. Proper documentation performed.
❖ Sterilization Process Failure Checklist		No Failures	
❖ Heat Block Temp		✓	
• Inventory		✓	
Staff			
• Training Checklist		✓	All staff performing sterilization have been trained.

Infection Control / Coordinator
7/6/18

Americans United for Life

T028

Month/Year July 2018

Daily Nursing Checklist

Daily Duties – Pre-Surgery	Date 7-1-18	Date 7-5-18	Date 7-6-18	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
Checked Refrigerator Temperature & filled out log	✓IK	CA	AO												
Checked Recovery Room Set-up	✓IK	CA	AO												
Checked OR Room(s) Set-up	IK	CA	AO												
Checked O_2 tanks (Recovery & OR's)	IK	CA	AO												
Checked AED for "OK" Electrode Expiration Date: 09/20/22	IK	CA	AO												
Performed Pre-Surgery Narcotic Count with Authorized Signatures	IK	nA	AO												
Reviewed Charts Pre-Surgery	IK	CA	AO												
Prepared IV Bags & Medications for Surgery	IK	CA	AO												
Prepared Anesthesia ER med kit	IK	CA	AO												
Prepared scripts/meds for Patients	IK	CA	AO												
Verified Correct Locks are intact on Crash Cart	IK	CA	AO												
Daily Duties – Post-Surgery															
Recorded Rh Negative Patients in Rhogam Log	IK	CA	AO												
Recorded Scant ordered Patients in Scant Tissue Log	IK	CA	AO												
Recorded cases in the complication log (if applicable)	IK	CA	AO												
Checked all Charts for Signatures, Time Discrepancies, Missing Info, etc.	IK	CA	AO												
Re-Stocked OR's & Recovery Room	IK	CA	AO												
Faxed Completed Recovery Room Log to Accounting	IK	CA	AO												
Performed Post Surgery Narcotic Count with Authorized Signatures	IK	CA	AO												
Restock IV Bags in Warmer	IK	CA	AO												
→ All Medications Secured & Locked	IK	CA	AO												
Returned Keys to Management	IK	CA	AO												
Manager Initials	AO	AO	AO												

RN's Initial Box when completed, Managers check all logs (Narcotic, RR, Rhogam, Scant, etc.) for Discrepancies as well as verifying all work.

T028

Month/Year July 2018

End of Day O.R. Checklist

Daily Duties	Date 7-1	Date 7-5	Date 7-6	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
Carts: All medications returned	✓	✓	✓												
Cleaned with disinfectant	✓	✓	✓												
Locked	✓	✓	✓												
Tables: Cleaned with disinfectant	✓	✓	✓												
Move & Clean Under	✓	✓	✓												
In Down Position	✓	✓	✓												
Remote Turned OFF	✓	✓	✓												
Floors/Walls: Check for Debris	✓	✓	✓												
Spot Clean for visible stains	✓	✓	✓												
Waste: Empty Wastebaskets	✓	✓	✓												
Remove Biohazardous Waste	✓	✓	✓												
Equipment: Turned OFF	✓	✓	✓												
Cleaned with disinfectant (Medical)	✓	✓	✓												
Check O_2 Tanks (off & secured)	✓	✓	✓												
Check Hoses (area clear)	✓	✓	✓												
Check Suction Filter (Replace if necessary)	✓	✓	✓												
Other: Stock O.R.	✓	✓	✓												
Close ***& Lock*** Cabinets.	✓	✓	✓												
Lights OFF	✓	✓	✓												
Manager Initials	✓	✓	✓												

Staff Initial Box when completed, RN verify all work.

T028

Month/Year July 2018

End of Day O.R. Checklist

Daily Duties		Date 7-1	Date 7-5	Date 7-6	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
Carts:	All medications returned	RG	LM	ED												
	Cleaned with disinfectant	RG	LM	ED												
	Locked	RG	LM	ED												
Tables:	Cleaned with disinfectant	RG	LM	ED												
	Move & Clean Under	RG	LM	ED												
	In Down Position	RG	LM	ED												
	Remote Turned OFF	RG	LM	ED												
Floors/Walls:	Check for Debris	RG	LM	ED												
	Spot Clean for visible stains	RG	LM	ED												
Waste:	Empty Wastebaskets	RG	LM	ED												
	Remove Biohazardous Waste	RG	LM	ED												
Equipment:	Turned OFF	RG	LM	ED												
	Cleaned with disinfectant (Medical)	RG	LM	ED												
	Check O_2 Tanks (off & secured)	RG	LM	ED												
	Check Hoses (area clear)	RG	LM	ED												
	Check Suction Filter (Replace if necessary)	RG	LM	ED												
Other:	Stock O.R.	RG	LM	ED												
	Close ***& Lock*** Cabinets.	RG	LM	ED												
	Lights OFF	RG	LM	ED												
Manager Initials																

Staff Initial Box when completed, RN verify all work.

POST-OPERATIVE STANDING ORDERS
APPROVED DISCHARGE CRITERIA

T056

POLICY:

To set forth the criteria for which a patient may be discharge from the Recovery Room.

PROCEDURE:

The following criteria must be met before a patient is discharged home from the Recovery Room:

1. Stable vital signs consistent with per-op baseline.
2. No respiratory distress.
3. No abnormal bleeding.
4. Minimal nausea or vomiting.
5. Ability to ambulate independently with no dizziness.
6. Circulation checks to affected area with normal limits.
7. Minimal pain.
8. No narcotic pain medication for at least 30 minutes.
9. Alert and oriented, or equal to his/her pre-operative level of consciousness.
10. Aldrette score of 8 or more.

The attending physician may also request specific procedure related criteria to be met before discharge.

Any patient receiving "twilight" or general anesthesia must be evaluated by a qualified physician prior to discharge. The anesthesia provider and/or primary surgeon is responsible for the pre-discharge evaluation. The "anesthesia copy" of the medical record form provides the area for documentation under the heading: "Post-Operative Anesthetic Evaluation". A nurse can discharge the patient once the discharge criteria are met.

No patient receiving "twilight" or general anesthesia may operate an automobile after surgery. The patient must be driven home by family/friend.

PATIENT INFORMATION

(affix label)

T056

RECOVERY ROOM RECORD

Operative Procedure	Hgb	Pre-op B/P

Time					
B / P					
Pulse					
Resp.					
SaO_2					
Temp					

Circle One: RH - + N/A

☐ RHOGAM Administered _____

☐ Minigam Administered _____

_____ Lot # _____ Exp. Date

☐ Refusal Form Signed _____

ALDRETTE SCORING SYSTEMS ↓ Upon RR Entry Prior to Discharge↓

		Time					
Activity	2 Able to move 4 extremities 1 Able to move 2 extremities 0 Able to move 0 extremities						
Respiration	2 Able to deep breathe & cough freely 1 Dyspnea or limited breathing 0 Apneic						
Circulation	2 BP = <20mmHg of Pre-anesthetic level 1 BP = 20 to 50mmHg of Pre-anesthetic level 0 BP = >50mmHg of Pre-anesthetic level						
Consciousness	2 Fully awake 1 Arousal on calling 0 Not responding						
Color	2 Pink or normal 1 Pale or dusty 0 Cyanotic						
		Total					

O_2 @ _____ per Cannula_____ Mask_____

STARTS: Time_____ D/C'd at_____

EKG Monitor: Time_____ Rhythm_____

Current Drugs / Medications (including aspirin) taken within the last 10 days:

Post-op Medication:

Nurses Signature (Initial)

Alert Sticker(s)

I.V. Fluids	Time	Bag No.	Solution Name	Additives	Amt. Up	Amt. In	Time Absorbed	Rate	Site	Signature

DISCHARGE NOTES

Up to BR _____ Voided _____ Drainage_____

1. Dressings_____

Other_____

Medication Reconciliation Form Given to Patient

Initials_____

Discharge instructions given to patient. _____

Discharge criteria met. _____ RN

Condition at Discharge: ☐ Stable Condition Time _____ Home with: _____

☐ Ambulatory

EXHIBIT A

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7001613	30195	5/24/18

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Access Health	1700 75th St., Downers Grove, IL 60516

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
000	A licensure survey was conducted on 5/21/18 through 5/24/18. An Immediate Jeopardy (IJ) began on 5/22/18 due to the Facility's failure to ensure a chemical indicator was included in each sterilized pack to ensure successful sterilization; failure to ensure biological indicator tests were performed weekly; failure to maintain sterilizer logs which included the load number, contents, chemical indicator, and operator identification; and failure to ensure surveillance of the sterilization process, and was identified on 5/23/18, at TITLE 77: PUBLIC HEALTH CHAPTER I: DEPARTMENT OF PUBLIC HEALTH SUBCHAPTER b: HOSPITAL AND AMBULATORY CARE FACILITIES PART 205 AMBULATORY SURGICAL TREATMENT CENTER LICENSING REQUIREMENTS SECTION 205.710 PREGNANCY TERMINATION SPECIALTY CENTERS, 205.410 b) 1-3. The IJ was announced on 5/23/18 at 9:00 AM to the Chief of Operations (E #5) and the Assistant Administrator (E #1). The IJ was removed by the survey exit date of 5/24/18 based on observation, document review, and interview as follows: 1. The sterile processing and storage room was observed on 5/24/18 at 4:30 PM. Every surgical instrument had been re-sterilized, and every pack was labeled with the load number, the sterilizer number, the date, and the operator's initials. 2. The "Autoclave Sterilization In-Service Training Record" (dated 5/24/18) was reviewed on 5/24/18 and included that 5 of the employees responsible for performing sterile processing had completed the training. 3. The Staff Schedule for 5/25/18-6/1/18 was reviewed on 5/24/18 at 10:45 AM. One of the employees who had been trained in sterilization on 5/24/18 was on the schedule every day to perform sterilization.		See Page 10	

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE

TITLE Chief of Operations

DATE 6/25/18

EXHIBIT A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
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000	000 (cont'd) 4. On 5/24/18 at approximately 11:00 AM, an interview was conducted with the Chief of Operations/Infection Control Officer (E #5). E #5 stated that E #5 will be present at the Facility to train all of the remaining employees and oversee the sterilization until all staff are trained. 5. The "Sterilization Policy" was revised on 5/23/18 and included, "...Place chemical indicator strip in pouch... All autoclaved items must have the following documentation: a. Date b. Contents of package c. Autoclave #, d. Cycle #...Surveillance Schedule for Sterilization: Daily: performed by POC (point of care) staff: I. Review cycle tapes and initial. II. Inspect for presence of chemical indicators/ indicator tape. III. Inspect packets for integrity. IV. Autoclave log to be completed...Weekly: performed by POC staff: ...III. Documentation of test results on Biological Spore Testing Log... Quarterly Infection control Survey by Infection Control Coordinator: I. Monitor all sterilization activities and documents. II. Review autoclave log and tapes... IV. Prepare report for Quarterly Consulting Committee..." 6. The "Operative Notes" form in the patient's record had been revised to include a space to document each sterile instrument used on the patient. 7. The Sterilization Log Form (effective 5/23/18) was reviewed on 5/24/18 and required documentation of the sterilizer number; load number; load contents; the use of a chemical indicator; comments; weekly biological spore test; and the operator's initials.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE 6/25

EXHIBIT A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
7001613	30195	5/24/18

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T026	205.410 b) 1-3 b) The facility shall have written policies and procedures and shall maintain documentation governing the care, use, decontamination, sterilization, storage and disposal of all materials to ensure that an adequate supply of sterile equipment, instruments and supplies is available for each procedure. Written policies and procedures shall include documentation that the facility has considered, selected and implemented nationally recognized guidelines, including the Centers for Disease Control and Prevention publication, "Guidelines for Disinfection and Sterilization in Healthcare Facilities" or "Guide to Infection Prevention in Outpatient Settings"; or the Association of perlOperative Registered Nurses (AORN) publication "Perioperative Standards and Recommended Practices for Inpatient and Ambulatory Centers". The policies, procedures and documentation shall include and address: 1) Staff orientation and in-service training to understand and implement facility policies and procedures for infection control, and to adhere to manufacturer's instructions for receiving, decontaminating, cleaning, preparing, sterilizing and high-level disinfection, handling, storage and quality control of equipment, supplies and instruments; 2) Preventive maintenance of all central supply service equipment pursuant to manufacturer's instructions or infection control guidelines; and 3) The Infection Control Program (Section 205.550), which shall be under the direction of a designated qualified health care professional with training in infection control. This Regulation is not met as evidence by: A. Based on document review, observation, and interview, it was determined that for 6 of 48 dilators (surgical instruments) and 6 of 6 hose connectors (surgical instruments), the Facility failed to ensure chemical indicators (sensitive chemicals to assess critical variables [e.g., time, temperature, or steam saturation] during a sterilization cycle) were included in the sterilization pouch/pack/wrap, potentially affecting the safety of the 50 - 60 patients undergoing surgical procedures at the Facility every month.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE 6/5/18

EXHIBIT A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
7001613	30195	5/24/18

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T026	205.410 b) 1-3 (cont'd) Findings Include: 1. On 5/22/18 at 2:30 PM, the Facility's policy titled, "Sterilization Policy" (reviewed on 1/15/18), was reviewed and required, "Steam Autoclave.. Wrapped Instrument Procedure... Lay instruments on to center of wrap in this order... indicator strip..." 2. On 5/23/18 at 10:35 AM, the Facility's policy titled, "Infection Control and Tissue Review Program" (reviewed on 1/15/18), was reviewed and required, "II. Purpose... 2. Develop a system for surveillance (detecting by interview, recording, reporting and evaluation)... V. Methods of Surveillance: Daily... 4. Sterilization: a. Autoclaves: Review of cycle tapes, chemical indicators, indicator tape used..." 3. On 5/22/18 at approximately 2:00 PM, an observational tour of the sterile storage room was conducted. During the tour, 48 transparent sterile packs containing dilators (instrument used to open the cervix) were observed. (These packs were selected because they were packed in transparent wrap and did not need to be opened to observe the presence of the chemical indicators.) 6 of the 48 packs observed had no chemical indicators present in the packs to indicate successful sterilization (sensitive chemicals to assess critical variables [e.g., time, temperature, or steam saturation] during a sterilization cycle). A chemical indicator should be present in every sterile pack per policy and the manufacturer's guidelines. (A chemical indicator is a paper strip that is visible through the transparent, sterile wrap.) The packs were dated as being sterilized on: 7/16/15 (2 packs), 3/28/18, 5/21/18 (2 packs) and one undated pack.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE 6/5

EXHIBIT A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
7001613	30195	5/24/18

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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T026	205.410 b) 1-3 (cont'd) 4. On the counter in the sterile processing and supply room were 6 of 6 hose connector pouches, all lacking chemical indicators. Sterilization dates included: 5/19/18 (2 pouches), 5/21/18 (3 pouches), and one undated pouch. 5. On 5/22/18 at 10:00 AM, an interview was conducted with the Chief of Operations (E #5). E #5 stated that all sterilized pouches/ packs should have a chemical indicator in the pouch. 6. On 5/23/18 at 9:00 AM, another interview was conducted with E #5. E #5 stated that all surgical procedures scheduled for 5/24/18 (next surgical date) would be canceled, and every instrument in the Facility would be re-sterilized to ensure the presence of a chemical indicator in each pack. E #5 stated that all staff will be retrained on sterilization, and the contents of each load and the presence of a chemical indicator will be documented on a log sheet. E #5 stated that E #5 would oversee the re-sterilization of all of the instruments.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE 6/25

EXHIBIT A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
7001613	30195	5/24/18

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T026	205.410 b) 1-3 b) (continued) B. Based on document review and interview, it was determined that for 2 of the last 7 months (December 2017 and February 2018), the Facility failed to ensure biological indicator tests were performed weekly, potentially affecting the safety of the 50 - 60 patients undergoing surgical procedures at the Facility every month. Findings include: 1. On 5/22/18 at 3:00 PM, the Facility's policy titled, "Autoclave Quality Control" (reviewed on 1/15/18), was reviewed. The policy required, "Principle: The biological indicator ampules are autoclaved [sterilized] at least once a week with a regular sterilization cycle..." 2. On 5/23/18 at 10:35 AM, the Facility's policy titled, "Infection Control and Tissue Review Program" (reviewed 1/15/18), was reviewed. The policy required, "II. Purpose... 2. Develop a system for surveillance (detecting by interview, recording, reporting and evaluation)... V. Methods of Surveillance: Weekly: 1. Autoclaves - Biological Indicator." 3. On 5/21/18 at 10:00 AM, the Biological Indicator Testing Logs from November 2017 through May 2018 were reviewed. There was no documentation of a weekly biological indicator for the entire month of December 2017 and for the last 3 weeks in February 2018. 4. On 5/22/18 at 10:00 AM, an interview was conducted with the Chief of Operations (E #5). E #5 stated that biological tests are supposed to be completed each week for each sterilizer. E #5 stated that all staff will be retrained on sterilization.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE 6/25

EXHIBIT A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
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T026	205.410 b) 1-3 (cont'd) C. Based on document review and interview, it was determined that the Facility failed to ensure surgical instrument sterilizer load logs were maintained, potentially affecting the safety of the 50 - 60 patients undergoing surgical procedures at the Facility every month. Findings include: 1. On 5/23/18 at 9:00 AM, the 2013 Association for the Advancement of Medical Instrumentation (ANSI/AAMI) ST79 Comprehensive Guide to Steam Sterilization and Sterile Assurance in Health Care Facilities was reviewed. The Guide required, "10.3.2. Sterilizer records: For each sterilization cycle, the following information should be recorded and maintained: 1) the lot number, b) the specific contents of the load...c) the exposure time and temperature, if not provided on the sterilizer recording chart, d) the name or initials of the operator..." 2. On 5/21/18 at 10:00 AM, the Facility sterilizer logs were requested from the Assistant Administrator (E #1). E #1 stated that there were no sterilizer logs which included the load number, contents of the load, or operator's identification. E #1 asked the surveyor how the Facility could track sterilized loads. E #1 was referred to the ANSI/AAMI Guidelines. 3. On 5/23/18 at approximately 9:00 AM, an interview was conducted with the Chief of Operations/Infection Control Officer (E #5). E #5 stated that the Facility follows the ANSI/AAMI Guidelines. E #5 stated that all surgical procedures scheduled for 5/24/18 (next surgical date) would be canceled, and every instrument in the Facility would be re-sterilized. E #5 stated that all staff will be retrained on sterilization, and the contents of each load and the presence of a chemical indicator will be documented on a log sheet. E #5 stated that E #5 would oversee the re-sterilization of all of the instruments.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE 5/25

EXHIBIT A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
7001613	30195	5/24/18

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T026	205.410 b) 1-3 (cont'd) D. Based on document review and interview, it was determined that the Infection Control Officer (E #5) failed to ensure surveillance of sterilization was conducted per policy. Findings include: 1. On 5/23/18 at 10:35 AM, the Facility's policy titled, "Infection Control and Tissue Review Program" (reviewed 1/15/18), was reviewed and required, "II. Purpose... 2. Develop a system for surveillance (detecting by interview, recording, reporting and evaluation)... V. Methods of Surveillance: Daily: Sterilization: Autoclaves: Review of cycle tapes, chemical indicators, indicator tapes used... Weekly: 1. Autoclaves - Biological Indicator... Sterilization policy shall be followed by all personnel..." 2. The Facility's Quarterly Quality Assessment/Quality Improvement Meeting Minutes (which includes the Infection Control Meeting Minutes) from 01/2017-05/2018 were reviewed on 5/22/18 and lacked any surveillance reports regarding sterilization. 3. On 5/22/18 at approximately 9:00 am, sterilization logs (including cycle tapes, chemical indicator use, load content, and biological indicators) were requested from the Assistant Administrator (E #1). E #1 presented the surveyor with boxes of sterilizer cycle tapes and biological indicator logs. E #1 stated that the contents of each load are not documented, and no log of the presence of a chemical indicator in each pack is maintained at the Facility.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE 6/25/18

EXHIBIT A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
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	205.410 b) 1-3 (cont'd)			
T026	4. On 5/23/18 at approximately 9:00 am, an interview was conducted with the Chief of Operations/Infection Control Officer (E #5). E #5 stated that E #5 reviews the sterilization logs quarterly. E #5 stated that the last review was in January 2018. E #5 stated that E #5 did not identify any issues with sterilization at that time, and there was no documentation of the completion of this review. E #5 stated that the quarterly review by E #5 consisted of a visual inspection of the sterile processing and storage room. E #5 stated that all surgical procedures scheduled for 5/24/18 (next surgical date) would be canceled, and every instrument in the Facility would be re-sterilized to ensure the presence of a chemical indicator in each pack. E #5 stated that all staff will be retrained on sterilization, and the contents of each load and the presence of a chemical indicator will be documented on a log sheet. E #5 stated that E #5 would oversee the re-sterilization of all of the instruments. E. Based on document review and interview, it was determined that for 2 of 2 staff (E #1 and E #5) sterilizing instruments, documenting sterilization on the logs, and reviewing the logs for completion, the Facility failed to ensure that sterilization was documented correctly to identify the instruments included in each load on the logs. Findings include: 1. On 5/23/18 at approximately 2:00 PM, the "Autoclave Log" (effective 5/23/18), was reviewed and included spaces on the log which required the recording of the autoclave number; date; cycle number; contents of the load; presence of a chemical indicator; autoclave tapes; comments; and the initials of the sterilization operator. 2. On 5/24/18 at approximately 4:30 PM, the Autoclave Logs from 5/23/18 - 5/24/18 were reviewed. The logs lacked documentation of the specific instruments which were included in the contents of each load. Documentation included, "Dilators x 4, Curettes x 7..." However, the documentation lacked the sizes of the instruments to identify which instruments were in each load. (There are 14 different size dilators and			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE 6/25

EXHIBIT A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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T026	205.410 b) 1-3 (cont'd) 8 different size currettes). Some instruments were documented by different names rather than the names of the instruments on the Instrument Inventory List. Therefore, it could not be determined which items were sterilized in each load. 3. On 5/24/18 at approximately 5:00 PM, an interview was conducted with the Chief of Operations (E #5). E #5, who had been present at the Facility to oversee the sterilization of every surgical instrument on 5/23/18 and 5/24/18, reviewed the Autoclave Logs and could not identify the instruments documented in each load. E #5 stated that the staff would have to be trained on documenting the instruments on the logs as they appear on the Instrument Inventory List so that every instrument would be documented using the correct name and size for each instrument.	T026	The POC for all sterilization issues was completed the week of the inspection 5/25/18. 1. Sterilization Log for both autoclaves has been audited and completed. 2. All instruments in the facility are on the Instrument Inventory Log have been properly sterilized and verified by the Infection Control Coordinator by comparison to the Autoclave Log. 3. An existing "Aseptic Technique" Policy has been modified to include the documentation to identify what sterile instrument was used on the patient. 4. The "Operative Notes" form in the patient's record has been revised and now has space to record the details of each sterile item used on a patient. Managers, and Assistant Managers have been trained on all the new policies. All medical staff have been trained by the Infection Control Coordinator regarding the new protocols. The Infection Control Coordinator has been monitoring the sterilization department weekly. The Infection Control Coordinator will prepare a surveillance report for the next Quarterly Consulting Committee to be scheduled in July 2018.	5/25/18

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE 6/25

EXHIBIT A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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Access Health	1700 75th St., Downers Grove, IL 60516

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T028	205.410 d) d) The facility shall have written procedures to assure the safety in storage and use of all narcotics and medications in accordance with State and federal law. This Regulation is not met as evidence by: Based on document review, observation and interview, it was determined for 1 of 1 anesthesia medication tray, the Facility failed to ensure medications were secured at all times. This potentially affected the 3 patients in the clinic on 5/21/18. Findings include: 1. The Facility's policy titled, "Medication Control & Accountability" (reviewed 1/15/18)" was reviewed on 5/23/18 and required, "Drugs shall be accessible only to responsible personnel designated by the facility ... Narcotics and all controlled substances are stored in a locked area or compartment." 2. An observational tour of the recovery room (RR) was conducted on 5/21/18 from 9:55 AM to 11:00 AM. The anesthesiologist entered the RR at approximately 10:20 AM with a small medication tray containing vials of: Labetalol (for blood pressure), Atropine (decrease mucous secretions before surgery), Flumazenil (treat drowsiness caused by sedatives), and Dopram (treats breathing problems after surgery). The bin also contained syringes with needles attached. The anesthesiologist placed the bin on a desk at the entrance/exit to the RR. These medications remained unattended for approximately 45 minutes, until the nurse placed them in the locked medication cart. 3. During an interview on 5/23/18 at 9:40 AM, the Assistant Administrator (E#1) stated, "The medications should be locked or kept in the possession of the anesthesiologist at all times."	T028	Per our policy all Narcotics and Controlled Substances are stored in a double locked Narcotic Cabinet. The tray of medications that were left unattended were not Narcotics or Controlled Substances. These other medications are locked up in the Medication Cart at the end of the day. After interviewing the staff and the anesthesiologist, they informed me that the tray was left out because the surveyors were busy examining the medication prep area and that the staff could not get to the medication cart in a timely matter. Nevertheless, a memo has been released addressing the fact that all medications need to be locked up immediately after use, and that they never to be left unattended (See Enclosure). The Nurse Supervisor and Manager of the center will monitor the proper return of the medication to the appropriate locking drawer at the end of the surgery on a daily basis.	6/25/18

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE 6/25/18

EXHIBIT A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
7001613	30195	5/24/18

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Access Health	1700 75th St., Downers Grove, IL 60516

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
T056	205.540 a) a) All patients' postoperative conditions shall be observed and assessed in the facility for a period of time sufficient to ensure that the patient is awake, physiologically stable, manifests no immediate postoperative complications, and is ready to return to home or to a similar environment. Overnight stays are not permissible. Before discharge from the facility, each patient shall be evaluated by a qualified practitioner for proper anesthesia recovery. No patient shall be required to leave the facility in less than one hour following the procedure or procedures. Each post-surgical patient's overall condition shall be assessed and documented in the medical record by a qualified practitioner, showing that the patient is ready for discharge or in need of further treatment or monitoring. This Regulation is not met as evidence by: Based on document review, observation and interview, it was determined that for 3 of 3 (Pts. #1, #2 and #3) patients observed, the Facility failed to ensure that each patient was evaluated by a nurse prior to discharge. Findings include: 1. The Facility's policy titled, "Post - Operative Standing Orders Approved Discharge Criteria" (reviewed 1/15/18) was reviewed on 5/21/18 and required, "When the criteria is met, the Recovery Room Nurse may discharge the patient. Any inconsistencies with the above criteria or any concerns that the nurse may have will be brought to the attention of the physician." 2. An observational tour of the recovery room (RR) was conducted on 5/21/18 from 9:55 AM to 11:00 AM. Two staff members were in the room waiting for patients to arrive (E#2 – Health Education Counselor and E#3 – Medical Assistant). During the observation, 3 patients came to the RR after a pregnancy termination procedure.	T056	A memo has been released re-educating staff that all patients must be evaluated by a nurse prior to discharge. Medical assistants have been reminded that a nurse must assess the patient to see if the patient meets the discharge criteria (See Enclosure). The Nurse Supervisor will monitor the discharge of patients.	6/25/18

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE

EXHIBIT A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
7001613	30195	5/24/18

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Access Health	1700 75th St., Downers Grove, IL 60516

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
T056	205.540 a) (cont'd) 3. Pt. #1 arrived in the RR at 9:58 AM. Pt. #1 was a 23 year old female admitted on 5/21/18 for pregnancy termination. Pt. #1 was transported by wheelchair to a chair in the RR. Pt. #1 was very sleepy and was unable to keep her eyes open. Pt. #1 required the assistance of 3 staff members to stand. Pt. #1 had an intravenous line (IV) that was opened all the way (allowing fluids to be administered quickly). After sitting in the chair, Pt. #1 was placed on oxygen per nasal canula (tube in the nose). Vital signs were taken upon arrival and every 10 minutes for two additional times. The IV was discontinued (half bag remaining) and Pt. #1 walked to the bathroom, dressed herself and was discharged at 10:30 AM. Pt. #1 was in the recovery room for 32 minutes. Pt. #1 was not evaluated by a nurse prior to discharge. 4. Pt. #2 arrived in the RR at 10:17 AM. Pt. #2 was a 28 year old female, admitted on 5/21/18 for pregnancy termination. Pt. #2 was nauseated and requested a pan to vomit. The IV was discontinued and Pt. #2 walked to the bathroom, dressed herself and was discharged at 11:06 AM. When getting ready to leave the RR, Pt. #2 requested a basin because she was still nauseated. Pt. #2 was given a basin and E#3 walked Pt. #2 out of the facility. Pt. #2 was in the recovery room for 49 minutes. Pt. #2 was not evaluated by a nurse prior to discharge. 5. Pt. #3 arrived in the RR at 10:37 AM. Pt. #3 was a 36 year old female admitted on 5/21/18 for pregnancy termination. Vital signs were taken upon arrival and every 10 minutes for two additional times. The IV was discontinued and Pt. #3 walked to the bathroom, dressed herself and was discharged at 11:22 AM. Pt. #3 was in the recovery room for 45 minutes. Pt. #3 was not evaluated by a nurse prior to discharge. 6. During an interview on 5/23/18 at 9:40 AM, the Assistant Administrator (E#1) stated, "We encourage patients to stay for about an hour and depend on our Medical Assistants to evaluate the patients and inform the nurse of any abnormal findings. If everything is normal, the patients are discharged without seeing a nurse."			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE 6/25/18

EXHIBIT B

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7001613	30195	5/24/18

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Access Health	1700 75th St., Downers Grove, IL 60516

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
T000	An investigation was conducted for Complaint #162912 on 5/24/18. The Facility was not in compliance with TITLE 77: PUBLIC HEALTH CHAPTER I: DEPARTMENT OF PUBLIC HEALTH SUBCHAPTER b: HOSPITAL AND AMBULATORY CARE FACILITIES PART 205 AMBULATORY SURGICAL TREATMENT CENTER LICENSING REQUIREMENTS SECTION 205.710 PREGNANCY TERMINATION SPECIALTY CENTERS as evidenced by:			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE 6/25

EXHIBIT B

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7001613	30195	5/24/18

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Access Health	1700 75th St., Downers Grove, IL 60516

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T063	205.550 a) a) Each ASTC shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers and visitors. This Regulation is not met as evidence by: Based on document review, observation, and interview it was determined that for 1 of 1 Medical Assistant (E # 6) observed for procedure room cleaning, the Facility failed to ensure that staff left the Cetylcide II (disinfectant) spray on surfaces for ten (10) minutes and allowed to dry. Findings include: 1. On 5/21/18 at 1:30 PM, the Manufacturer's guidelines for Cetylcide II concentrate (reviewed 02/16) was reviewed and required, "...Disinfection...treated surfaces must remain wet for 10 minutes..." 2. On 5/21/18 at 2:05 PM, the Facility 's policy titled, "Cleaning O.R. (Operating Room) Between Cases" (undated) was reviewed and included, "...damp clean the back table, the Mayo (metal tray table) stand and any other equipment which could have become soiled during the case, if deemed necessary..."	T063	The staff has been retrained on proper procedure room cleaning between cases (See Enclosure). It has also been brought to their attention that different disinfectants have different wet or "kill" times. We are currently evaluating faster acting disinfectants. The Nurse Supervisor will monitor the proper cleaning of the rooms.	6/25/18

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE 6/25

EXHIBIT B

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7001613	30195	5/24/18

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Access Health	1700 75th St., Downers Grove, IL 60516

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	205.550 a) (cont'd)			
T063	3. On 5/21/18 at approximately 9:55 AM, an observational tour of Operating Room #2 was conducted following a surgical procedure. The Medical Assistant (E #6) cleaned the procedure table using Cetylcide II (disinfectant) spray and paper towels. The same paper towels were used to clean the procedure tray and the supply table. The procedure tray and supply table were immediately covered with exam paper and blue pads and not allowed to dry. E #6 did not allow the Cetylcide II to remain on the on the surface for 10 minutes. 4. On 5/21/18 at approximately 10:22 AM, a second observational tour was conducted of Operating Room #2 following another surgical procedure. E #6 was observed cleaning the procedure table using Cetylcide II spray and paper towels to wipe the surface. The procedure table was immediately covered with exam paper and blue pads and not allowed to dry. E #6 did not allow the Cetylcide II to remain on the surface for 10 minutes. 5. On 5/21/18 at approximately 9:55 AM, during the observational tour of operating room #2, E #6 explained the cleaning process. E #6 stated that the Cetylcide II should be sprayed on the procedure tray and supply table and wiped with a paper towel to clean between patients. E #6 did not verbalize that the solution must remain on the surface for 10 minutes. 6. On 5/22/18 at approximately 9:45 AM, an interview was conducted with the Assistant Administrator (E #1). E #1 stated that the Cetylcide II spray must remain on the equipment for 5 – 7 minutes before wiping the surface and must be allowed to dry before being covered with exam paper and blue pads.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE 4/25

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7001613	30195	5/24/18

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Access Health	1700 75th St., Downers Grove, IL 60516

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T070	205.550 h) 1-5 h) The ASTC shall develop, implement, monitor and enforce a hand hygiene program. 1) The ASTC shall assess the current practice and compliance, assess current hand hygiene products, solicit input from clinical staff, and develop a hand hygiene program for all staff. 2) All staff (including contractual and medical) shall be educated in the hand hygiene program during initial orientation and at least annually. This education shall be documented. 3) The program shall have clear goals that require quantitative, time-specific improvement targets. 4) The ASTC shall develop and implement ongoing measurement tools to assure compliance with the program. 5) The results of the monitoring shall be incorporated in the clinical statistical data required in Section 205.620. This Regulation is not met as evidence by: Based on document review, observation, and interview, it was determined that for 2 of 2 staff (E#2 and E#3) observed, the Facility failed to ensure hand hygiene was performed between treating patients. Findings include: 1. On 5/22/18, the Facility's Policy titled, "Handwashing" (undated), was reviewed and required, "Hands must be washed with an approved antimicrobial soap or alcohol-based hand sanitizer after treating a patient, after touching blood or any other body fluid or substance. After touching any object or surface that is or may be contaminated. As soon as gloves and other PPE are removed, before eating/drinking and after using the restroom." 2. On 5/22/18, between 9:55 AM and 11:10 AM, a tour was conducted of the Recovery Room. The following was observed:			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE 6/25

EXHIBIT B

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7001613	30195	5/24/18

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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T070	205.550 h) 1-5 (cont'd) -At approximately 9:58 AM, Pt. #1 was brought into the recovery room. Pt. #1 was a 23 year old female, admitted on 5/21/18 for pregnancy termination. A Health Education Counselor (E#2) and a Medical Assistant (E#3) were wearing gloves while assisting with the care of Pt. #1. At 10:17 AM, Pt. #2 was brought into the Recovery Room. Pt. #2 was a 28 year old female, admitted on 5/21/18 for pregnancy termination. After working with Pt. #1, both E#2 and E#3 went to care for Pt. #2 without changing their gloves or performing hand hygiene. - At approximately 10:20 AM, after assisting with the care of Pt. #2, E#2 went back to take off Pt. #1's nasal cannula (tubing that supplies oxygen via nose), without changing gloves or performing hand hygiene. E#2 then went to the sink area, opened a pack of crackers, removed them with her gloved hand, and placed them into a pink basin. E#2 gave the crackers and a cup of ginger ale to Pt. #1 to consume. E#2 continued to work between Pt. #1 and Pt. #2, without changing gloves or performing hand hygiene, until approximately 10:30 AM, when Pt. #1 was discharged. 3. During an interview on 5/23/18, at approximately 9:15 AM, the Assistant Administrator (E#1) stated that staff should be changing their gloves and washing their hands in between working with patients. E#1 stated, "Staff will need to be re-educated (on hand hygiene)."	T070	The staff have been retrained on Hand Hygiene and Glove Donning on 5/25/18 and again on 6/25/2018 (See Enclosure). Additional hand sanitizers have been installed in the Recovery Room and the O.R. hallway. Additional Glove dispensers will be installed July 2018. The Nurse Supervisor will be responsible for monitoring Hand Hygiene.	6/25/18

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE 6/25

EXHIBIT C

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7001613	30195	5/24/18

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Access Health	1700 75th St., Downers Grove, IL 60516

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T000	An investigation was conducted for Complaint #172128 on 5/24/18. The Facility was not in compliance with TITLE 77: PUBLIC HEALTH CHAPTER I: DEPARTMENT OF PUBLIC HEALTH SUBCHAPTER b: HOSPITAL AND AMBULATORY CARE FACILITIES PART 205 AMBULATORY SURGICAL TREATMENT CENTER LICENSING REQUIREMENTS SECTION 205.710 PREGNANCY TERMINATION SPECIALTY CENTERS as evidenced by:			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE 6/25

EXHIBIT C

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7001613	30195	5/24/18

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T030	205.420 a) a) The ambulatory surgical treatment center shall ensure maintenance of a safe and sanitary facility by developing and adhering to an infection control program that is based on nationally recognized infection control guidelines, including the Centers for Disease Control and Prevention publication "Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings" or "Guide to Infection Prevention In Outpatient Settings: Minimum Expectations for Safe Care", and by maintaining all equipment in good working order. Written procedures shall include provision for maintaining a clean and sanitary facility, including appropriate environmental cleaning, garbage and refuse removal, insect and rodent control, maintenance of water, heat, ventilation and air conditioning, and electrical service. This Regulation is not met as evidence by: Based on document review and interview, it was determined, that for 4 of 4 disinfectant bottles, the Facility failed to ensure disinfectant had not passed the expiration/viability date and was applied properly, potentially affecting the safety of 50 - 60 patients per month. Findings include: 1. On 5/22/18 at 3:50 PM, the Cetylcide II Product Insert was reviewed. The Insert included, "Bactericidal Stability of Use – Dilution: Tests confirm that this product... remains effective against Pseudomonas aeruginosa, Staphlococcus aureus, Salmonella enterica for up to 64 days when stored in a sealed container at room temperature..." 2. On 5/21/18 at 9:10 AM, an observational tour was conducted in the Facility, including the patient waiting area, laboratory, reprocessing room, cleaning/ disinfection room, patient washrooms, operating suites, and recovery room. There was Cetylcide II Concentrate Disinfectant found in several areas including the reprocessing room, recovery room, and laboratory. The Cetylcide II Consentrate	T030	Staff have been retrained on how to prepare and date disinfectant solution. They have also been informed of 64-day expiration date. New Labels for the spray bottle have been created to document date filled and expiration (See Enclosure). Nurse Supervisor will monitor expiration of the bottles daily.	6/25/18

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE 6/25

EXHIBIT C

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
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T030	205.420 a) (Continued) Disinfectant was transferred from a Manufacturer's container into spray bottles. Two of the 4 spray bottles did not contain a filled date and 2 spray bottles included the filled date as 9/1/17, 199 days past the 64 day period of proven potency. 3. On 5/22/18 at approximately 9:45 AM, an interview was conducted with the Assistant Administrator (E #1). E #1 stated that the spray bottles of disinfectant should be dated, but did not know how long the disinfectant could be kept in the spray bottles without loosing potency.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE 6/25

EXHIBIT C

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
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T070	205.550 h) 1-5 h) The ASTC shall develop, implement, monitor and enforce a hand hygiene program. 1) The ASTC shall assess the current practice and compliance, assess current hand hygiene products, solicit input from clinical staff, and develop a hand hygiene program for all staff. 2) All staff (including contractual and medical) shall be educated in the hand hygiene program during initial orientation and at least annually. This education shall be documented. 3) The program shall have clear goals that require quantitative, time-specific improvement targets. 4) The ASTC shall develop and implement ongoing measurement tools to assure compliance with the program. 5) The results of the monitoring shall be incorporated in the clinical statistical data required in Section 205.620. This Regulation is not met as evidence by: Based on document review, observation, and interview, it was determined that for 2 of 2 staff (E#2 and E#3) observed, the Facility failed to ensure hand hygiene was performed between treating patients. Findings include: 1. On 5/22/18, the Facility's Policy titled, "Handwashing" (1/15/18), was reviewed and required, "Hands must be washed with an approved antimicrobial soap or alcohol-based hand sanitizer after treating a patient, after touching blood or any other body fluid or substance. After touching any object or surface that is or may be contaminated. As soon as gloves and other PPE are removed, before eating/drinking and after using the restroom." 2. On 5/21/18, between 9:55 AM and 11:10 AM, a tour was conducted of the Recovery Room. The following was observed:	T070	Our POC response is the same as TO70 in Exhibit B.	6/25/18

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE 6/25

EXHIBIT C

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
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T070	205.550 h) 1-5 (cont'd) -At approximately 9:58 AM, Pt. #1 was brought into the recovery room. Pt. #1 was a 23 year old female, admitted on 5/21/18 for pregnancy termination. A Health Education Counselor (E#2) and a Medical Assistant (E#3) were wearing gloves while assisting with the care of Pt. #1. At 10:17 AM, Pt. #2 was brought into the Recovery Room. Pt. #2 was a 28 year old female, admitted on 5/21/18 for pregnancy termination. After working with Pt. #1, both E#2 and E#3 went to care for Pt. #2 without changing their gloves or performing hand hygiene. - At approximately 10:20 AM, after assisting with the care of Pt. #2, E#2 went back to take off Pt. #1's nasal cannula (tubing that supplies oxygen via nose), without changing gloves or performing hand hygiene. E#2 then went to the sink area, opened a pack of crackers, removed them with her gloved hand, and placed them into a pink basin. E#2 gave the crackers and a cup of ginger ale to Pt. #1 to consume. E#2 continued to work between Pt. #1 and Pt. #2, without changing gloves or performing hand hygiene, until approximately 10:30 AM, when Pt. #1 was discharged. 3. During an interview on 5/23/18, at approximately 9:15 AM, the Assistant Administrator (E#1) stated that staff should be changing their gloves and washing their hands in between working with patients. E#1 stated, "Staff will need to be re-educated (on hand hygiene)."			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE: Chief of Operations | DATE: 6/25/18

Memo

To: **All staff**

From: **Administration**

Date: **6-22-2018**

RE: **Discharge of patients**

Please be advised that only a physician or nurse can discharge a patient once they have met the established discharge criteria.

If medical assistants are assisting in the Recovery room they will need to ask a physician or nurse to evaluate the patient and discharge that patient.

Americans United for Life

Memo

To: All staff

From: Administration

Date: 6-22-2018

RE: Medication Trays

Please be advised that medication trays used by the anesthesiologist cannot be left unattended. If the anesthesia provider needs to step away from the tray, the tray needs to be either locked up or assigned to a nurse if it is for a short period of time.

Nursing staff need to make sure that all medication trays are locked up expeditiously at the end of the procedure.

Americans United for Life

IN-SERVICE TRAINING RECORD

DATE: 6/25/18 TIME: 9:20 am

PRESENTOR: Infection Control Coordinator

TOPIC: Disinfectant Solution Preparation / Stability

OUTLINE:

Must follow Manufacturer's instructions
Discussion of Cetylcide II concentrate and how to dilute to 1:64 dilution. Use 2 ounces per gallon of water, then pour into clean Sprayer / Bottle.
Cetylcide II solution once prepared and poured into a sealed container is effective for 64 days. After 64 days it must be discarded and new solution made; do not add to old solution.
Open Containers / buckets are only good for daily use and must be discarded at end of day and not to be reused
New Labels have been created to document fill / exp date
ALL SPRAYERS / BOTTLES Must Be Labelled!

ATTENDEES:

NEW LABEL →

Cetylcide-II Disinfectant
Date started _____
Date to dispose _____
(dispose 64 days after start)

VERIFIED BY:

Americans United for Life

IN-SERVICE TRAINING RECORD

DATE: 6/25/18 TIME: 9:30 am

PRESENTOR: Infection Control Coordinator

TOPIC: Disinfectants used to clean procedure rooms.

OUTLINE:

Current disinfectants in use:
Cetylcide II spray - must remain wet for 10 minutes
Henry Schein Disinfecting Wipes - must remain wet for 2 minutes
Use wipe/towel per item and do not reuse on another surface.
Must follow manufacturer's instructions
Wipe down all OR tables/pads, carts, and any equipment use.
Demonstration of cleaning and disinfecting between cases.

Discussion of ideas for new products

ATTENDEES:

Sanjeeta Kumar MD

VERIFIED BY:

Americans United for Life

IN-SERVICE TRAINING RECORD

DATE: 5/25/18 TIME: 9:15 am

PRESENTOR: Infection Control Coordinator

TOPIC: Hand Hygiene / Glove Donning

OUTLINE:

When to wash hands / sanitize

1. Between Patient Contact
2. After / Before donning gloves
3. After Bathroom Use
4. Before Eating
5. Between Breaks

Discussion of new hand sanitizers and glove dispensers
Staff prefer Gel over foam

ATTENDEES:

Ch. Sampath Kumar, M.D

LILIA WIDKEND

K. Kinnaith, RN

VERIFIED BY:

Americans United for Life

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7003184	30195	8/22/19

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Access Healthcare Center	110 S. River Rd. #7, DesPlaines, IL 60016

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
000	A licensure survey was conducted on 8/22/19. The Facility was in compliance with TITLE 77: PUBLIC HEALTH CHAPTER I: DEPARTMENT OF PUBLIC HEALTH SUBCHAPTER b: HOSPITAL AND AMBULATORY CARE FACILITIES PART 205 AMBULATORY SURGICAL TREATMENT CENTER LICENSING REQUIREMENTS SECTION 205.710 PREGNANCY TERMINATION SPECIALTY CENTERS for this survey.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
7003184	15168/37971	04/19/2018

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Access Health Care Center, Ltd	110 S. River Road Suite7, Des Plaines, Illinois 60016

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
000	A licensure complaint investigation was conducted for complaint #182310 on 4/19/18 at Access HealthCare in Des Plaines. The Facility was in compliance with Title 77: Public Health Subchapter b: Hospital and Ambulatory Care Facilities Part 205 Ambulatory Surgical Treatment Center licensing requirements Section 205.710 Pregnancy Termination Specialty Centers, for this survey.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7003184	30195 & 19843	7/26/16

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Access Health Care Center	110 S. River Rd., Suite 7, Des Plaines, IL 60016

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T000	A licensure survey was conducted on 7/26/16. The Facility was not in compliance with Rules and Regulations for Pregnancy Termination Centers for this survey as evidenced by:			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE

TITLE ADMINISTRATOR

DATE 8/22/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7003184	30195 & 19843	7/26/16

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Access Health Care Center	110 S. River Rd., Suite 7, Des Plaines, IL 60016

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
T016	Policies and Procedures Manual 205.240 b) b) The procedures shall provide for the acceptance, care, treatment, anesthesia services, discharge, referral, and follow-up of all patients and all incidental operations of the facility. This Regulation is not met as evidence by: A. Based on document review, observation, and interview, it was determined, for 4 of 4 boxes of clinical records, the Facility failed to ensure clinical records were maintained in a secure location. This could potentially violate the privacy of the health information for approximately 140 patients undergoing procedures in the Facility each month. Findings include: 1. On 7/26/16 at 2:00 PM, Facility policy titled, "Protection of the Medical Record", effective 11/20/08, was reviewed. The policy required, "2. All patient records will be secured. a. Files will be locked at night... If the room is left unattended, the door will be locked" 2. On 7/26/16 at 9:00 AM, a tour was conducted of the Facility. The conference / break room was observed with the door wide open. The room contained a refrigerator, microwave, and coffee maker. The Office Manager (E #3) stated the room was used as a break room for staff. There were 4 large cardboard, file boxes observed under the table which contained patients' clinical records. 3. On 7/26/16 at approximately approximately 8:45 AM, an interview was conducted with the E #3. E #3 stated the boxes were going to be sent to storage. E #3 stated the room was not kept locked during the day, and a contracted janitorial service cleaned the room after office hours.		1) Policy and procedures were reviewed with the staff on Management of Information-HIPPA and Protection of Medical records. See attached Policy: HIPPA (T106A); Protection of Medical Records (T106B). 2) In-service/training were conducted with the staff on Protection of Medical Records. See attached In-service record and sign-in sheet (T106C). 3) All records were relocated in a secured room and access was reserved to Managers or er designee. 4) Activities will be monitored daily under the Performance Improvement Activities for the next 3 months, reported to the Manager monthly. PI activities will be evaluated for improvements and changes made if needed. See attached Performance Improvement Activities plan and form (T106D).	8/18/2016 8/18/2016 08/17/2016 8/18/2016

AGENCY MANAGER/REPPESENTATIVE'S SIGNATURE TITLE DATE 8/22/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7003184	30195 & 19843	7/26/16

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Access Health Care Center	110 S. River Rd., Suite 7, Des Plaines, IL 60016

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
T025	Equipment 205.410 a) Equipment shall be in good working order and shall be available in numbers sufficient to provide quality patient care based on the types of procedures to be performed in the facility. a) Monitoring equipment, suction apparatus, oxygen and related items shall be available within the surgical and postoperative recovery areas. Cardiac and pulmonary resuscitation equipment shall be available in all facilities. This Regulation is not met as evidence by: Based on document review, observation, and interview, it was determined, for 1 of 2 procedure tables, the Facility failed to ensure procedure tables were not taped or contained tape residue, potentially affecting the safety of approximately 140 patients undergoing procedures in the Facility each month. Findings include: 1. On 7/26/16 at 1:35 PM, Facility policy titled, "Equipment Management Plan", effective 11/20/08, was reviewed. The policy required, "... Monitor, and investigate, equipment management problems, failures, and user errors that have or may have an adverse effect on patient safety and/or quality or care." 2. On 7/26/16 at 9:35 AM, an observational tour was conducted of the procedure area. The procedure table in procedure room #2 included 3 areas of ripped cushion covering which was held together by pieces of thick tape. Tape residue was also present on the table, making appropriate disinfection of the table impossible. 3. On 7/26/16 at 1:40 PM, an interview was conducted with the Office Manager (E #3). E #3 stated the table in procedure room 2 was in need of repair and should not be in use.		1) A review of Policy & Procedure on Environment of Care - Titled: Equipment Management Plan and Infection Control-Infection Control Plan has been conducted (T025A; T025B). 2) New table was purchased (T025C). 3) Staff in-service/training has been conducted on Equipment Management Plan and Infection Control Plan (T025D). 4) Memo was written and posted for the staff on the importance of adhering to infection Control practices and emphasis on prohibition of the use of tapes on medical equipments (T025E). 5) Activities for monitoring adherence to Infection Contorl Policies was added in the Performance Improvement Activities, monitored daily for 3 consecutive months, evaluated monthly and will revise as needed (T025F).	8/15/2016 8/30/2016 8/18/2016 8/18/2016 8/18/2016

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE

TITLE

DATE 8/22/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7003184	30195 & 19843	7/26/16

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
T026	205.410 b) 1-3 b) The facility shall have written policies and procedures and shall maintain documentation governing the care, use, decontamination, sterilization, storage and disposal of all materials to ensure that an adequate supply of sterile equipment, instruments and supplies is available for each procedure. Written policies and procedures shall include documentation that the facility has considered, selected and implemented nationally recognized guidelines, including the Centers for Disease Control and Prevention publication, "Guidelines for Disinfection and Sterilization in Healthcare Facilities" or "Guide to Infection Prevention in Outpatient Settings"; or the Association of perlOperative Registered Nurses (AORN) publication "Perioperative Standards and Recommended Practices for Inpatient and Ambulatory Centers". The policies, procedures and documentation shall include and address: 1) Staff orientation and In-service training to understand and implement facility policies and procedures for infection control, and to adhere to manufacturer's instructions for receiving, decontaminating, cleaning, preparing, sterilizing and high-level disinfection, handling, storage and quality control of equipment, supplies and instruments; 2) Preventive maintenance of all central supply service equipment pursuant to manufacturer's instructions or infection control guidelines; and 3) The Infection Control Program (Section 205.550), which shall be under the direction of a designated qualified health care professional with training in infection control. This Regulation is not met as evidence by: A. Based on document review and interview, it was determined, for the biological log book from 1/2/10 through 7/19/16, the Facility failed to ensure biological indicator test results were accurately documented in the biological log book, potentially affecting approximately 140 patients having procedures each month. Findings include:			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE

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	7003184	30195 & 19843	7/26/16

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Access Health Care Center	110 S. River Rd., Suite 7, Des Plaines, IL 60016

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T026	205.410 b) 1-3 b) The Facility shall have written policies and procedures and shall maintain documentation governing the care, use, decontamination, sterilization, storage and disposal of all materials to ensure that an adequate supply of sterile equipment, instruments and supplies is available for each procedure. Written policies and procedures shall include documentation that the facility has considered, selected and implemented nationally recognized guidelines, including the Centers for Disease Control and Prevention publication, "Guidelines for Disinfection and Sterilization in Healthcare Facilities" or "Guide to Infection Prevention in Outpatient Settings"; or the Association of periOperative Registered Nurses (AORN) publication "Perioperative Standards and Recommended Practices for Inpatient and Ambulatory Centers". The policies, procedures and documentation shall include and address: 1) Staff orientation and in-service training to understand and implement facility policies and procedures for infection control, and to adhere to manufacturer's instructions for receiving, decontaminating, cleaning, preparing, sterilizing and high-level disinfection, handling, storage and quality control of equipment, supplies and instruments; 2) Preventive maintenance of all central supply service equipment pursuant to manufacturer's instructions or infection control guidelines; and 3) The Infection Control Program (Section 205.550), which shall be under the direction of a designated qualified health care professional with training in infection control. This Regulation is not met as evidence by: A. Based on document review and interview, it was determined, for the autoclave/ sterilizer, the Facility failed to ensure the sterilizer was cleaned weekly, as recommended by the Manufacturer, potentially affecting approximately 140 patients having procedures each month. Findings include:			

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T026	205.410 b) 1-3 1. On 7/26/16 at 2:40 PM, Facility policy titled, "Sterilizer Monitoring", effective 11/20/08, was reviewed. The policy required, "A Spore testing will be conducted... 3... The control test should be positive. 4. Record the results of the test on the spore [biological indicator] testing log..." 2. On 7/26/16 at 10:50 AM, the "3M Attest 1262/1262P Biological Indicator" Manufacturer's Instructions were reviewed. The instructions included, "The 3M Attest 1262 Biological Indicator... is designed for monitoring [the] steam sterilization process... 10. Incubate at least one unprocessed Attest biological indicator (positive control) each day when a processed indicator is incubated... 12. Incubate processed and control biological indicators for 48 hours... 14. Record the sterilized and biological indicator results..." 3. On 7/26/16 at 10:15 AM, the Biological Indicator Log was reviewed from1/2/10 through 7/19/16. All weekly biological indicator tests were recorded as negative. However, the weekly biological indicator control test results (positive/negative) had not been documented on the log for over 5 years. 4. On 7/26/16 at approximately 10:45 AM, during a tour of the sterile processing room, there were 2 biological indicators (1 control and 1 load indicator) observed in the incubator. The biological control indicator result was positive, and the biological indicator result was negative for this load. 5. On 7/26/16 at 11:00 AM, an interview was conducted with the Reprocessing Technician (E #1). E #1 stated the control biological indicator results have always been positive. E #1 stated the form used in the biological indicator log changed		1) A review of Policy on Infection Control titled: Sterilizer Monitoring; Documentation of Spore testing was done (T026A). 2) Policy review was done in Infection Control titled: Sterile Processing (T026B). 3) Policy revision/addendum was done on Sterile Processing (based on Manufacturer's Cleaning Recommendation of Magna Clave), presented to and approved by the Consulting Committee (T026C; T026D). 4) Staff in-service/Training was conducted and Spore testing form was revised (T026E). 5) Staff in-service/Training was conducted on the Policy Changes on Cleaning of AutoClave (T026F). 6) Monitoring will be added to the Performance Improvement Activities and will be monitored daily for the next 3 months, reported monthly and will be revised as needed (T026G).	8/18/2016 8/18/2016 8/22/2016 8/22/2016 8/22/2016 8/22/2016

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7003184	30195 & 19843	7/26/16

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T026	several years ago, and no longer included the column to record the control result. Therefore, E #1 did not document the result of the control test on this log. E #1 stated the former biological indicator log included a column to record both the control and sterilized test results,and the Facility would return to using that form and documenting both the control and test results. 205.410 b) 1-3 1. On 7/26/16 at 11:30 AM, the "Magna-Clave" autoclave/ sterilizer Manufacturer's Guidelines were reviewed. The Guidelines recommended, "4. Care and Maintenance: 4.01 It is highly recommended that the autoclave be cleaned a minimum of once a week..." 2. On 7/26/16 at 11:00 AM, the autoclave cleaning log for 2016 was reviewed. The log documented monthly cleaning, not weekly. 3. On 7/26/16 at 11:00 AM, an interview was conducted with the Reprocessing Technician (E #1). E #1 stated that the autoclave was cleaned monthly, and was not aware weekly cleaning was required.		205.410b) 1-3 1. Staff In-service/training was conducted and Policy and Procedures were reviewed and revised. 2. In-service training was conducted with the staff 3. In-service training was conducted with the staff	8/16/16 8/16/16 8/16/16

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7003184	30195 & 19843	7/26/16

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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T028	205.410 d) d) The facility shall have written procedures to assure the safety in storage and use of all narcotics and medications in accordance with State and federal law. This Regulation is not met as evidence by: A. Based on document review, observation, and interview, it was determined, for 2 of 2 anesthesia carts, the Facility failed to ensure anesthesia carts were locked when not in use, potentially affecting the safety of approximately 140 patients undergoing procedures in the Facility each month. Findings include: 1. On 7/26/16 at 10:00 PM, Facility policy titled, "Medication Policy", effective 11/20/08, was reviewed. The policy required, "H. Security: 1. Medications... should be kept locked or in areas where only appropriate staff members have access." 2. On 7/26/16 at 9:35 AM, an observational tour was conducted in the procedure area. Unlocked anesthesia carts were in both procedure rooms. Both carts contained several medications including Atropine Sulfate, 10% Calcium Chloride, Epinephrine, Labetalol, Toradol, and Diphenhydramine. 3. On 7/26/16 at 9:40 AM, an interview was conducted with a Registered Nurse (E#2). E #2 stated that she was checking the anesthesia cart in procedure room 2 for out dated medications and had not locked the cart. 4. On 7/26/16 at 9:40 AM, an interview was conducted with the Office Manager (E #3), who was present during the observational tour. E #3 stated that the carts should be kept locked.		1) A review of the Medication Management Policy: Medication Policy has been done (T025A). 2) Staff in-service was conducted and memo was passed regarding the Medication Policy (T028B). 3) Medication Policy Monitoring was added to the Performance Improvement Activities that will be conducted daily and reported monthly (T028C).	8/18/2016 8/18/2016 8/18/2016

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE

Illinois Department of Public Health

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T028	205.410 d) d) The facility shall have written procedures to assure the safety in storage and use of all narcotics and medications in accordance with State and federal law. This Regulation is not met as evidence by: B. Based on document review, observation, and interview, it was determined, for 1 of 1 multi-dose medication vial, the Facility failed ensure a vial of multi-dose medication was not available for used after being opened more than 28 days, potentially affecting the safety of approximately 140 patients undergoing procedures in the Facility each month. Findings include: 1. On 7/26/16 at 12:35 PM, Facility policy titled, "Expiration Dates", revised 3/12/13, was reviewed. The policy required, "C. Multi-dose vials, once opened, are good for 28 days." 2. On 7/26/16 at 9:35 AM, an observational tour was conducted in the procedure area. An open vial of Flumazenil, 10 ml (a benzodiazepine receptor antagonist - reverses sedation) was found in procedure room 2, in the anesthesia cart. The label included "12-1 - 12-28", perhaps indicating an open date of 12/01/(year unknown). 3. On 7/6/16 at 9:40 AM, an interview was conducted with a Registered Nurse (E#2). E #2 stated she did not know what the Anesthesiologist meant when writing "12-1 - 12-28", but the open vial should have been disposed of.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE

American Women's Medical Center - Des Plaines
STAFF TRAINING

Date: 8/18/14 Presented by: Perla Anicicte RN.

Purpose of Training: ☐ Orientation ☐ Annual Review ☐ QA Follow-up

Topics covered: Medical Records

1. Proper handling of Medical records updated
2. Hippa Compliance
3. Proper Storage of Medical Records

Attended By

Name	Title
Marie Frukacz	office Manager
Mariela Escampita	Atoclave Tech
Alejandra Perez	Medical Asst
Betty Dela Pena	Receptionist
PERLA ANICIETE RN	RN
Sylvia Elena	office supervisor
Monique Carpenter	MA
Magaly Napoles	Lab Tech

American Women's Medical Center - Des Plaines
Policy Manual

Section: Management of Information

Subject: HIPPA Notice of Patient Privacy Page 1 of 2

Approved By: Effective Date: 11-20-08 Revised:

I. PURPOSE

To comply with federal and state privacy laws.

II. POLICY

It is the policy of American Women's Medical Center - Des Plaines to inform patients of our management process to protect their Protected Health Information (PHI)

III. PROCEDURES

A. The Notice of Privacy Practices (NPP) is fundamental privacy document. The requirements for its preparation and use are detailed in the Privacy Rule, Section 164.520.

B. A proper NPP will inform the patient of all the basic uses the practice will make of a patient's Protected Health Information (PHI) in the ordinary course of providing treatment, seeking payment for care to the patient, and managing the practice's health care operations. The NPP also will apprise the patient of other circumstances in which their PHI may be released, such as to comply with court orders, subpoenas and government investigations.

C. The NPP advises patients of certain special rights they have:
1. To revoke any authorization or consent they may have given to the practice to authorize disclosures of their phi (usually for non-TPO purposes);
2. To request special limits or conditions on the use of their phi;
3. To receive communications from the practice by more confidential means or at alternate locations;
4. To inspect and copy their phi; and
5. To amend their phi.

D. This NPP should be acknowledged by all patients receiving service after the compliance date for the Privacy Rule, April 14, 2003.
1. The practice must make a good faith effort to obtain the patient's acknowledgment of receipt of the NPP from the patient and/or his/her legal representative/caregiver.
2. If the patient is unable or unwilling to acknowledge receipt of the NPP, a staff person will document that he/she attempted to obtain this acknowledgment, but the patient would not or could not acknowledge its receipt.

Individual Rights
You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

American Women's Medical Center - Des Plaines Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information
As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to gain access to your records by contacting our receptionist or privacy officer.

Complaints
If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filling a complaint.

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns.

Contact Person
The name and address of the person you can contact for further information concerning our privacy practices is:

Office Manager
American Women's Medical Center - Des Plaines
110 S. River Rd., Suite 7.
Des Plaines , Illinois 60616
Phone: (847) 294-9614

This Notice is effective on or after April 14, 2003

Americans United for Life

American Women's Medical Center - Des Plaines
Policy Manual

Section: Management of Information

Subject: Protection of the Medical Records Page 1 of 2

Approved By: _____ Effective Date: 11-20-08 Revised: _____

I. POLICY

It is the policy of American Women's Medical Center - Des Plaines to restrict access to medical records to authorized personnel only.

II. PROCEDURE

A. The medical record is the property of American Women's Medical Center - Des Plaines and is maintained for the benefit of the patient, the medical staff and other health care workers.
   1. All required records, either as originals or accurate reproductions of the contents of such originals, shall be maintained in such form as to be legible and readily available upon request of the physician, or any other person authorized to make such a request.
   2. All patient records will be secured.
      a. Files will be locked at night.
      b. The medical record room will be locked at night.
      c. The medical record room will not be left unattended during working hours.
      d. If the room is left unattended, the door will be locked.
   3. American Women's Medical Center - Des Plaines shall safeguard all information in the medical record against loss, defacement, tampering, or use by unauthorized persons.
      a. Adequate measures will be taken to physically safeguard the medical record from loss by fire, water and foreseeable sources of potential damage.
      b. Records will be removed from the facility only by court order, subpoena or statute.
      c. Written consent of the patient or legally qualified representative is required for release of information from the medical record.
      d. Records shall be signed out when removed from the facility.
      e. Access to computerized patient information is controlled through the use of access codes.

B. The Office Manager is responsible for supervising and maintaining the medical records system.
   1. This includes, but is not limited to the following activities:
      a. Supervising staff in the collection, processing, maintenance, storage, timely retrieval, and distribution of medical records;
      b. Retention of active medical records;
      c. Retirement of inactive medical records;
      d. Timely entry of data into the medical records;

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Policy Manual

Section: Management of Information

Subject: Protection of the Medical Records Page 2 of 2

Approved By: _____ Effective Date: 11-20-08 Revised: _____

e. Maintaining the confidentiality, security, and physical safety of the medical records;
f. Maintaining the unique identification of each patient's medical record;
g. Maintaining a log of records leaving the facility;
h. Obtaining the patient's, or the patient's legally authorized representative, authorization prior to the release of patient records.

2. Orienting and training staff regarding the medical records system.
   a. Patients will not be discussed by clinical or non-clinical personnel outside of the organization;
   b. Comments and conversations relating to patients made by physicians, nurses or other personnel will be made in confidential settings.
   c. The patient's medical record will not to be released to other individual(s) without a written release of information signed by the patient and/or his/her representative.

American Women's Medical Center - Des Plaines
STAFF TRAINING

Date: 8/18/16 Presented by: Perla Aniceto RN

Purpose of Training: ☐ Orientation ☐ Annual Review ☐ QA Follow-up

Topics covered: Equipment MANAgement

1. functionality of equipment before each procedure day.
2. Maintenance
3. Reporting to MANAgement of failure or error of equipment

Attended By

Name	Title
Mariela Escarpita	Autoclave. Tech
Betty DeLaPena	Receptionist
Mary Frukacz	office manager
PERLA ANICETE	RN
Magaly Napoles	Lab Tech
Monique Carpenter	MA
[illegible]	office Supervisor
Alejandra Perez	Medical Assc

American Women's Medical Center – Des Plaines
Policy Manual

Section: Environment of Care

Subject: Equipment Management Plan Page: 1 of 4

Approved by: _____ Effective Date: 11-20-08 Revision Date: 08-29-11

I. PURPOSE

The purpose of the Equipment Management Plan is to implement and maintain an Equipment Management Plan that controls and reduces the risk of medical equipment for the diagnosis and treatment of patient care.

II. POLICY

It is the policy of American Women's Medical Center - Desplaines to promote the safe and effective use of medical equipment.

III. SCOPE

The Equipment Management Plan applies to all fixed and portable medical equipment used within the facility.

IV. OBJECTIVES

- Establish written criteria for identifying, evaluating, and taking inventory of medical equipment to be included in the management plan before the equipment is used.
- Assess and minimize clinical and physical risks of equipment use through inspection, testing, and maintenance.
- Monitor and act on equipment hazard notice recalls.
- Report incidents in which a medical device is connected with the death, serious injury or serious illness or any individual as required by the Safe Medical Device Act of 1999.
- Monitor, and investigate, equipment management problems, failures, and user errors that have or may have an adverse effect on patient safety and/or the quality of care.

V. RESPONSIBILITIES

A. The President or his/her designee is responsible for selecting and acquiring all medical equipment and ensuring the proper functioning and maintenance of all equipment that has to do with the safety of staff and patients.

B. The Office Manager is responsible for the implementation of the Equipment Management Plan.

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Section: Environment of Care

Subject: Equipment Management Plan Page: 2 of 4

Approved by: _____ Effective Date: 11-20-08 Revision Date: 08-29-11

VI. PROCESSES OF THE EQUIPMENT MANAGEMENT PLAN

A. Medical equipment is inventoried by the Office Manager to assess:
   1. Equipment function,
   2. Physical risks associated with use,
   3. Maintenance requirements, and
   4. Equipment incident history.

B. Incident Reporting and Investigation
   1. Any equipment management problems, failure or user error should be reported to the Office Manager.
   2. All hazard notices and equipment recalls are to be sent to the Office Manager.
   3. Equipment malfunctions will be tracked by the Office Manager and reported to the Performance Improvement Committee quarterly.
   4. The Office Manager will report to the manufacturer, and/or the FDA any equipment that is connected to the serious injury, illness, or death of any individual. (Required by the Safe Medical Devices Act of 1990)
   5. The equipment will be tagged as "out of order, do not use".

C. Inspect, Test and Maintain Equipment
   1. All electrical equipment in patient care areas must be inspected by a Bio- Medical engineer annually and prior to initial use.
   2. Maintenance records should be kept on medical equipment to provide contact information on the manufacturer, service representative, date of service and description of service.
   3. Critical equipment such as a defibrillator, cardiac monitors and anesthesia machines will be checked prior to the first procedure of the day.
      a. Logs will be kept that reflect this check, and the individual doing the testing will initial upon completion.
      b. In the event that a piece of critical equipment (i.e. defibrillator) malfunctions, surgery will be canceled until fixed and inspected by a bio-medical engineer, or a loaner obtained.
      c. Alarms on medical equipment will be tested monthly.
   4. Sterilizers will be monitored based on manufacturer's instructions.
      a. Each pack/tray is monitored to ensure the proper temperature was reached and a log kept that reflects the date, and initials of the individual performing this task.
      b. Spore testing is performed based on volume; but at least monthly.

American Women's Medical Center – Des Plaines
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D. Orientation and Training

1. The Office Manager is responsible for training all employees who will be using medical equipment during orientation or prior to use on the following:
   a. Capabilities, limitations, and special applications of the equipment.
   b. Basic operating and safety procedures.
      i. Manufacturer's directions are to be followed at all times,
      ii. All manuals for equipment will be kept in the area of use.
   c. Emergency procedures in the event of equipment failure.
      i. Specific procedures in the event of equipment failure;
      ii. When and how to perform emergency clinical interventions when medical equipment fails;
      iii. Availability of backup equipment; and
      vi. How to obtain repair services.
   d. Information and skills necessary to perform the necessary maintenance; and
   e. How to fill out an incident report on equipment failure, malfunction, or user error.
2. Training can be met by classroom activities, one-on-one discussions or through the completion of a self-study packet.
3. All training is documented in the employee's personnel file.

E. Performance Monitoring

1. The Office Manager is responsible for coordinating the performance monitoring process for the Equipment Management program.
2. Performance standards to be monitored is the responsibility of the Office Manager in collaboration with the Performance Improvement Committee.
3. Performance Standards relate to one or more of the following:
   a. Staff knowledge and skills;
   b. Level of staff participation;
   c. Monitoring and inspection activities;
   d. Emergency and incident reporting, or
   e. Inspection, preventive maintenance and testing of equipment.

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Section: Environment of Care

Subject: Equipment Management Plan Page: 4 of 4

Approved by: _____ Effective Date: 11-20-08 Revision Date: 08-29-11

4. Summaries of findings and recommendations, based on trends, performance measures, and performance improvement activities will be documented quarterly by the Performance Improvement Committee.
5. Specific information will be communicated to staff when issues or opportunities to reduce the risk of equipment hazards exist.

F. Annual Review

1. The Office Manager in collaboration with the Performance Improvement Committee is responsible for the annual review of the Equipment Management Plans' objectives, scope, performance, and effectiveness.
2. The annual review will be compiled at the end of the year based on information from a variety of sources including, but not limited to: incident reports of equipment failure and user errors; product safety recall notices; staff orientation and training; Performance Improvement Committee minutes; performance monitoring activities; and other summaries of activities, including the findings of regulatory agencies.
3. The annual review will be presented to the Board of Directors during the first quarter of the following year in a narrative report that covers the Equipment Management Plans' objectives, scope, performance and effectiveness.

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Section: Infection Control

Subject: Infection Control Plan

Approved By: M Spuka Effective Date: 11/20/08 Effective Date: 11-10-2011 7-31-2014 7-30-2015

IV. STRATEGIES TO MINIMIZE, REDUCE OR ELIMINATE PRIORITIZED RISKS

A. General Precautions
1. Hand washing—Hand washing will be performed to prevent cross-contamination between patients and personnel.
   a. Alcohol-based hand cleaner available in each room.
   b. Monitor staff for handwashing.
2. Needles, Syringes and Sharps—After use, needles and other sharps will be placed directly into a puncture-proof container.
   a. Needles should not be re-capped, bent, broken or clipped; however,.needles may be re-capped (e.g., after pre-filling syringes) using the one-handed method or a safety device.
3. Laboratory specimens will be transported in a zip-lock bag or other leak-proof container. The leak-proof container will be transported to the lab site in a puncture resistant container that is properly labeled.
4. Eating, drinking, smoking, applying makeup or lip-balm or handling contact lenses will be avoided in work areas where there is a reasonable chance of exposure.
5. Sterile technique will be employed for sterile dressing changes, IV insertion, and whenever appropriate to prevent infection.
6. Multi-use vials will be swabbed with alcohol after use and kept until expiration date, so long as solution is not cloudy.
7. Sterile supplies are kept separate from non-sterile supplies.
8. Patient care items are not placed under sinks. (Only cleaning supplies).
9. Staff are to report any potential risk of safety/infection control to the Surgical Coordinator.

B. Personal Protective Equipment
1. Gloves are to be changed between patient contacts.
2. Sterile gloves are to be worn for sterile procedures.
3. Utility Gloves—rubber household gloves, for housekeeping duties involving potential blood contact and for instrument cleaning and decontamination procedures. Utility gloves may be decontaminated and reused, but will be discarded if they are peeling, cracked, or discolored, or if they have punctures, tears, or other evidence of deterioration.
4. Gowns—The use of gowns is required when splashes to the skin and/or clothing is likely. The gowns will be made of or lined with fluid-proof or

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Approved By:_____ Effective Date:_____ Effective Date:_____

fluid-resistant material and will protect all areas of exposed skin. The type and characteristics will depend on the task and degree of exposure anticipated.

5. Mask/Protective Eye Wear—Masks, protective eye wear, or face shields are required when contamination of mucosal membranes, eyes, mouth or nose is possible, such as splashes or aerosolization of material. They are not required for routine care.

C. Labels

1. Biohazard labels will be used to prevent accidental injury or illness to personnel exposed to hazardous or potentially hazardous conditions.
2. Labels will state BIOHAZARD or display the hazard symbol.
3. Labels will be affixed as close as possible to respective hazards.
4. Labels will be used to identify equipment and containers containing hazardous agents.
5. If labels are not used, other effective means will be used, such as RED bagging.

D. Housekeeping and Hygiene

The following guidelines will be implemented and taught to staff:

1. All equipment, environmental and working surfaces shall be cleaned and decontaminated after contact with blood or other potentially infections materials.
2. Blood/body fluid spills can be mopped or wiped up with hot soapy water and then disinfected with bleach or hospital disinfectant spray. Disposable gloves must be worn.
3. An appropriate disinfectant will be used to clean floors, toilet bowl, sink, counter tops and soiled furniture, when appropriate.
4. Rooms will be kept well aired to decrease the risk of colds, flu and other airborne communicable disease.
5. Humidifiers and air conditioners can harbor infectious organisms, and will be cleaned and serviced regularly.
6. All bins, pails, cans (e.g., wastebaskets) intended for reuse, which have a reasonable likelihood for becoming contaminated with blood and other potentially infectious materials, will be inspected and decontaminated immediately, or as soon as feasible upon visible contamination.
7. Linen, clothing, or other materials that are visibly contaminated with blood, body fluids or other infectious materials must be placed in bags or

containers that are impervious to moisture, before transport for cleaning. Gloves must be worn while bagging these materials.

8. Single-use disposable medical devices will not be reused, except for those not requiring maintenance of sterility.

E. Contagious diseases in local demographic population

1. Stay informed on infections occurring locally through local newspapers, radio, television and alerts from local hospitals.
2. Assist in providing care to patients as directed by local, regional, or state authorities.
3. Send patients with contagious diseases to Emergency Room or Emergency Care/Urgent Care Centers.
4. Close office if large influx of infectious patients (i.e. bird flu).
5. Reopen when third party responders (city, state, or department of public health) state it is appropriate to resume service.

V. EDUCATION OF PERSONNEL

A. American Women's Medical Center - Des Plaines will educate all personnel on infection control policies and procedures and their responsibilities for implementation as contained throughout this section.

B. Personnel will be provided training on the basics of transmission of pathogens to patients and staff, bloodborne diseases, the use of Universal Precautions. handwashing, infectious waste management and other infection control procedures when their work activities, as indicated below, may result in an exposure to blood, other potentially infectious materials, or under circumstances in which differentiation between body fluid types is difficult or impossible.

C. Staff and Licensed Independent Contractors will receive Influenza Vaccine training annually, on on the control and prevention measures; and the diagnosis, transmission, and impact of influenza.

1. Influenza Vaccine will be offerred annually by the organization. If not purchased and provided in-house, reimbursement for the vaccine will be given to staff and LIP's who elect to have it.
2. Infection control training will be scheduled annually.
3. A goal or 40% has been set for having staff vaccinated against the flu.

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Section: Infection Control

Subject: Infection Control Plan Page 5 of 5

Approved By:_____ Effective Date:_____ Effective Date:_____

D. Attendance will be mandatory and will be documented.

E. Records of in-training attendance will be maintained.

VI. MONITORING AND EVALUATION OF INFECTION CONTROL

A. The infection control plan will be monitored and evaluated by the Performance Committee.
   1. Infection control data will be collected, analyzed and trended. Information obtained will be given to the Surgical Coordinator or designee, and used to improve patient care, as well as improve practice's performance in the implementation of its infection/exposure control plan.
   2. The Surgical Coordinator will be responsible for reviewing and reporting the infection control plan to the Board of Directors and other appropriate authorities.
   3. Any health care associated infection that results in death or a major loss of function will be managed as a sentinel event.
      a. A root cause analysis and action plan will be developed.
      b. JCAHO will be notified.

B. Resources available on the internet:
Association for Professionals Infection Control & Epidemiology: www.apic.org
Centers for Disease Control: www.cdc.gov
Occupational Safety Health Administration: www.osha.gov

KINGS
HEALTHCARE FINANCE

Sales Invoice

Two Conway Park
150 North Field Drive - Suite 193
Lake Forest, IL 60045
847.264.5560

Invoice Number:	KBH02049
Date:	08/03/2016
Authorized by:	JTL
Ship via:	Ground
Ship to attn:	Arnold
Ship by date:	TBD

Issued To:
Access Health Care Center
110 S. River Rd.
Suite 7
Des Plaines, IL 60016
ATTN: SOPHIA DEMAS

Qty	Description		
1	AMSCO 2080L Refurbished Surgical Table	$	5,950.00
1	Discount	$	(400.00)
1	Old Table Trade-Credit	$	(200.00)
1	Moving Credit	$	(100.00)

***** Payment Must Be Made In Full to Initiate Shipment *****

***** One Year Parts Warranty *****

	Subtotal	$	5,250.00
	Tax rate		10.25%
	Sales tax	$	538.13
"White Glove" delivery of Refurbished table and removal of current table.	Shipping	$	675.00
	Total	$	6,463.13

Acceptance Signature **Date** **PO #**

Purchase order number must appear on all invoices and correspondence.
Please Return Via email (jlueken@kingsbridgeholdings.com) or Fax 847.574.8025

CUSTOM UPHOLSTERY BY JOE,INC.

2452 E.OAKTON ST.
ARLINGTON HEIGHTS, IL 60005
TEL(847) 956-6803
FAX(847) 956-6807

Invoice

DATE	INVOICE #
8/22/2016	15316

BILL TO
ACCESS HEALTH CENTER 110 S. RIVER RD DES PLAINES IL 60016 847-294-9614

P.O. NO.	TERMS	DUE DATE	SHIP DATE
MARIE	C.O.D	8/22/2016	8/23/2016

QTY	DESCRIPTION	RATE	AMOUNT
1	EXAMINING TABLE (FABRIC DUBOIS CHAMEA CY 34 SPICE)	450.00	450.00
	PICK UP & DELIVERY	0.00	0.00

Thank you for your business.

Total $450.00

(830) 643 6275
(937) 526-3662
Midmark Sales Corporation
Versailles Ohio 45380

Email: awmcmf@sbcglobal.net

CUSTOMER ACKNOWLEDGEMENT

BILL TO:

Access Healthcare Center
110 S River Rd Ste 7
DES PLAINES, IL, 60016,
United States

SHIP TO:

Access Healthcare Center
110 S River Rd Ste 7
DES PLAINES, IL, 60016,
United States

MARK FOR:

SO NUMBER	PO NUMBER
189680	MARIE
AGREEMENT	SALESPERSON
	NSC-Domestic Medical
ORDER DATE	PAYMENT TERMS
08/11/2016	Credit Card
METHOD OF SHIPMENT	DROP SHIP PO
UPS-Parcel-Ground	
TERMS OF SALE	FREIGHT TERMS
FOB Factory	Prepaid FA

Line	Ordered Item	Item Description	Sched Ship Date	Qty	Unit Price (USD)	Extended Price (USD)
1	053-0387-00	PIVOT BOSS	08/12/2016	3	1.70	5.10
2	016-0400-00	SPRING - STIRRUP INDEX	08/12/2016	4	0.50	2.00
3	050-5027-00	STIRRUP BRACKET	08/12/2016	3	6.00	18.00
				Subtotal:		25.10
				Additional Charges:		9.99
				Tax Total:		1.58
				Total (USD):		36.67

Order Notes:
CONTACTS FOR ORDER: Ext: 128320 Lynn U
Department: Medical CX
Ordered By: MARIE FRUKACZ 847-294-9614

Your order is shipping from the following: Versailles, OH Warehouse.

Freight Service(s) Required:
Shipping and Handling

RETURNED GOODS: All returned items must be accompanied by a returned goods authorization (RMA) number. Merchandise can be returned only with our permission, subject to a restocking and handling charge. You can obtain this number from our sales/service department by calling 1-800-MIDMARK.

Acceptance of this order is expressly conditioned on the applicability of Midmark Sales Corporation's Terms and Conditions of Sale, which are incorporated herein by reference. The Terms and Conditions of Sale are available at www.Midmark.com or a copy will be provided upon request. This is to certify that the merchandise listed on this order has been produced in compliance with the Fair Labor Acts of 1938 as amended.

Americans United for Life

American Women's Medical Center - Des Plaines
Policy Manual

Section: Infection Control

Subject: Sterilizer Monitoring Page 1 of 1

Approved By: _____ Effective Date: 11-20-08 Revised: _____

I POLICY

It is the policy of American Women's Medical Center - Des Plaines to monitor the efficacy of the sterilizing process to insure the sterility of instruments, and to maintain a documented monitoring control system to meet national guidelines.

II. PROCEDURES

A. Spore testing will be conducted for routine loads, and on every load for implantables.
   1. Biological indicators are placed in a test pack representative of the load.
   2. When removed the vial (results test) is place in a biological spore testing machine with a biological indicator vial (control test) that has not been placed in the sterilizer.
   3. After the appropriate time has elapsed (24 to 48 hours), read the results. The indicator in the results test should be negative (–); the control test should be positive (+).
   4. Record the results of the test on the spore test log, and initial as confirmation of physical parameters being attained.

B. If the results of the spore tests from the vial placed in with the instruments is positive, the sterilizer is not used, and the tests are reported to the Clinical Coordinator.
   1. The Clinical Coordinator will perform a second test. If the second test is positive the sterilizer is repaired, and not used until all tests are negative.
   2. All instruments and packages processed with a positive test result are pulled from the shelves and re-sterilized.
   3. The spore test log with a positive test will be compared to the surgical log. Patients identified will be called and asked to come into the office to check for infection

American Women's Medical Center - Des Plaines
Policy Manual

Section: Infection Control

Subject: Sterile Processing

Approved By: _____ Effective Date: 11-20-08 Revised: _____

I. POLICY

It is the policy of American Women's Medical Center - Des Plaines to provide guidelines in sterile processing.

II. PROCEDURES

A. There must be proper ventilation, adequate lighting for task illumination, and order and neatness in work areas.

B. All equipment used in sterile processing must be checked for electrical and mechanical safety, prior to use.
   1. Any defective equipment must be removed from service, repaired and rechecked.
   2. Safety regulations concerning the operation of all equipment must be strictly adhered to.
   3. Preventive maintenance on sterile processing equipment is performed on a periodic basis, but no less than annually.
   4. Documentation of inspection and preventive maintenance must contain date of inspection and service, type of service performed and signature. These reports must be on file.

C. All personnel using sterile processing equipment must be well trained in the handling, care and use of equipment and supplies.

D. Manufacturers' safety instructions must be on the equipment in view of the operator, and equipment manuals must be on file and accessible to all operators of the equipment.

E. Personnel operating sterile processing equipment must be:
   1. Warned of all dangers and possible consequences,
   2. Instructed in how to prevent and avoid accidents; and
   3. Informed of proper emergency measures to take, should an accident occur.

F. In case of accident, it must be reported on an Incident Report.

American Women's Medical Center

Memo

To: AWMC Staff & Anesthesiologist

From: Sophia

CC: Dr. Xia

Date: August 18, 2016

Re: Medication

Please be advised that all medication stored in carts should be locked at the end of the day.

It is the responsibility of the Nurse and Anesthesiologist to make sure all **medication is properly locked**.

Americans United for Life

American Women's Medical Center - Des Plaines
STAFF TRAINING

Date: 8/18/16 Presented by: Perla Anicieta RN

Purpose of Training: ☐ Orientation ☐ Annual Review ☐ QA Follow-up

Topics covered: Medication

Medication

① Refresher course of importance of Medication carts locked

② checking of expiration dates on Medicaton

Attended By

Name	Title
Betty Des R	Receptionist
S Klem	office Supervison
Maria Frukacz	office manager
Mariela Escapita.	Autoclave Tech
~~Perla Anicieta~~	RN
Monique Carpenter	MA
Maggly Napoles	Lab Tech
Alejandra Perez	Medical Asst

American Women's Medical Center - Des Plaines
Policy Manual

Section: Medications Management

Subject: Medications Policy Page 1 of 5

Reviewed and Approved By: Ayn Effective Date 11.20.08

I. POLICY

It is the policy of American Women's Medical Center - Des Plaines to ensure the safety of patients through the proper ordering, storage, preparation, reconciliation, administering , prescribing, security and monitoring of medications(s).

II. PROCEDURES

A. Medications
1. All medications administered to patients will be those approved by the Food and Drug Administration.
2. Medications used for anesthesia will be determined for use by the Anesthetist.
3. If medications are not available within the facility, they will be obtained from a local pharmacy.
4. Medications to be administered within this facility may not be brought into the facility by a physician or patient.

B. Ordering
1. Only physicians may order medications to be used at American Women's Medical Center - Des Plaines.
2. A list of all medications kept in the facility will be maintained.
   a. This list will include the medication name, strength, dosage and form.
   b. The list will identify high-risk, and look-alike, sound-alike medications, and these medications will be reviewed annually.
3. All orders for treatment, including medications, will be in writing. A verbal order will be considered to be in writing, if dictated and signed by the physician.

C. Storage
1. All medications are to be checked in and stored appropriately by the Medical Assistant/ Nurse / Surgical Tech.
2. All medications are stored based on the manufacturer's directions.
   a. If medications are to be refrigerated, they are kept in a refrigerator that does not contain food products or specimens.
   b. The refrigerator's temperature is monitored daily and logged.
3. All medications will be inspected upon shelving and stocking for color, clarity, product integrity and expiration date.
4. Dry packaged materials should be placed on shelves above liquid medications. (If spillage occurs, there is less chance of spoilage).

American Women's Medical Center - Des Plaines
Policy Manual

Section: Medications Management

Subject: Medications Policy Page 2 of 5

Reviewed and Approved By: _____ Effective Date 11-20-08

5. Chemicals, reagents and medications that look alike and/or sound alike, are segregated from each other so that they may not be mistaken.
6. Concentrated electrolytes are stored separately from patient care areas so that they are not immediately available.
7. Emergency medications are consistently available, controlled and secured.
   a. Emergency medications are controlled and secure in patient care areas, and in the operating/procedure room area(s).
   b. Emergency medications are sealed or stored in containers that are clearly labeled so that staff can determine that the contents are complete and medications have not expired.
8. The Clinical Coordinator is responsible for ensuring that expiration dates of all medications are checked monthly.
   a. Medications that are expired, contaminated or damaged are removed from stock and segregated from other medications until removed from the facility.
   b. The Clinical Coordinator will dispose of all expired medication.

D. Preparation
1. Staff should use techniques to assure accuracy in medication preparation.
   a. Use of clean, sterile techniques.
   b. Maintain clean, uncluttered separate areas for preparation.
   c. Visually inspect integrity of all medications.
2. Syringes and needles are sterile, single patient-use items.
   a. Disposable plastic syringes should not be refilled after the original contents have been injected.
   b. Medications from a single syringe must not be administered to multiple patients, even if the needle on the syringe is changed.
   c. After entry into or connection with a patient's intravenous infusion, the syringe and needle are contaminated and used only for that patient.
   d. Contaminated syringes and equipment should be kept separate from clean, unused syringes.
   e. After use, used syringes and needles should be discarded immediately in an appropriate, puncture-resistant container.
   f. Unused syringes, needles, and related items should be stored in a clean area away from patients to avoid contamination.
3. Medications drawn up must be administered immediately, or labeled.
4. Expiration time for a drug drawn into a syringe.
   a. Medications should be drawn up into a sterile syringe as close as possible to the time of administration.
   b. All drugs drawn into a syringe should be discarded within 24 hours or when completely used, whichever comes first.

(1) An assembled, non-contaminated, prefilled syringe, containing medication not formulated in a lipid emulsion, can be kept for later use.
(2) Medication formulated as a lipid emulsion must be discarded within 6 hours after the ampule, vial or prefilled syringe is opened.
(3) A syringe containing a lipid emulsion (propofol) must be labeled with the date and time opened so that disposal after 6 hours is ensured.

4. Multidose Vials
   a. If aseptic technique is consistently used, an uncontaminated multidose vial may be used until the manufacturer's expiration date.
   b. If contamination has occurred, or if sterility is questionable, the vial should be discarded.
   c. Each time a multidose vial is entered, aseptic technique should be used, including cleansing the rubber stopper with alcohol and using a sterile needle and syringe.

E. Reconciliation Process
1. A list of current medications will be developed by asking all new patient's for a list of their current prescriptions, over-the-counter drugs, vitamins and/or minerals.
2. This list will be reviewed with the patient prior to administering and/or prescribing any medication.
3. This list will be placed in a consistent, highly visible location within the patient chart.
4. Medications to be administered or prescribed will be reviewed against this list for potential adverse interactions.
5. The list is updated with medications administered that may have an effect on the patient after he/she leaves the office.
6. The list should be updated with any sample medication or prescription given to the patient.
7. The list should be reviewed with the patient prior to discharge so that he/she understands how to take the medication(s), and how long to continue taking any newly prescribed medication.
8. A copy of the list should be given to the patient and communicated to the next provider of care when the patient is referred or transferred to another provider or level of care.

American Women's Medical Center - Des Plaines
Policy Manual

Section: Medications Management

Subject: Medications Policy Page 4 of 5

Reviewed and Approved By: _____ Effective Date 11.20.08

F. Administration
1. Prior to the administration of any medication, a reconciliation process will occur to ensure the patient is receiving all medications necessary, and to eliminate any medications that are no longer needed and/or do not react with what the patient is currently taking (prescriptions, over-the-counter drugs, vitamins and/or minerals).
2. A physician must give the medication order, which should include the patient name, drug name in full, time or schedule, and route of administration.
   a. Written orders must be legible and entered on the patient chart.
   b. Only the physician or a registered nurse may administer any medication.
3. Medications are administered only afer the following:
   a. Medication selected is the correct one based on the medication order and product label.
   b. Medication is visually inspected for particulates or discoloration and expiration date.
   c. There is no contraindication for administrating the medication.
4. All medications administered to a patient must be documented in full: patient name, date, time, drug name, dose, route and response.

G. Prescribing
1. Complete medication orders contain the name of the drug, strength, dosage form, route of administration, and dosage regime.
2. "Blanket orders," "continue previous meds," "resume preoperative meds" and "discharge on current meds" is not acceptable as they are not clear or complete.

H. Security
1. Medications, prescription pads, needles and syringes should be kept locked or in areas where only the appropriate staff members have access.
2. If medications are kept in an area that is unlocked, the area must be visible by staff.

American Women's Medical Center - Des Plaines
Policy Manual

Section: Medications Management

Subject: Medications Policy Page 5 of 5

Reviewed and Approved By: _____ Effective Date 11-20-08

I. Monitoring of Medications
   1. Medications will be monitored for risk points, and areas for improvement will be identified.
      a. Medications will be monitored monthly for outdates.
      b. Refrigerated medications will be monitored for temperature, and that no food is not placed in the medication refrigerator.
      c. Integrity locks on Crash Carts and Emergency Kit Medications will be monitored weekly.
   2. Any "significant"medication error or adverse drug reaction will be considered an adverse outcome and a root cause analysis will be preformed with appropriate, interdisciplinary staff.

American Women's Medical Center - Des Plaines
STAFF TRAINING

Date: 8/18/16 Presented by: M. FRUKACZ

Purpose of Training: ☒ Orientation ☐ Annual Review ☐ QA Follow-up

Topics covered: Spore Testing.

Attended By:

Name	Title
Mariela Escarpita.	
Sara Mendez	office manager.
Mara Frukacz	office manager
Berta De La Peña.	receptionist.
Perla Canela	RN
Monique Carpenteos	Autoclave Tech.
Alex Perez	MA

American Women's Medical Center - Des Plaines
STAFF TRAINING

Date: 8/18/16 Presented by: M. FRUKACZ

Purpose of Training: ☒ Orientation ☐ Annual Review ☐ QA Follow-up

Topics covered: Cleaning of Autoclave

Attended By:

Name	Title
Berta De La Pena	receptionist.
Maria Frukacz	office Manager
Sophia Ulenda	office MANAG.
Perla Daniele	RN

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

April 14, 2016

Renlin Xia, Administrator
Access Health Care Center, Ltd.
110 S. River Road, Suite 7
Des Plaines, IL 60016-

Re: Access Health Care Center, Ltd.
Des Plaines
Licensure survey

Dear Renlin Xia:

On April 12, 2016, a life safety code licensure monitoring survey was conducted at the above Ambulatory Surgical Treatment Center to verify completion of your Plan of Correction. All previously cited deficiencies have been corrected; therefore, the facility is no longer under monitoring.

If you have any questions, please do not hesitate to call us at 217/785-4247. The Department's TTY # is 800/547-0466, for use by the hearing impaired.

Sincerely,

[redacted]

Mujeeb Ahmed, Project Designer
Design and Construction Section
Division of Life Safety and Construction

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
7002850 Y1	A. Building 01 - MAIN BUILDING B. Wing Y2	4/12/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESS HEALTH CARE CENTER LTD	110 SOUTH RIVER ROAD SUITE 7 DES PLAINES, IL 60016

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix L0046	Correction	ID Prefix L0050	Correction	ID Prefix L0051	Correction
Reg. # 20.2.9.1/21.2.9.1	Completed	Reg. # 21.7.1.2	Completed	Reg. # 20.3.4/21.3.2	Completed
LSC	04/12/2016	LSC	04/12/2016	LSC	04/12/2016
ID Prefix L0077	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 21.3.2.2	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/12/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
2/9/2016	☐ YES ☐ NO

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7002850	A. BUILDING: 01 - MAIN BUILDING B. WING _____	R 04/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESS HEALTH CARE CENTER LTD	110 SOUTH RIVER ROAD SUITE 7 DES PLAINES, IL 60016

(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
{L 000}	Initial Comments The Illinois Department of Public Health (IDPH) conducted an onsite Life Safety Code Licensure Periodic inspection on February 9, 2016. Access Health Cre Center, Ltd.is a Pregnancy Termination Center (PTC) located at 110 S. River Road, Suite 7, Des Plaines, IL. The surveyor met with and toured the facility with two office managers of the facility . The cneter is locate in teh southwest corner of a one story, non-sprinklered building which is Type II (000) construction. The PTC is a tenant occupant with other busness tenant space ans vacant tenat spaces. It has a smoke barrier and za one hour tenant separation wall. It has an fire alarm system which is independent of other tenant spaces. There is no emergency generator and no piped in medical gasses. The center was apparently relocate to this location in 2004. The facility was surveyed as an existing ambulatory health care occupancy under the 2000 Edition of the NFPA 101 Life Safety Code, including Chapter 21, and Chapter 39, as an existing Ambulatory Surgical Treatment Center under 77 Illinois Administrative Code 205, as amended by Section 205.710. Unless otherwise noted, those code sections listed herein that do not include a reference to a specific NFPA code and year of issue (such as NFPA 70 1999) are taken from the 2000 Edition of the NFPA 101 Life Safety Code. The requirements of 77 Illinois Administrative Code 205 are NOT MET as evidenced by the deficiencies cited under the following L-Tags. On April 12, 2016, a life safety code monitoring	{L 000}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7002850	A. BUILDING: 01 - MAIN BUILDING B. WING _____	R 04/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESS HEALTH CARE CENTER LTD	110 SOUTH RIVER ROAD SUITE 7 DES PLAINES, IL 60016

(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
{L 000}	Continued From page 1 visit was conducted. Based on observation, document reviews and staff interviews, no deficiencies remain uncorrected. The requirements of 77 Illinois Administrative Code 205 are MET as evidenced by.	{L 000}		

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

March , 2016

Renlin Xia, Administrator
Access Health Care Center, Ltd.
110 S. River Road, Suite 7
Des Plaines, IL 60016-

Re: Access Health Care Center, Ltd.
Des Plaines
Life Safety Code Licensure survey

Dear Renlin Xia:

On February 9, 2016, a life safety code licensure survey was conducted at the above Pregnancy Termination Center for the purpose of determining compliance with the Ambulatory Surgical Treatment Center Licensing Requirements and the 2000 Edition of the Life Safety.

Based on the Facility's Plan of Correction (PoC) dated 2/23/16, we have no further comments. The facility will receive an unannounced Life Safety Code Monitoring Survey in order to confirm that previously cited deficiencies have been corrected in accordance with your PoC.

Please also note teh following: Included in your transmission was a revised Policy Manual in which "activate the fire alarm" was hand marked as step "1". Please note that activating the fire alarm system is part of Step 2, after removal of people from immediate danger. Activation of the fire alarm system is part of the same step which includes calling 911.

If you have any questions, please do not hesitate to call us at 217/785-4247. The Department's TTY # is 800/547-0466, for use by the hearing impaired.

Sincerely,

[redacted]

Lynn W. Manley, Staff Architect
Design and Construction Section
Division of Life Safety and Construction

cc: Arch File

LM Replace Cyl.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7002850	A. BUILDING: 01 - MAIN BUILDING B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESS HEALTH CARE CENTER LTD	110 SOUTH RIVER ROAD SUITE 7 DES PLAINES, IL 60016

(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
L 000	Initial Comments Surveyor: 07113 The Illinois Department of Public Health (IDPH) conducted an onsite Life Safety Code Licensure Periodic inspection on February 9, 2016. Access Health Cre Center, Ltd.is a Pregnancy Termination Center (PTC) located at 110 S. River Road, Suite 7, Des Plaines, IL. The surveyor met with and toured the facility with two office managers of the facility . The cneter is locate in teh southwest corner of a one story, non-sprinklered building which is Type II (000) construction. The PTC is a tenant occupant with other busness tenant space ans vacant tenat spaces. It has a smoke barrier and za one hour tenant separation wall. It has an fire alarm system which is independent of other tenant spaces. There is no emergency generator and no piped in medical gasses. The center was apparently relocate to this location in 2004. The facility was surveyed as an existing ambulatory health care occupancy under the 2000 Edition of the NFPA 101 Life Safety Code, including Chapter 21, and Chapter 39, as an existing Ambulatory Surgical Treatment Center under 77 Illinois Administrative Code 205, as amended by Section 205.710. Unless otherwise noted, those code sections listed herein that do not include a reference to a specific NFPA code and year of issue (such as NFPA 70 1999) are taken from the 2000 Edition of the NFPA 101 Life Safety Code. The requirements of 77 Illinois Administrative Code 205 are NOT MET as evidenced by the deficiencies cited under the following L-Tags.	L 000		

RECEIVED-CTRCH
FEB 26 2016
LIFE SAFETY & CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7002850	A. BUILDING: 01 - MAIN BUILDING B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESS HEALTH CARE CENTER LTD	110 SOUTH RIVER ROAD SUITE 7 DES PLAINES, IL 60016

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L 046	20.2.9.1/21.2.9.1 Emergency Illumination Emergency lighting shall be provided in accordance with 7.9 and 21.2.9.2. This Regulation is not met as evidenced by: Surveyor: 07113 The surveyor finds that monthly and annual testing of emergency lighting with battery back up is preformed; however the documentation is incomplete Findings include: 1) On February 8, 2016, at 11:30AM, with both office managers present, the surveyor reviewed the documentation of testing for the previous 12 months. The surveyor finds the the documentation of testing does comply with 9.7.3 of NFPA 101. a) The documentation for monthly testing does not identify testing of devices location by location and/or does not include the total number of device vs the number of devices tested. b) The documentation for annual testing lists every device tested along with a "pass" notification. The documentation fails to indicate that the devices were tested for 90 minutes and fails to identify what the pass/fail criteria is .	L 046	L046 1(a) We will comply and will correct this deficiency and forward the full Report with the proper documentation. Shown all the emergency light devises with there location. The work will be done by our electrical/Fire protection consultant "Direct Fire Company" 1(b) We will test all the emergency light devises for the 90 minute test then recharge them check and report if they are fully charged. Those that fail will be identified and be replaced.	03-03-16 03-03-16
L 050	21.7.1.2 FIRE DRILLS Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift, using the fire alarm system, except at night. The staff is familiar with procedures and is aware that drills are part of	L 050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7002850	A. BUILDING: 01 - MAIN BUILDING B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESS HEALTH CARE CENTER LTD	110 SOUTH RIVER ROAD SUITE 7 DES PLAINES, IL 60016

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L 050	Continued From page 2 established routine. 21.7.1.2 This Regulation is not met as evidenced by: Surveyor: 07113 Based on a document review of fire drill testing, the surveyor finds that fire drills are not conducted and documented in properly On February 8, 2016, at 11:00AM, with both office managers present, the surveyor reviewed fire alarm documents for the previous twelve months. The surveyor determined that fire drills are not conducted in accordance with 21.7.1.2 of NFPA 101. Findings include: 1) Although the provider indicates that the activated the fire alarm for all fire drills, the documentation does not support this. The fire drill documentation does not clearly indicate that the fire alarm was activated and/or that staff heard the flier alarm system. 2) The education fails to document confirmation that the fire alarm monitoring company received that alarm signal created from each fire drill.	L 050	L050 1) We will comply and will revise Our Fire Plan in our Policy Manual Our Fire Drill Report will be Revised showing activation and Indicating that staff heard the fire Alarm. 2) We will comply and retain Conformation from The Fire Alarm Co. "Tyco" They will document the fire alarm signal has been received by the fire alarm Co.	03-03-16 03-03-16
L 051	20.3.4/21.3.2 FIRE ALARM SYSTEM A manual fire alarm system, not a pre-signal type, is provided to automatically warn the building occupants. The fire alarm system is arranged to automatically transmit an alarm to summon the fire department. 20.3.4 and 21.3.4 This Regulation is not met as evidenced by:	L 051		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7002850	A. BUILDING: 01 - MAIN BUILDING B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESS HEALTH CARE CENTER LTD	110 SOUTH RIVER ROAD SUITE 7 DES PLAINES, IL 60016

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L 051	Continued From page 3 Surveyor: 07113 The surveyor finds that documentation of testing of the fire alarm system is incomplete Findings include: 1) On February 8, 2016, at 11:30AM, with both office managers present, the surveyor reviewed the documentation of testing of the fire alarm system for the previous 12 months. The surveyor finds the testing does comply with NFPA 72 - 1999. The surveyor finds that documentation of testing of the fire alarm batteries is incomplete and does not include discharge testing.	L 051	L051 1. Tyco Fire Alarm Co. is scheduled to perform an annual fire alarm Test and will be provide us with documentation that is required along with documentation regarding the Fire alarm battery and will include discharge testing.	03-03-16
L 077	21.3.2.2 MEDICAL GASSES By reference: Locations for the supply and storage of medical gases are installed and protected in accordance with NFPA 99-2002. This Regulation is not met as evidenced by: Surveyor: 07113 Based on direct observation, the surveyor finds that oxygen tanks are not store properly. The surveyor notes that this is a repeat deficiency which did not occur in the same room as previously cited. On February 8, 2016, at 2:00PM,with both office managers present the surveyor observed 8 oxygen E tanks store in a room full of cardboard boxes (supplies?) and cardboard waste. The oxygen tanks were not stored at least 20' from all combustibles (in an unsprinklered room) in	L 077	L 077 We will comply. We are making sure this room will be dedicated to oxygen tank storage only. We will educate the staff and will do visual inspections of the room frequently. Also will be placing an eight by eleven inch signs " The Room is for Oxygen Tank Storage Only"	02-26-16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7002850	A. BUILDING: 01 - MAIN BUILDING B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESS HEALTH CARE CENTER LTD	110 SOUTH RIVER ROAD SUITE 7 DES PLAINES, IL 60016

(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
L 077	Continued From page 4 accordance with NFPA 19-1999	L 077		

Advantage
Health Care, Ltd.

July 17, 2019

Karen Senger, R.N., BSN, Chief
Division of Health Care Facilities and Programs
Illinois Department of Public Health
525 West Jefferson, 4th Floor
Springfield, IL 62761

Via: Overnight Delivery UPS

Dear Ms. Senger,

On July 11, 2019 date we received your Statement of Deficiencies letter dated July 2, 2019. Enclosed please find your form with our Plan of Correction (POC).

Sincerely,

[redacted]

Vera Schmidt
Chief of Operations
Advantage Health Care, Ltd.
Business Office
Tel: 847-255-7400
Fax: 847-398-4585

Americans United for Life

203 E. Irving Park Rd.
Wood Dale, IL 60191

Tel: 630-595-1515
Toll Free: 888-795-1515
Fax: 630-595-9097

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER 7002140		SURVEYOR ID 19843, 32820	(X3) DATE OF SURVEY COMPLETED 6/19/19
NAME OF FACILITY Advantage Health Care, Ltd.	STREET ADDRESS, CITY, STATE, ZIP CODE 203 E. Irving Park Rd., Wood Dale, IL 60191			
(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFFICIENCES (EACH DEFINICENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
000	An renewal licensure survey was conducted on 6/19/19. The Facility was not in compliance with Title 77: Public Health, Chapter 1: Department of Public Health, Subchapter b: Hospital and Ambulatory Care Facility, Part 205: Ambulatory Surgical Treatment Center Licensing requirements, as evidenced by:			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE

Chief of Operations
TITLE

7/17/2019
DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER 7002140	SURVEYOR ID 19843, 32820	(X3) DATE OF SURVEY COMPLETED 6/19/19
NAME OF FACILITY Advantage Health Care, Ltd.	STREET ADDRESS, CITY, STATE, ZIP CODE 203 E. Irving Park Rd., Wood Dale, IL 60191		

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205.410 A)	Section: 205.410 a) Equipment Equipment shall be in good working order and shall be available in numbers sufficient to provide quality patient care based on the types of procedures to be performed in the facility. a) Monitoring equipment, suction apparatus, oxygen and related items shall be available within the surgical and postoperative recovery areas. Cardiac and pulmonary resuscitation equipment shall be available in all facilities. This Regulation was not met as evidenced by: Based on document review and interview, it was determined that the Facility failed to ensure that Operating Room (OR) equipment and supplies were checked and ready for surgery, prior to surgery, potentially effecting approximately 120 patients each month. Findings include: 1. On 6/18/19 at approximately 2:00 PM, the "Daily Nursing Checklist" was reviewed. Some items were included as "Pre-Surgery," including, "Checked Refrigerator Temperature & filled out log; Checked Recovery Room Set-up; Checked OR Room(s) Set-up; Checked O2 (oxygen) tanks (recovery & ORs); Checked AED (automatic external defibrillator to monitor abnormal heart rhythm) for 'OK' Electrode Expiration Date; Performed Pre-Surgery Narcotic Count with Authorized Signature; Prepared IV (intravenous) Bags & Medicatons for Surgery; Prepared Anesthesia ER (emergency) med kit; Prepared scripts/ meds for Patients. Verified Correct Locks are intact on Crash Cart" The check list had not been completed today (6/18/19). 2. On 6/18/19 at 2:10 PM, an interview was conducted with a Registered Nurse (E #2). E #2 stated that she completes the crash cart check (contained in the "Daily Nursing Checklist") at the end of the day. When asked why the pre-surgery checks were not done at the beginning of the day, E #2 stated that the check list was always completed at the end of the day.	205.410 A	On 6/21/2019 an interview was conducted with RN (E#2). She clarified that she physically performs all pre-surgery checks, but does not record them until the end of the day. RN was informed that documentation must be done immediately upon performing checks. An Inservice for all staff was held on 7/16/2019 on importance of completing all documentation immediately into the records when doing checks and logs. See Exhibit I. Administrator and Nursing Supervisor will ensure checks are documented when performed at the start of each day.	7/16/2019

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE

Chief of Operations
TITLE

7/17/2019
DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER 7002140		SURVEYOR ID 19843, 32820	(X3) DATE OF SURVEY COMPLETED 6/19/19
NAME OF FACILITY Advantage Health Care, Ltd.	STREET ADDRESS, CITY, STATE, ZIP CODE 203 E. Irving Park Rd., Wood Dale, IL 60191			
(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFFICIENCES (EACH DEFINICENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
205.410 d)	Section: 205.410 d) Equipment d) The facility shall have written procedures to assure the safety in storage and use of all narcotics and medications in accordance with State and federal law. This Regulation was not met as evidenced by: Based on document review, observation, and interview, it was determined that the Facility failed to ensure that medication syringes were labeled, potentially effecting the safety of approximately 15 patients receiving pregnancy termination procedures on 6/18/19. Findings include: 1. On 6/18/19, the Facility's policy titled, "Medication Control and Accountability," (not dated), was reviewed. The policy required, "C. Labeling: 1. All medications drawn into syringes must be labeled..." The policy lacked guidance as to what the label should include. 2. On 6/18/19 at 9:10 AM, an observational tour was conducted in the Operating Room (OR). At 9:35 AM, in OR #2, there were 2 unlabeled 10 milliliter syringes containing a clear fluid. The medication, date/ time of preparation, and preparer's identity was unknown. OR #2 was prepared for a pregnancy termination procedure and there was no one in the room. 3. On 6/18/19 at 9:10 AM, an interview was conducted with the Chief Operating Officer (E #4). E #4 stated that she did not know what was in the syringes and medication syringes should be labeled.	205.410 d	The policy regarding drawing up medicating into syringes has been revised. See Policy Exhibit IIA. Inservice held on 6/12/2019 with all staff regarding protocol for labeling syringes. Exhibit IIB. A memo has also been sent out. Exhibit IIC. The nursing supervisor will monitor the labeling of syringes on a daily basis. Any unlabeled syringes will be reported to administration.	7/16/2019

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE	Chief of Operations TITLE	7/17/2019 DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER 7002140	SURVEYOR ID 19843, 32820	(X3) DATE OF SURVEY COMPLETED 6/19/19
NAME OF FACILITY Advantage Health Care, Ltd.	STREET ADDRESS, CITY, STATE, ZIP CODE 203 E. Irving Park Rd., Wood Dale, IL 60191		

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFFICIENCES (EACH DEFINICENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
205.504 f)	Section: 205.540 f) Postoperative Care f) Patients shall be discharged only on the written signed order of a physician. The name, or relationship to the patient, of the person accompanying the patient upon discharge from the facility shall be noted in the patient's medical record. This Regulation was not met as evidenced by: Based on document review and interview, it was determined that for 1 of 13 (Pt. #3) patient records reviewed for discharge procedures, the Facility failed to ensure that a patient was discharged to a responsible adult following a post anesthesia (state of controlled, temporary loss of sensation and awareness that is induced medically) surgical procedure. Findings include: 1. On 6/19/19, the Facility's policy titled, "Duties of the Post-Operative Nurse" (dated 3/1/18) was reviewed. The policy required, "...M. After criteria for discharge has been met...3. Assist patient to the discharge door, assuring that the patient is discharged to a responsible adult who will be staying with the patient. Chart all of the above on the nursing note." 2. On 6/19/19 at 9:00 AM, Pt. #3's medical record was reviewed. Pt. #3 was a 31 year old female who was treated on 5/17/19 for pregnancy termination. - Pt. #3's OR/Anesthesia Record dated 5/17/19, indicated that Pt. #3 received Fentanyl (narcotic used to treat pain), Versed (sedative that causes relaxation, sleepiness and, temporary memory loss), and Propofol (anesthetic that causes relaxation and sleepiness) between 8:54 AM – 9:10 AM on 5/17/19, for twilight (mild anesthesia)/MAC (monitored anesthesia care) sedation during the pregnancy termination. - Pt. #3's discharge note dated 5/17/19 at 10:30 AM, included, "...Home with: Taxi."	205.504 f	Per our policy, all patients are informed that they must be discharged to a responsible adult. See Policy Exhibit III. Patient was counselled and signed the "Against Medical Advice" form (See Form Exhibit IV); she had no other ride options. Patient #3 was originally informed of this policy when she made her appointment but her responsible adult could not return to pick her up. The Nursing Supervisor will monitor these types of patients and submit a report to the next Quarterly Consulting Committee for a Plan of Action. Inservice was held with all staff on how to better uphold current Discharge/Transport Policy. A reminder memo was also sent out. (See Exhibit V.)	7/16/2019

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE

Chief of Operations
TITLE

7/17/2019
DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER 7002140		SURVEYOR ID 19843, 32820	(X3) DATE OF SURVEY COMPLETED 6/19/19
NAME OF FACILITY Advantage Health Care, Ltd.	STREET ADDRESS, CITY, STATE, ZIP CODE 203 E. Irving Park Rd., Wood Dale, IL 60191			
(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFFICIENCES (EACH DEFINICENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
205.40 f)	Section: 205.540 f) Postoperative Care (Continued) - Pt. #3's discharge note lacked documentation that Pt. #3 was discharged to a responsible adult who would be staying with Pt. #3. 3. On 6/19/19 at approximately 10:55 AM, an interview with the Facility Administrator (E #5) was conducted. E #5 stated that patients are usually discharged to someone who will drive them home. E #5 stated that she does not know if the responsible party must stay with the patient.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE

Chief of Operations
TITLE

7/17/2019
DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER 7002140	SURVEYOR ID 19843, 32820	(X3) DATE OF SURVEY COMPLETED 6/19/19
NAME OF FACILITY Advantage Health Care, Ltd.	STREET ADDRESS, CITY, STATE, ZIP CODE 203 E. Irving Park Rd., Wood Dale, IL 60191		

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFFICIENCES (EACH DEFINICENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
205.550 j)	Section: 205.550 j) Infection Control j) Thorough hand hygiene shall be required after touching any contaminated or infected material. This Regulation is not met as evidence by: Based on document review, observation, and interview, it was determined that for 2 of 6 staff (E #1 & MD #2) in Operating Room (OR), the Facility failed to ensure that staff disinfected their hands after removing gloves. Findings include: 1. On 6/18/19, the Facility's policy titled, "Handwashing," (not dated), was reviewed. The policy required, "B. Hands must be washed with an approved antimicrobial soap or alcohol-based hand sanitizer... As soon as gloves... are removed." 2. On 6/18/19 at 9:10 AM, an observational tour was conducted in the OR. At 9:45 AM, in OR # 1, a Medical Assistant (E #1) wearing gloves opened a sterile pack and arranged the instruments on the sterile field. E #1 removed the gloves, did not disinfect her hands, donned new gloves, and assisted the Surgeon (MD #2) in preparing for a pregnancy termination procedure. 3. On 6/18/19 at 9:55 AM, MD #2, wearing gloves, started an IV (intravenous) line, removed the gloves, did not disinfect his hands, donned new gloves, and continued preparation for a pregnancy termination procedure. 4. On 6/19/19 at 9:55 AM, an interview was conducted with the Chief Operating Officer (E #4). E #4 stated that she just gave an in-service regarding hand disinfection after removing gloves.	205.550 j	An Inservice was held on 7/16/2019 to retrain staff on Hand Hygiene and to remind staff that hands need to be disinfected after removing gloves and before donning new gloves. (See Exhibit VI.) The Nursing Supervisor will monitor staff's Hand Hygiene and prepare a report for the next Quarter Consulting Committee.	

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE	Chief of Operations TITLE	7/17/2019 DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER 7002140	SURVEYOR ID 19843, 32820	(X3) DATE OF SURVEY COMPLETED 6/19/19
NAME OF FACILITY Advantage Health Care, Ltd.	STREET ADDRESS, CITY, STATE, ZIP CODE 203 E. Irving Park Rd., Wood Dale, IL 60191		

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFFICIENCES (EACH DEFINICENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A076	205.610 a) 2) a) The ASTC shall maintain accurate and complete clinical records for each patient, and all entries in the clinical record shall be made at the time the surgical procedure is performed and when care, treatment, medications, or other medical services are given. The record shall include, but not be limited to, the following: 2) Admitting information including patient history, physical examination findings, diagnosis or need for medical services; This Regulation is not met as evidence by: Based on document review and interview, it was determined that for 1 of 13 (Pt. #3) patients reviewed for pre-admission history assessment, the Facility failed to ensure that the patient receiving surgical services signed the registration form containing pertinent medical history. Findings include: 1. On 6/19/19, Pt. #3's medical record was reviewed. Pt. #3 was a 31 year old female who was treated on 5/17/19 for pregnancy termination. -Pt. #3's registration form dated 5/17/19, included, Pt. #3's medical history, social history, allergies, medication and pregnancy history. There was a signature different from Pt. #3's name in the attestation box. The form lacked Pt. #3's signature. 2. On 6/19/19 at approximately 12:32 PM, an interview with the Facility Administrator (E #5) was conducted. E #5 stated that the Facility does not have a patient with the name signed on Pt. #3's registration form. E #5 stated that it is possible that Pt. #3 used someone else's identity and accidentally signed a different name on the form. E #5 stated that the Facility does not have a policy for patient registration.	A076	A memo has been sent out reminding pre-op staff to verify patient's signatures with their I.D.s and other documents. See Exhibit VII. Any discrepancies must be brought to the attention of the Manager who will discuss with Administration. The Manager will review all patients charts daily and signature verification has been added to the Medical Record Review Report which will be submitted to the next Quarterly Consulting Committee Meeting.	7/16/2019

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE	TITLE	DATE
	Chief of Operations	7/17/2019

Exhibit I

IN-SERVICE TRAINING RECORD

DATE: 7/16/19 TIME: 2:50pm

PRESENTOR: Vera Schmidt, Chief of Op

TOPIC: Documentation of Checklists

OUTLINE:

(1) Different Checklists and Logs in the Center.
(2) Pre-Surgery Checklists need to be documented immediately after performing the Checks before surgery.
(3) Post-Op & End of Day Checklists can be documented at the end of the day when appropriate.
(4) All Checklists will be monitored on a daily basis by the manager.
(5) All temperature logs will also be documented at the start of the day before surgery or lab work.

ATTENDEES:

Mikaela — NANCY NELSON
Zahid Sohail MD
[illegible]
Eileen Ra
Rikki
Nurse B Hoke
Tamara Bellistri
[illegible]
Rose Ortiz
G. JAWORSKI
[illegible]

VERIFIED BY: [illegible]

Americans United for Life

ASEPTIC TECHNIQUE FOR INJECTION SAFETY AND SINGLE / MULTI – DOSE VIALS

Exhibit II A

POLICY:

Reusing needles and syringes to administer medications on multiple patients is strictly prohibited. The following guidelines must be adhered to in order to reduce the risk of infection associated with the administration of medications through injection.

PROCEDURE:

Injection Safety:

- Use a sterile, single-use, disposable needle and syringe for each injection and discard intact in an appropriate sharps container after use.
- Label syringe with the medication name, strength, and initials (syringes must be used within one hour).
- Use single-dose medication vials, prefilled syringes, and ampules when possible. Do not administer medications from single-dose vials to multiple patients or combine leftover contents for later use.
- Do not use bags or bottles of intravenous solution as a common source of supply for multiple patients.
- Use aseptic technique to avoid contamination of sterile injection equipment and medications.

Single and Multi-Dose Vials:

When possible, use single-dose rather than multi-use vials. Even with bacteria-fighting preservatives, multi-dose vials are prone to contamination. If multi-dose vials must be used; adhere to these infection control guidelines:

- Draw up medications as close to administration time as possible (< 1 hour), since medications in multi-dose vials can become contaminated from non-sterile glass fragments, airborne contaminants or failure to aseptic technique.
- Do not aspirate medication from a multi-dose vial with a previously used needle if any of the contents of the vial will be administered to another patient.
- Refrigerate multi-dose vials after they are opened and when recommended by the manufacturer.
- Date multi-dose vials with an expiration date of 28 days or the manufacturer's recommendation.
- Cleanse the access diaphragm of multi-dose vials with 70 percent alcohol before inserting any device into the vial.
- Use sterile needles and avoid touching needles before penetrating the vial's access diaphragm.
- Dispose of needle, syringe and vial after use. Never leave a needle in the septum of the vial, as this may encourage reuse of the syringe.
- Discard any multi-dose vials if there is any chance that its sterility is compromised.

IN-SERVICE TRAINING RECORD

Exhibit II B

DATE: 7-16-19

TIME: 2:30pm

Exhibit VI

PRESENTOR: Vera Schmidt

TOPIC: Various Infection Control Topics

OUTLINE:

VI → 1. Hand Hygiene: Hands to be washed or hands sanitized after removing gloves and before new donning gloves. Staff must have access to sanitizers in their immediate area and follow manufacturer's instructions for use. Medical assistants should make the hand sanitizer easily assessable for the surgeon to use prior to donning sterile gloves.

2. Dirty linen must be stored separately from clean linen: Should be in hamper.

3. Corrugated boxes cannot enter the O.R. Items inside shipping boxes must be removed from "outdoor" shipping box prior to storage in the O.R.

4. All cleaning/disinfecting products must be used per manufacturer's instructions.

5. Ultrasound probes must 1st be cleaned and then disinfected per manufacturer's instructions.

II → 6. All syringes must be labelled and monitored; they should never be left attended (see Memo).

ATTENDEES:

Mikaela [illegible] NANCY NELSON

Batuhan Sakar MD

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

VERIFIED BY: [illegible]

Americans United for Life

Memo

Exhibit II C

To: **All Staff**

From: **Administration**

Date: **6-21-2019**

RE: **Labeling of syringes**

Please be advised that all syringes must be labeled with Medication Name and strength initialed.

All labeled prefilled syringes must always be monitored by the physician and/or RN and never left unattended. Syringes must be used within 1 hour; any unused syringes must be disposed of.

The only time syringes do not need to be labeled is if they are drawn up for immediate use by the person administering the medication and that is the only medication that is being given at the time.

Americans United for Life

RELEASE FOR RESPONSIBILITY FOR TAXI/RIDE SHARE PICK-UP POST ANESTHESIA

OLICY:

All patients must have a responsible adult transport them home post anesthesia. Taxi/ride shares can be used if the patient has a friend/family member accompany them. Any patient demanding to take a taxi or ride share service alone, is leaving against the advice of the physician or the Center shall sign the "Release from Responsibility for Taxi/Ride Share Pick-Up".

PROCEUDRE:

A. Attending physician or anesthesiologist shall counsel patient on potential problems.

B. If patient insists on having an unfamiliar third party drive, the release form shall be signed.

C. Completed form shall be place in the patient's medical record.

D. If patient refuses to sign:

1. An incident report shall be completed.
2. The unsigned "Release from Responsibility . . ." form will note: ***"Patient refused to sign"***, and the form will be placed in the medical record.

Americans United for Life

Exhibit IV

ADVANTAGE HEALTH CARE, LTD.
203 E. Irving Park Rd., Wood Dale, IL 60191
Phone: (630) 595-1515 • Fax: (630) 595-9097

RELEASE FROM RESPONSIBILITY FOR TAXI/RIDE SHARE PICK-UP
POST ANESTHESIA

DATE: 5/17/9
TIME: 1025 A.M./P.M.

I [redacted] a patient at the Health Center, have chosen to leave the center in a

- ☐ taxi
- ☐ Uber
- ☒ Lyft
- ☐ other (please identify _____)

against the advice of the Center Administration and medical professionals. I acknowledge that I have been informed of the risks involved and hereby release the Center and its employees from any and all liability whatsoever.

[redacted]
Patient Signature

[redacted]
Witness

Americans United for Life

Memo

Exhibit V

To: **All Staff**

From: **Administration**

Date: **7-12-2019**

RE: **Patient Transport Home**

Please be advised that per our policy, all patients undergoing anesthesia must have a responsible adult transport them home. Taxi, ride share (Uber, Lyft) are not acceptable unless they have another responsible adult to accompany them.

When making/verifying appointments make sure that the patient understands that they must have a responsible adult transport them home and that taxi or rideshare is not an option.

Americans United for Life

Memo

Exhibit VII

To: **All Staff**

From: **Administration**

Date: **7-15-2019**

RE: **Patient Signature and I.D. Verification**

It is imperative that we check Patient I.D. Cards and that Patient Signatures are compared to their I.D. Cards. Any discrepancies should be brought to the Manager's attention.

If a patient goes by another name, "nickname", married name, etc., please verify what their legal name is and, if necessary, have them sign both names.

Both Front Desk Staff and Pre-operative Counseling Staff should do their verification.

Americans United for Life

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7002140	30461	8/9/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Advantage Health Care	203 E Irving Park Rd, Wood Dale IL 60191

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A000	An Annual Licensure Survey was completed at Advantage Health Care on 8/9/2016. The Facility was found to be in compliance with Illinois Administrative Code: Title 77, Chapter 1, Subpart b: Hospital and Ambulatory Care Facilities Part 205 Ambulatory Surgical Treatment Center Licensing Requirements			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE

Close.

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

May 11, 2017

Nancy Nelson, Administrator
Advantage Health Care, Ltd.
203 E. Irving Park Road
Wood Dale, IL 60191-

Re: Advantage Health Care, Ltd.
Wood Dale
Licensure survey

Dear Nancy Nelson:

On *5/9/17*, a life safety code licensure monitoring survey was conducted at the above Ambulatory Surgical Treatment Center to verify completion of your Plan of Correction dated *3/21/17*. All previously cited deficiencies have been corrected, therefore, the facility is no longer under monitoring.

If you have any questions, please do not hesitate to call us at 217/785-4247. The Department's TTY # is 800/547-0466, for use by the hearing impaired.

Sincerely,

[redacted]

Pam Hastings, Project Designer
Design and Construction Section
Division of Life Safety and Construction

Americans United for Life

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
7002140 Y1	A. Building 01 - MAIN BUILDING B. Wing Y2	5/9/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANTAGE HEALTH CARE LTD	203 EAST IRVING WOOD DALE, IL 60191

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix L0029	Correction	ID Prefix L0046	Correction	ID Prefix L0051	Correction
Reg. # 38.2.1/39.3.2	Completed	Reg. # 20.2.9.1/21.2.9.1	Completed	Reg. # 20.3.4/21.3.2	Completed
LSC	05/09/2017	LSC	05/09/2017	LSC	05/09/2017
ID Prefix L0130	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # as indicated	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/09/2017	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 2/28/2017

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7002140	A. BUILDING: 01 - MAIN BUILDING B. WING _____	R 05/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANTAGE HEALTH CARE LTD	203 EAST IRVING WOOD DALE, IL 60191

(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
{L 000}	Initial Comments On February 28, 2017, the Life Safety Code portion of a State Licensure Survey was conducted at the above facility. The surveyor was accompanied during the survey walk-through by the following provider representatives: The Chief of Operations (CO). The Administrator (A). The facility was observed to be the sole tenant in a single story building of Type II (000) construction. The building was observed to be partially covered by an automatic sprinkler system, in selected hazardous areas only. The facility was surveyed as an existing ambulatory health care occupancy under the 2000 Edition of the NFPA 101 Life Safety Code, including Chapter 21. Unless otherwise noted, those code sections listed herein that do not include a reference to a specific NFPA code and year of issue (such as NFPA 70 2010) are taken from the 2012 Edition of the NFPA 101 Life Safety Code. Unless otherwise noted, all deficiencies cited herein were found through observation during the survey walk-through, staff interview, or document review. The requirements of the Ambulatory Surgical Treatment Center Licensing Requirements (77 Illinois Administrative Code 205) are NOT MET as evidenced by the deficiencies cited under the following K-Tags. On May 9, 2017, the monitoring survey for the Life Safety Code portion of a State Licensure	{L 000}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7002140	A. BUILDING: 01 - MAIN BUILDING B. WING _____	R 05/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANTAGE HEALTH CARE LTD	203 EAST IRVING WOOD DALE, IL 60191

(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
{L 000}	Continued From page 1 Survey was conducted at the above facility. The requirements of the Ambulatory Surgical Treatment Center Licensing Requirements (77 Illinois Administrative Code 205) are NOW MET	{L 000}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7002140	A. BUILDING: 01 - MAIN BUILDING B. WING _____	02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANTAGE HEALTH CARE LTD	203 EAST IRVING WOOD DALE, IL 60191

(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
L 000	Initial Comments On February 28, 2017, the Life Safety Code portion of a State Licensure Survey was conducted at the above facility. The surveyor was accompanied during the survey walk-through by the following provider representatives: The Chief of Operations (CO). The Administrator (A). The facility was observed to be the sole tenant in a single story building of Type II (000) construction. The building was observed to be partially covered by an automatic sprinkler system, in selected hazardous areas only. The facility was surveyed as an existing ambulatory health care occupancy under the 2000 Edition of the NFPA 101 Life Safety Code, including Chapter 21. Unless otherwise noted, those code sections listed herein that do not include a reference to a specific NFPA code and year of issue (such as NFPA 70 2010) are taken from the 2012 Edition of the NFPA 101 Life Safety Code. Unless otherwise noted, all deficiencies cited herein were found through observation during the survey walk-through, staff interview, or document review. The requirements of the Ambulatory Surgical Treatment Center Licensing Requirements (77 Illinois Administrative Code 205) are NOT MET as evidenced by the deficiencies cited under the following K-Tags.	L 000		
L 029	38.2.1/39.3.2 HAZARDOUS AREAS	L 029		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7002140	A. BUILDING: 01 - MAIN BUILDING B. WING _____	02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANTAGE HEALTH CARE LTD	203 EAST IRVING WOOD DALE, IL 60191

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L 029	Continued From page 1 39.3.2.1 Hazardous Areas: Hazardous areas that include, but are not limited to general storage, boiler or furnace rooms, and maintenance shops shall be protected in accordance with Section 8.4. High hazard areas shall comply with 39.3.2.2. This Regulation is not met as evidenced by: Based on observation during the survey walk-through, not all hazardous areas are protected as required. These deficiencies could affect any patients, staff, or visitors in the building because fire could spread to other parts of the building. Findings include: On February 28, 2017 at 8:56 AM, while accompanied by the CO, the following deficiencies were observed at the (unsprinklered) Medical Records Room as prohibited by 21.3.2 and 39.3.2.1: A. The enclosure walls were observed to not extend to the underside of the deck above. B. The door to the room was observed to not carry a minimum 3/4 fire resistance rating as required by 8.2.3.2.3.1(2). C. The door to the room was observed to be held open by an unapproved device (a basket) as prohibited by 8.2.3.2.3.1(2).	L 029		
L 046	20.2.9.1/21.2.9.1 Emergency Illumination Emergency lighting shall be provided in	L 046		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7002140	A. BUILDING: 01 - MAIN BUILDING B. WING _____	02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANTAGE HEALTH CARE LTD	203 EAST IRVING WOOD DALE, IL 60191

(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
L 046	Continued From page 2 accordance with 7.9 and 21.2.9.2. This Regulation is not met as evidenced by: Based on observation during the survey walk-through, not all emergency lights are installed and maintained as required. These deficiencies could affect any patients, staff, or visitors in the facility because the required egress path may not be illuminated under emergency conditions. Findings include: On February 28, 2017, while accompanied by the CO, exterior exit doors were observed that are not equipped with battery-powered emergency lights required by 7.8.1.1. Locations observed include: A. 9:09 AM: East exit door. B. 9:11 AM: South exit door (main entry).	L 046		
L 051	20.3.4/21.3.2 FIRE ALARM SYSTEM A manual fire alarm system, not a pre-signal type, is provided to automatically warn the building occupants. The fire alarm system is arranged to automatically transmit an alarm to summon the fire department. 20.3.4 and 21.3.4 This Regulation is not met as evidenced by: Based on observation during the survey walk-through, not all portions of the facility fire alarm system are installed as required. These deficiencies could affect any patients, staff, or visitors in the building because the fire alarm system could fail to operate properly under emergency conditions.	L 051		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7002140	A. BUILDING: 01 - MAIN BUILDING B. WING _____	02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANTAGE HEALTH CARE LTD	203 EAST IRVING WOOD DALE, IL 60191

(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
L 051	Continued From page 3 Findings include: A. On February 28, 2017, while accompanied by the CO, smoke detectors were observed that are located within 3'-0" of supply air diffusers as prohibited by NFPA 72 1999 2-3.5.1. Locations observed include: 1. 8:38 AM: Corridor adjacent to Specimen Lab. 2. 8:50 AM: Specimen Lab. 3. 9:12 AM: Lobby/Reception Area (adjacent to door to Vestibule). B. On February 28, 2017 at 9:05 AM, while accompanied by the CO, the following deficiencies were observed at Electrical Panel 1B located in the Specimen Lab, all as prohibited by NFPA 72 199 1-5.2.5.2: 1. Circuit 23, which was identified as serving the fire alarm system, was observed to lack a mechanical lock-on device. 2. Circuit 39, which is not indicated on the Fire Alarm Control Panel as providing power to it, was observed to be labeled "Fire Alarm."	L 051		
L 130	as indicated OTHER REFERENCED REQUIREMENTS Other Referenced Requirements: NFPA 70 - 2002 NFPA 13 -1999 NFPA 25 - 1998	L 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7002140	A. BUILDING: 01 - MAIN BUILDING B. WING _____	02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANTAGE HEALTH CARE LTD	203 EAST IRVING WOOD DALE, IL 60191

(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
L 130	Continued From page 4 Illinois State Plumbing Code Illinois Accessibility Code As Indicate below: This Regulation is not met as evidenced by: Based on observation during the survey walk-through, not all portions of the facility's automatic sprinkler system are installed or maintained as required. This deficiency could affect any patients, staff, or visitors in the building because the sprinkler system could fail to operate properly under fire conditions. Findings include: On February 28, 2017 at 8:49 AM, while accompanied by the CO, the sprinkler head in the Medical Gas Storage Room was observed to lack an escutcheon required by NFPA 25 1998 2-4.1.8.	L 130		

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH, STATE OF ILLINOIS, Complainant, v. ALBANY MEDICAL SURGICAL CENTER, *License No. 7000789*, Respondent.	)	Docket No. ASTC 15-005

FINAL ORDER

The attached Consent Agreement of the parties is approved, and IT IS HEREBY ORDERED that this matter is dismissed pursuant to the terms contained herein.

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

By: [redacted]
Nirav D. Shah, M.D., J.D.
Director

March 25, 2016
Date

Americans United for Life

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH, STATE OF ILLINOIS, Complainant, v. ALBANY MEDICAL SURGICAL CENTER, *License No. 7000789*, Respondent.	)	Docket No. ASTC 15-005

PROOF OF SERVICE

The undersigned certifies that she caused a true and correct copy of the attached Final Order to be served by regular mail in a sealed envelope, postage prepaid, to:

Richard M. Kates
Attorney at Law
111 West Washington Street, Suite 1900
Chicago, IL 60602

That said document was deposited in the United States Post Office at Chicago, Illinois, on the _____ day of _____, 2015.

_____
Marcia Hollins
Illinois Department of Public Health

cc: Camela Gardner, A.L.J.
Debra Bryars, OHCR
Karen Senger, OHCR
Henry Kowalenko, OHCR
Melissa Cheffy [Springfield Final Order File]

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH, STATE OF ILLINOIS, Complainant, v. ALBANY MEDICAL SURGICAL CENTER, *License No. 7000789*, Respondent.	)	Docket No. ASTC 15-005

CONSENT AGREEMENT AND REQUEST FOR FINAL ORDER

NOW COME the Complainant and the Respondent, by and through their attorneys, and request the Director of the Illinois Department of Public Health to issue a Final Order in the above-captioned matter consistent with the following:

RECITALS

1. The Illinois Department of Public Health ("Department") is designated as the State Agency to administer the provisions of the Ambulatory Surgical Treatment Center Act (210 ILCS 5/1 *et seq.*) ("Act") and the Ambulatory Surgical Treatment Center Licensing Requirements Code (77 Ill. Adm. Code 205) ("Code").

2. Albany Medical Surgical Center ("Respondent" or "Facility") was, at all pertinent times, licensed by the Department to operate a facility located at 5086 North Elston Avenue, Chicago, Illinois 60630. Respondent is the licensee of the ambulatory surgical treatment center as that term is defined in § 3(A) of the Act.

3. The Department issued an ambulatory surgical treatment center license - License No. 7000789 - to Respondent on or about November 24, 2014. Per Code § 205.118(g), licenses are valid for one year. Respondent's license was due to expire on November 24, 2015.

4. On July 24, 2015, the Department and Respondent executed a Consent Agreement and Final Order, incorporated herein as Enclosure I, to resolve *Illinois Department of Public Health v. Albany Medical Surgical Center* - Notice of License Revocation; Notice of Fine Assessment; and Notice of Opportunity for Administrative Hearing (Docket No. ASTC 15-002).

5. On or about September 23, 2015, Respondent submitted an ambulatory surgical treatment center licensure renewal application pursuant to Code § 205.125. The

application stated that Family Planning Associates Medical Group ("FPAMG") was the independent contractor that would manage and operate the Facility.

6. On or about October 26, 2015, the Department received a letter from E. Steve Lichtenberg, MD, MPH, stating that FPAMG would no longer be managing the Facility, effective October 21, 2015. Additionally, the letter informed the Department that the Facility's administrator, medical director and supervising nurse – the same individuals identified in Respondent's renewal application – were resigning effective 11:59 p.m., October 21, 2015.

7. With the departure of FPAMG, Respondent did not have the necessary staff to comply with the Act or Code §§ 205.118, 205.125, 205.210, 205.220 and 205.230 since October 21, 2015.

8. On or about November 18, 2015, the Department issued a Notice of Refusal to Renew License; and Notice of Opportunity for Administrative Hearing to Respondent (Docket No. ASTC 15-005), incorporated herein as Enclosure II.

9. Respondent timely requested a hearing to contest the Department's allegations, determinations, and notices set forth in Paragraph 8 above.

10. The Department and Respondent have agreed, in order to resolve this matter, that Respondent be permitted to enter into this Consent Agreement and Request for Final Order ("Consent Agreement") with the Department, providing for the imposition of certain provisions that are consistent with the best interests of the People of the State of Illinois, subject to the entering of a Final Order dismissing this matter.

11. This Consent Agreement is a compromise and settlement of violations alleged in Docket Number ASTC 15-005. This Consent Agreement shall not be used in determining liability in any action brought by a third party not a signatory to this Consent Agreement against Respondent. Nothing herein shall be considered an admission of fault of any kind by Respondent as to any action brought by a third party, nor shall anything herein be considered a reflection of any weakness of proof by the Department. The parties agree that this Consent Agreement is entered into solely for the purpose of settlement and, except for actions between the Department and Respondent, does not constitute an admission of any liability or wrongdoing by the Respondent, its parent, subsidiaries or other related entities, or each of its directors, officers, employees, agents, successors, assigns and attorneys. Nothing in this Paragraph shall prevent the Department from using violations admitted herein in any other matter before the Department.

NOW, THEREFORE, in consideration of the aforesaid Recitals and representations, the mutual covenants and provisions hereinafter set forth, and for other good and valuable

consideration, the receipt and sufficiency of which are mutually acknowledged by the parties, the parties hereby agree as follows:

ARTICLE I
Respondent's Consideration

1.1 Respondent hereby withdraws its request for a hearing in this matter, thereby expressly waiving its right to contest the Notice of Refusal to Renew License as described in Paragraph 8 of the Recitals.

1.2 Within ten days of receipt of the Department's Final Order in this matter, Respondent shall voluntarily surrender its ambulatory surgical treatment center license - License No. 7000789 – to the Department. The license must be delivered to Karen Senger, Division of Health Care Facilities and Programs, Illinois Department of Public Health, 525 West Jefferson Street, 4th Floor, Springfield, Illinois 62761.

1.3 Upon execution of this Consent Agreement, Respondent releases the Department from its obligations under the Consent Agreement dated July 24, 2015, as described in Paragraph 4 of the Recitals.

ARTICLE II
Department's Consideration

2.1 The Department hereby acknowledges that Respondent, notwithstanding varied efforts, has been unable to locate quality staff to manage and operate the Facility in compliance with the Act and Code.

2.2 Upon execution of this Consent Agreement, the Department releases Respondent from its obligations under the Consent Agreement dated July 24, 2015, as described in Paragraph 4 of the Recitals.

ARTICLE III
General Provisions

3.1 This Consent Agreement shall become binding on, and shall inure to the benefit of, the parties hereto, their successors, or assignees immediately upon the execution of this Consent Agreement by the Director of Public Health, or his designee, dismissing the above-captioned matter with prejudice.

3.2 The provisions of this Consent Agreement shall apply notwithstanding any transfer of facility ownership or interest. Should Respondent fail to comply with any

provisions of this Consent Agreement, the Department may reinstate this action against Respondent, and if Respondent no longer exists as a legal entity, said action shall proceed against any person having five percent (5%) or more interest in Respondent.

3.3 In the event that any of the provisions of Article I are not complied with within the times specified therein, this Consent Agreement will be held for naught, except for the provisions referred to in Paragraph 1.1 wherein Respondent has withdrawn its request for hearing to contest this matter.

3.4 It is hereby agreed that this matter be dismissed with prejudice, all matters in controversy for which this matter was brought having been fully settled, compromised, and adjourned.

3.5 This Consent Agreement constitutes the entire agreement of the parties, and no other understandings, agreements, or representations, oral or otherwise, exist or have been made by or among the parties with respect to Docket No. ASTC 15-005. The parties hereto acknowledge that they, and each of them, have read and understood this Consent Agreement in all respects.

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

[redacted] 3/25/16

By: Snigdha Acharya
Deputy General Counsel
Illinois Department of Public Health

Date

ALBANY MEDICAL SURGICAL CENTER

[redacted] 3/25/16

By: Richard M. Kates
Attorney on behalf of
Albany Medical Surgical Center

Date

Americans United for Life

Enclosure I

Americans United for Life

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH, STATE OF ILLINOIS, Complainant, v. ALBANY MEDICAL SURGICAL CENTER, *License No. 7000789*, Respondent.	)	Docket No. ASTC 15-002

PROOF OF SERVICE

The undersigned certifies that she caused a true and correct copy of the attached Final Order to be served by certified mail in a sealed envelope, postage prepaid, to:

Richard M. Kates
Attorney at Law
111 West Washington Street, Suite 1900
Chicago, IL 60602

That said document was deposited in the United States Post Office at Chicago, Illinois, on the 24th day of July, 2015.

MARCIA K. HOLLINS
OFFICIAL SEAL
Notary Public - State of Illinois
My Commission Expires
September 18, 2017

Marcia Hollins
Illinois Department of Public Health

cc: Camela Gardner, A.L.J.
Debra Bryars, OHCR
Karen Senger, OHCR
Henry Kowalenko, OHCR
Melissa Cheffy [Springfield Final Order File]
Sean McAuliff

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH, STATE OF ILLINOIS, Complainant, v. ALBANY MEDICAL SURGICAL CENTER, *License No. 7000789*, Respondent.	)	Docket No. ASTC 15-002

FINAL ORDER

The attached Consent Agreement of the parties is approved, and IT IS HEREBY ORDERED that this matter is dismissed pursuant to the terms contained herein.

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

[redacted]

By: Nirav D. Shah, M.D., J.D.
Director

7-24-15
Date

Americans United for Life

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH, STATE OF ILLINOIS, Complainant, v. ALBANY MEDICAL SURGICAL CENTER, *License No. 7000789*, Respondent.	)	Docket No. ASTC 15-002

CONSENT AGREEMENT AND REQUEST FOR FINAL ORDER

NOW COME the Complainant and the Respondent, by and through their attorneys, and request the Director of the Illinois Department of Public Health to issue a Final Order in the above-captioned matter consistent with the following:

RECITALS

1. The Illinois Department of Public Health ("Department" or "IDPH") is designated as the State Agency to administer the provisions of the Ambulatory Surgical Treatment Center Act (210 ILCS 5/1 *et seq.* (2013)) ("Act") and the Ambulatory Surgical Treatment Center Licensing Requirements Code (77 Ill. Adm. Code 205) ("Code").

2. Albany Medical Surgical Center ("Respondent") was, at all pertinent times, licensed by the Department to operate a facility located at 5086 North Elston Avenue, Chicago, Illinois 60630. Respondent is the licensee of the ambulatory surgical treatment center as that term is defined in Section 3(A) of the Act.

3. Employees of the Department conducted investigations of Respondent's facility on or about August 28, 2013, August 21, 2014, and January 5, 2015, which resulted in the issuance of the Notice of License Revocation; Notice of Fine Assessment; and Notice of Opportunity for Administrative Hearing (collectively "Notice of Revocation"), as more fully set forth in Attachment A incorporated herein. The basis for the Department's determinations is set forth in the Statements of Deficiencies, also contained in Attachment A.

4. Respondent timely requested a hearing to contest the Department's allegations, determinations, and notices set forth in Paragraph 3 above.

5. The Department has approved Respondent's written plan of correction dated May 15,

2015 ("POC"), incorporated herein as Attachment B.

6. The Department and Respondent have agreed, in order to resolve this matter, that Respondent be permitted to enter into this Consent Agreement and Request for Final Order ("Consent Agreement") with the Department, providing for the imposition of certain provisions that are consistent with the best interests of the People of the State of Illinois, subject to the entering of a Final Order dismissing this matter.

7. This Consent Agreement is a compromise and settlement of violations alleged in Docket Number ASTC 15-002. This Consent Agreement shall not be used in determining liability in any action brought by a third party not a signatory to this Consent Agreement against Respondent. Nothing herein shall be considered an admission of fault of any kind by Respondent as to any action brought by a third party, nor shall anything herein be considered a reflection of any weakness of proof by the Department. The parties agree that this Consent Agreement is entered into solely for the purpose of settlement and, except for actions between the Department and Respondent, does not constitute an admission of any liability or wrongdoing by the Respondent, its parent, subsidiaries or other related entities, or each of its directors, officers, employees, agents, successors, assigns and attorneys. Nothing in this Paragraph shall prevent the Department from using violations imposed herein in any other matter before the Department, as set forth in Paragraph 1.2 below.

NOW, THEREFORE, in consideration of the aforesaid Recitals and representations, the mutual covenants and provisions hereinafter set forth, and for other good and valuable consideration, the receipt and sufficiency of which are mutually acknowledged by the parties, the parties hereby agree as follows:

ARTICLE I
Respondent's Consideration

1.1 Respondent hereby withdraws its request for a hearing in this matter, thereby expressly waiving its right to contest the Statements of Deficiencies and Notice of Fine Assessment, as described in Paragraph 3 of the Recitals and amended by this Consent Agreement.

1.2 The Respondent agrees not to contest the imposition of the violations in the present matter or contest that they were imposed in any future matter before the Department. Therefore, the violations of the Code identified in Attachment A are imposed against the Respondent and Respondent agrees to pay the Fine Assessment pursuant to the terms set forth in Paragraph 1.3 below.

1.3 Within thirty days of receipt of the Department's Final Order in this matter, Respondent must deliver to the Department a check in the amount of Twenty-five Thousand dollars

($25,000.00) ("agreed fine amount"). The check for the agreed fine amount shall be made out to the Illinois Department of Public Health, and delivered to the Illinois Department of Public Health, P.O. Box 4263, Springfield, Illinois 62708. The agreed fine amount will be in full satisfaction of all matters in controversy for which this action was brought by the Department against Respondent.

1.4 The Respondent must follow the plan of correction as set forth in Attachment B. The deadlines set forth in this Consent Agreement supersede the deadlines established in the POC.

1.5 The Respondent must adhere to the following deadlines related to the building construction plans in the POC:

a. Design Development Submittal:	September 4, 2015.
b. IDPH Review Complete:	September 18, 2015.
c. Construction Document IDPH Submittal (100%):	January 8, 2016.
d. IDPH Review Complete:	February 5, 2016.
e. Building Permit/Bidding Completion:	April 14, 2016.
f. Construction Completion:	December 14, 2016.
g. Pre-occupancy Certification Submission:	December 14, 2016.
h. IDPH Occupancy Permit:	January 14, 2017.

1.6 The Respondent must adhere to the following procedures until the Respondent receives written notification from the Department that the POC has been successfully completed:

a. Respondent will evaluate each patient to determine the patient's risk and appropriate level of sedation.

b. No more than one patient will be in active surgery at any given time.

c. Only short-duration anesthetic agents will be utilized. For short term anesthesia, intraveneous propofol given in bolus dosing will be used. A small amount of the analgesic Ketorolac (Toradol) will be given during surgery for post operative pain. Drugs to reverse the effects of reversible anesthetic agents will be maintained and immediately available in each of the two surgical suites and in the acute postsurgical recovery room. Patients will not be intubated.

d. All emergency equipment, including the oxygen flow monitor on the anesthesia machine, will have self-contained battery-powered backup in the event of an emergency generator failure. Each surgical suite will have a Detex-Ohmeda Cardiocap/5 that records pulse oximetry, end title CO-2, EKG and vital signs; its backup battery will power the unit for a minimum of fifteen minutes. A Care-E-Vac suction machine with a backup battery that will power the unit for a minimum of one hour will be present at all times. The defibrillator battery backup will function for a minimum of 2.5 hours. The following will be in the acute postsurgical recovery room at all times: 1) a Care-E-Vac3 suction machine with a backup battery that will power the unit for a minimum of one hour; 2) a Zoll M series defibrillator and pulse oximetry machine with a battery backup that will power the unit for a minimum of 2.5 hours; 3) a Welch Allyn spot vital sign machine that records pulse oximetry blood pressure and temperature with a fully charged battery that will provide up to 130 results; 4) a Dinamap Critikon Critikon 8100 blood pressure cuff with a battery backup that will power the unit for a minimum of ten hours; and 5) a Casmed 740 that records pulse oximetry, blood pressure and temperature with a battery backup that will function for a minimum of 2.5 hours.

e. Ambu bags and oxygen tanks will be readily available at all times in both surgical suites and the acute postsurgical recovery room to oxygenate patients without electricity.

f. All emergency generators and battery backup life safety systems will be inspected and tested weekly in accordance with the requirements of NFPA 101 (2000), Chapter 21, Existing Ambulatory Healthcare Occupancies, and associated references. Logs of such inspections will be provided to the Department on the first Wednesday of every month.

g. All medical machines will be serviced and certified as fully functional every six months by a company specializing in the service of medical equipment. Copies of these certifications will be provided to the Department with the following month's log, as referenced in Paragraph 1.6(f).

h. The operating room staff will always include a physician and a certified nurse anesthetist. The acute postsurgical recovery room will be monitored at all times by several specifically trained staff members, always including a registered nurse with experience in the clinic's specialties.

i. Both surgical suites and the acute postsurgical recovery room will remain located no more than thirty feet from a double-door-wide exit from the building, ensuring an easy and rapid evacuation of all patients in an emergency.

j. Staff will continue to be trained and drilled to evacuate the surgical center within less than five minutes after an alert, including the transport of a non-awake patient on a gurney to a secured area. The facility will regularly conduct emergency drills to prepare for sudden electrical failures, fire, and other examples of force majeure. Evacuation drills will be conducted monthly and a log will be provided to the Department on the first Wednesday of every month.

1.7 The Respondent must provide the Department written verification that all medical equipment referred to in Paragraph 1.6 has been inspected and found to be fully operational by a biomedical equipment technician within two weeks of the execution of this agreement. This verification and all reports referenced in Paragraph 1.6 must be delivered to Henry Kowalenko, Division of Life Safety and Construction, Illinois Department of Public Health, 525 West Jefferson Street, 4th Floor, Springfield, Illinois 62761; Fax Number (217) 782-0382.

1.8 The Respondent must submit a report of its daily census for the prior week to the Department every Wednesday until the Respondent receives written notification from the Department that the POC has been successfully completed. The report must include the following information regarding each surgical patient seen the preceding week:

a. Date of procedure.

b. Type of procedure.

c. Length of procedure, rounded to the nearest thirty minute increment.

d. Gestational age of pregnancy.

e. American Society of Anesthesiologists Physical Classification.

f. Complications, as listed in the Induced Termination of Pregnancy Report (77 Ill. Adm. Code 505).

g. Hospital transfer, if any.

1.9 The Respondent must provide the Department a list of its medical staff and clinical nursing staff, including the specifically trained staff members referenced in Paragraph 1.6(h), within one week of the execution of this agreement. This list and the reports referenced in Paragraph 1.8 must be delivered to Karen Senger, Division of Health Care Facilities and Programs, Illinois Department of Public Health, 525 West Jefferson Street, 4th Floor, Springfield, Illinois 62761; Fax Number (217) 524-0488.

ARTICLE II
Department's Consideration

2.1 The Department hereby reduces the fine assessment from Forty Thousand dollars ($40,000.00) to Twenty-five Thousand dollars ($25,000.00), taking into consideration the additional information presented by Respondent.

2.2 The Department may modify the deadlines in Paragraph 1.5 if Respondent shows just cause for such modification. Respondent must request any such modification in writing and provide documentation supporting its request at least fifteen days prior to the established deadline. For the purposes of this Paragraph only, "just cause" shall be defined as any events or circumstances beyond the control of the Respondent, which were not reasonably foreseeable to the Respondent, and which prevent the Respondent from meeting the established deadline in good faith. By signing this Consent Agreement, Respondent affirmatively states that it understands the definitive nature of the deadlines set forth in Paragraph 1.5 and the requirement to meet each deadline. The Department, having sole authority and discretion, shall act reasonably in determining whether the Respondent has met the definition of "just cause" as set forth above.

ARTICLE III
General Provisions

3.1 This Consent Agreement shall become binding on, and shall inure to the benefit of, the parties hereto, their successors, or assignees immediately upon the execution of this Consent Agreement by the Director of Public Health, or his designee, dismissing the above-captioned matter with prejudice.

3.2 The provisions of this Consent Agreement shall apply notwithstanding any transfer of facility ownership or interest. Should Respondent fail to comply with any provisions of this Consent Agreement, the Department may revoke Respondent's license immediately without further notice. If Respondent no longer exists as a legal entity, said action shall proceed against any person having five percent (5%) or more interest in Respondent.

3.3 In the event that any of the provisions of Article I are not complied with within the times specified therein, or, if applicable, within any approved modifications or extensions pursuant to the process set forth in Paragraph 2.2, this Consent Agreement will be held for naught, except for the provision in Paragraph 1.1 wherein Respondent has withdrawn its request for hearing to contest this matter; thereby the Notice of Revocation will be affirmed. **Respondent agrees that any failure to comply with any provision of this Consent Agreement between the time it is served on the Respondent until such time as the Respondent receives written notification from the Department that the POC has been successfully completed will result in the immediate forfeiture of Respondent's ASTC License Number 7000789 without the right to an**

administrative hearing before the Department. Respondent further agrees that this does not limit the Department's ability to impose violations for unrelated deficiencies, nor will it limit Respondent's right to contest those same, unrelated deficiencies.

3.4 It is hereby agreed that this matter be dismissed with prejudice, all matters in controversy for which this matter was brought having been fully settled, compromised, and adjourned.

3.5 This Consent Agreement constitutes the entire agreement of the parties, and no other understandings, agreements, or representations, oral or otherwise, exist or have been made by or among the parties with respect to Docket No. ASTC 15-002. The parties hereto acknowledge that they, and each of them, have read and understood this Consent Agreement in all respects.

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

[redacted]

By: Snigdha Acharya
Deputy General Counsel
Illinois Department of Public Health

7/24/2015
Date

ALBANY MEDICAL SURGICAL CENTER

[redacted]

By: Richard M. Kates
Attorney on behalf of
Albany Medical Surgical Center

July 24 2015
Date

Enclosure II

Americans
United
for Life

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH, STATE OF ILLINOIS, Complainant, v. ALBANY MEDICAL SURGICAL CENTER, *License No. 7000789* Respondent.	)	Docket No. ASTC 15-005

PROOF OF SERVICE

The undersigned certifies that a true and correct copy of the attached NOTICE OF REFUSAL TO RENEW LICENSE and NOTICE OF OPPORTUNITY FOR HEARING was sent by certified US mail in a sealed envelope, postage prepaid to:

REGISTERED AGENT:
Richard Kates
111 W Washington Street
Suite 1900
Chicago, IL 60602

Walter Dragosz
President, Albany Medical Corporation
5086 N Elston Avenue
Chicago, IL 60630

That said document was deposited in the United States Post Office at Chicago, Illinois, on the 18th day of November, 2015.

MARCIA K. HOLLINS
OFFICIAL SEAL
Notary Public - State of Illinois
My Commission Expires
September 16, 2017

Marcia Hollins
Illinois Department of Public Health

Cc: Karen Senger, OHCR
Snigdha Acharya, Deputy General Counsel

Americans United for Life

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH, STATE OF ILLINOIS, Complainant, v. ALBANY MEDICAL SURGICAL CENTER, *License No. 7000789* Respondent.	)	Docket No. ASTC 15-005

NOTICE OF REFUSAL TO RENEW LICENSE:
AND NOTICE OF OPPORTUNITY FOR ADMINISTRATIVE HEARING

Pursuant to the authority granted to the Illinois Department of Public Health ("Department") by the Ambulatory Surgical Treatment Center Act (210 ILCS 5/1 *et seq.*) ("Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF REFUSAL TO RENEW LICENSE

In accordance with Section 5/10f of the Act, Section 205.840 of the Ambulatory Surgical Treatment Center Licensing Requirements Code (77 Ill. Adm. Code 205) ("Code"), and Section 10-65(d) of the Illinois Administrative Procedure Act (5 ILCS 100/1-5 *et seq.*) ("APA"), incorporated into the Act at 210 ILCS 5/10a, the Department issues this Notice of Refusal to Renew License and hereby denies the license renewal of the facility known as Albany Medical Surgical Center ("Respondent" or "Facility") located at 5086 North Elston Avenue, Chicago, Illinois 60630.

ALLEGATIONS OF NONCOMPLIANCE

The Department has determined that there is and has been a substantial failure to comply with the Act and Code and that Respondent has failed to demonstrate the capacity to safely provide one or more of its services to patients. These failures to comply with both the Act and Code have resulted in the Respondent's inability to meet the public interest, health, safety or welfare needs of the community. Respondent is in violation, at a minimum, of the following Code Sections: 77 Ill. Adm. Code 205.118; 77 Ill. Adm. Code 205.125; and 77 Ill. Adm. Code 205.210; 77 Ill. Adm. Code 205.220; and 77 Ill. Adm. Code 205.230.

1. The Department issued an ambulatory surgical treatment center license - License No. 7000789 - to Respondent on or about November 24, 2014. Per Code section 205.118(g), the license is valid for one year. Therefore, Respondent's license expires on November 24, 2015.

2. Pursuant to Code Section 205.125, Respondent submitted an Ambulatory Surgical Treatment Center Renewal Licensure application dated September 23, 2015 ("2016 Renewal Application") to the Department. The 2016 Renewal Application is incorporated herein as Exhibit A.

3. Section 205.125(b) of the Code states:

An application for license renewal shall include the following information:

1) The names and addresses of all persons who own the facility, any names under which any of these persons do business, and the type of ownership of the facility (for example, individual, partnership, corporation, or association). In addition, a corporation shall submit:

A) A list of the title, name and address of each of its corporate officers.

B) A list of the name and address of each of its shareholders holding more than 5% of the shares.

2) For other than individual ownership, the name and address of the Illinois Registered Agent or person(s) legally authorized to receive service of process for the facility.

3) The names and addresses of all persons under contract to manage or operate the facility.

4) The location of the facility.

5) Information regarding any conviction of the applicant, or if the applicant is a firm, partnership or association, of any of its members, or if the applicant is a corporation, of any of its officers or directors, or of the person designated to manage or supervise the facility, of a felony, or of two or more misdemeanors involving moral turpitude during the previous year.

6) The name, address, and telephone number of the administrator, medical director, and supervising nurse. In addition, the education, experience, credentials and any professional licensure or certification of these individuals must also be submitted if this information was not submitted with the initial application or a prior renewal application or if this information has changed since the prior submission.

7) A list of the medical staff including name, specialty and license number.

8) A list of all staff personnel including name, position, education, experience, and any professional licensure or certification.

9) A list of surgical procedures being performed at the facility and documentation of the Consulting Committee's approval of the list.

4. Section 2, Paragraph 6 of the 2016 Renewal Application states Family Planning Associates Medical Group ("FPAMG") is the independent contractor that manages or operates the Facility. *See* Exhibit A.

5. Section 3, Paragraph 1 of the 2016 Renewal Application identifies Diana Maracich as the Facility's administrator. Section 3, Paragraph 2 identifies E. Steve Lichtenberg, MD, MPH as the Facility's medical director. Section 3, Paragraph 3 identifies Holly Hines, RN as the Facility's supervising nurse. *See* Exhibit A.

6. Supplement I of the 2016 Renewal Application lists the Facility's medical staff. *See* Exhibit A. The medical staff identified is affiliated with FPAMG.

7. Supplement II of the 2016 Renewal Application lists the Facility's personnel. *See* Exhibit A. The personnel identified is affiliated with FPAMG.

8. On or about October 26, 2015, the Department received a letter (incorporated herein as Exhibit B) from E. Steve Lichtenberg, MD, MPH, stating that FPAMG would no longer be managing the Facility, effective October 21, 2015. Additionally, the letter informed the Department that the Facility's administrator, medical director and supervising nurse – the same individuals identified in the 2016 Renewal Application – were resigning effective 11:59 p.m., October 21, 2015. *See* Exhibit B.

9. As of October 22, 2015, the Facility has not had an administrator, a medical director, a supervising nurse, any medical staff or any staff personnel. Given the foregoing, Respondent is in violation of or unable to comply with the following Code sections: 205.118(e); 205.125(b); 205.210; 205.220; and 205.230.

10. Section 6.1 of the Act and Section 205.118(e) of the Code state, in pertinent part:

> Any corporation operating an ambulatory surgical treatment center devoted primarily to providing facilities for abortion must have a physician who is licensed to practice medicine in all of its branches and is actively engaged in the practice of medicine at the ambulatory surgical treatment center, on the Board of Directors as a condition to licensure of the ambulatory surgical treatment center.

11. Respondent is devoted primarily to providing facilities for abortion. Respondent does not have a physician who is licensed to practice medicine in all of its branches and is actively engaged in the practice of medicine at the ambulatory surgical treatment center, on the Board of Directors. Respondent is therefore in violation of

Section 6.1 of the Act and Section 205.118(e) of the Code and does not meet the statutory conditions for licensure.

These conditions constitute the Facility's substantial or continued failure to comply with the Act and rules promulgated thereunder. Additionally, the Facility has failed to demonstrate the capacity to safely provide one of more of its services to patients. Given the foregoing, the Department hereby **DENIES RESPONDENT'S APPLICATION FOR LICENSE RENEWAL** effective immediately.

NOTICE OF OPPORTUNITY FOR HEARING

Respondent has a right to a hearing to contest the Refusal to Renew License under section(s) 5/10b, 5/10c, 5/10d, 5/10f, and 5/10g of the Act and Section 205.860 of the Code. If Respondent chooses to contest this Notice, **a written request for hearing must be sent within ten days of receipt of this Notice** to Snigdha Acharya, Deputy General Counsel, Illinois Department of Public Health, 122 South Michigan Avenue, 7th Floor, Chicago, Illinois 60603.

FAILURE TO REQUEST A HEARING AS SPECIFIED HEREIN CONSTITUTES A WAIVER OF THE RIGHT TO SUCH HEARING.

ANSWER BY RESPONDENT

In accordance with Section 100.7(d) of the Department's General Rules of Practice and Procedure in Administrative Hearings (77 Ill. Adm. Code 100), **Respondent must file a written answer to the Allegations of Noncompliance within twenty days of receipt of this Notice.** Such answer must be sent to Snigdha Acharya, Deputy General Counsel, Illinois Department of Public Health, 122 South Michigan Avenue, 7th Floor, Chicago, Illinois 60603.

FAILURE TO FILE AN ANSWER WITHIN TWENTY DAYS OF RECEIPT OF THIS NOTICE SHALL CONSTITUTE RESPONDENT'S ADMISSION OF THE ALLEGATIONS OF NONCOMPLIANCE.

[redacted]
Debra D. Bryars, MSN, RN
Deputy Director
Office of Health Care Regulation
Illinois Department of Public Health

Dated this 17th day of November, 2015

State of Illinois
Illinois Department of Public Health

Ambulatory Surgical Treatment Center Renewal Licensure

ASTC ID No. 7000789
Program Category - 86
Department Use Only

IMPORTANT NOTICE: Pursuant to the Ambulatory Surgical Treatment Center Licensing Act (210 ILCS 55/1 et seq.) and the rules of the Department of Public Health entitled "Ambulatory Surgical Treatment Center Licensing Requirements" (77 IL Adm Code 205).

☒ $300 Application Fee

1. Facility Name/Address

Name of ASTC Albany Medical Surgical Center

Address 5086 N. Elston Avenue

City Chicago County Cook State IL Zip Code 60630

Telephone Number (Area Code) (773) 725-0200 Fax Number (773) 725-6152 E-mail kfitch@fpachicago.com

Administrator's Signature

The Administrator of the facility must review this survey form for completeness and accuracy, then sign and date in the spaces below to certify that, to the best of his/her knowledge, the information provided is complete and accurate.

Typed or Printed Administrator Name Diana Maracich [redacted] 09/23/2015

Administrator Signature (original only) Date of Completeion

Signed and Sworn (or attested) to before me this 23rd day of September 20 15

Notary Public

My commission expires March 11th 20 19

OFFICIAL SEAL
KATHRYN R PHIPPS
Notary Public - State of Illinois
My Commission Expires Mar 11, 2019

This state agency is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under (210 ILCS 5/1 et seq.). Disclosure of this information is mandatory, this form has been approved by the Forms Management Center

DUE DATE: 30 DAYS PRIOR TO THE EXPIRATION OF YOUR CURRENT LICENSE

EXHIBIT A

2. Ownership

1. Please indicate type of ownership with an "X":

☐ Sole Proprietorship	☐ Limited Liability Partnership (*RA)
☒ Corporation (*RA)	☐ Limited Liability Company (*RA)
☐ Partnership (Registered within county)	☐ Other
☐ Limited Partnership (*RA)	* RA - Registered Agent

2. Registered Agent
If your facility ownership indicated above requires a registered agent, please indicate the name, address (including zip code plus four), and telephone number of this person or company. (If you are unable to identify this person or company, contact the Secretary of State's office to identify the facility's registered agent)

Name of Illinois Registered Agent: Richard Kates

Address of Illinois Registered Agent: 111 W. Washington

City, State, Zip Code plus four: Chicago, IL 60602-2703

Telephone of Illinois Registered Agent (including area code): (312) 236-0267

3. Ownership Information
If your facility is required to have a Registered Agent (see #2 above) or is required to have at least three officers, list the name of the state where the home or parent firm is incorporated or registered.

Name of Parent Firm or Organization: Albany Medical Corporation

State where Parent Firm or Organization is Incorporated or Registered: Illinois

List the name and address of the following officers:

TITLE	NAME	FULL ADDRESS
President	Walter Dragosz	5086 N. Elston Avenue, Chicago, IL 60630
Vice-President		
Secretary	Catherine Dragosz	5086 N. Elston Avenue, Chicago, IL 60630
Treasurer		

4. Shareholder Information

If your ASTC is a CORPORATION, list the number of shares held by shareholders with more than five percent of common stock or the top five stockholders, whichever is less. Also, indicate the percentage of total shares that each stockholder holds.

NAME OF STOCKHOLDER	SHARES HELD	PERCENT OF SHARES
Walter Dragosz	100%	100%

5. Other Ownership

Owners

If your facility is a SOLE PROPRIETORSHIP, PARTNERSHIP, LIMITED PARTNERSHIP, LIMITED LIABILITY PARTNERSHIP, LIMITED LIABILITY COMPANY, or OTHER-owned, list the name of the owner(s), the address (es) of each owner, the owner(s)'s profession, and the business that employs each owner. If the owner is self-employed, indicate this by entering "SELF" in the PROFESSION column.

NAMES OF OWNERS	FULL ADDRESS	PROFESSION	BUSINESS NAME

6. Contract Management

If management or operation of the ASTC is performed by independent contractor(s) and not an employee, list the individual name(s) and address(es) of the independent contractor(s). If management or operation is not performed by independent contractor(s), indicate this by checking the box.

☐ Check here if not applicable

NAME	FULL ADDRESS
Family Planning Associates Medical Group	5086 N. Elston Avenue, Chicago, IL 60630

7. History of Conviction
Have any of the following been convicted of a felony, or of two or more misdemeanors involving moral turpitude in the last five years? (If yes, attach explanation as Exhibit I)

1.	Applicant	☐ Yes	☒ No
2.	Any member of a firm, partnership or association	☐ Yes	☒ No
3.	Any officer or director of a corporation	☐ Yes	☒ No
4.	Administrator or manager of ASTC	☐ Yes	☒ No

3. ADMINISTRATION AND PERSONNEL

1. Administrator (attach resume as Exhibit II)

Name Diana Maracich

Address 5086 N. Elston Avenue, Chicago, IL 60630

Telephone Number (773) 725-0200 License Number N/A

2. Medical Director (attach resume as Exhibit III)

Name: E. Steve Lichtenberg, MD, MPH

Address: 5086 N. Elston Avenue, Chicago, IL 60630

Telephone Number (773) 725-0200 License Number 036-076998

3. Supervising Nurse (attach resume as Exhibit IV)

Name: Holly Hines, RN

Address: 5086 N. Elston Avenue, Chicago, IL 60630

Telephone Number (773) 725-0200 License Number 041-349943

Americans United for Life

APPLICATION ADDENDUM

This addendum must be completed as part of the following program/facility application:

Ambulatory Surgical Treatment Center

Home Health

Hospice

Hospital

Secion 10-65(c) of the Illinois Administrative Procedure Act, 5 ILCS 100/10-65(c), was amended by P.A. 87-823, and requires individual licensees to certify whether they are delinquent in payment of child support.

APPLICANT IS AN INDIVIDUAL (SOLE PROPRIETOR) ☐ Yes ☒ No

The following question must be answered only if the applicant is an Individual (sole proprietor):

I hereby certify, under penalty of perjury, that I ☐ am ☐ am not(chek one) more than 30 days delinquent in complying with a child support order.

Signed: _____

Date: _____

FAILURE TO SO CERTIFY MAY RESULT IN A DENIAL OF THE LICENSE AND MAKING A FALSE STATEMENT MAY SUBJECT THE LICENSEE TO CONTEMPT OF COURT. (5 ILCS 100/10-65-(C)).

SUPPLEMENT I

Medical Staff: List specialty, name, and license number of each physician, podiatrist, or dentist granted priveleges to perform surgical procedures in the center.

SPECIALTY	NAME	LICENSE NO.
OB/GYN	E. STEVE LICHTENBERG, MD, MPH	036-076998
OB/GYN	DARWIN C. JACKSON, MD	036-091457
OB/GYN	MURRAY PELTA, MD	036-051083
OB/GYN	WILLIE J. PARKER, MD, MPH	036-131869
OB/GYN	ALLISON A. COWETT, MD, MPH	036-104263

SUPPLEMENT II

Personnel: List position and/or classification; name, education, experience, professional licensure or certification.

POSITION AND/OR CLASSIFICATION	NAME		LICENSE NUMBER, REGISTRATION CERTIFICATION AND YEARS EXPERIENCE
First Clinician	Ali, Rose	PA-C	IL PA 085-0002130, 12 years exp., ACLS
Manager of Finance & Administration	Anderson, Brie	BA	12 years experience
Licensed Nurse	Ashley, Raquel	RN	IL RN 041-335223, 10 years exp., ACLS
Ancillary Back Office Staff	Cancel, Carmen		12 years experience, BLS
Ancillary Back Office Staff	Ciruelas, Aida	CNA	26 years experience, BLS
Certified Registered Nurse Anesthetist	Clanton, Pamela	CRNA, RN	IL CRNA 209-001587, 21 years exp., ACLS
Patient Representative	Cooper, Mary Allison	BA	11 years experience, BLS
Patient Representative	Esparza, Christina		2 years experience, BLS
Ancillary Lab Staff	Farb, Elizabeth	CLA-ASCP	39 years experience, BLS
Clinic Manager	Fitch, Kathy		30 years experience
Maintenance Engineer	Fitch, Timothy		17 years experience
Ancillary Back Office Staff	Fontanez, Julie	CNA	4 years experience, BLS
Assistant Manager	Freeman, Anita		26 years experience, BLS
Supervising Licensed Nurse	Hines, Holly	RN	IL RN 041-349943, 16 years exp., ACLS
Funding Coordinator	Hohmeier, Anne	BA	36 years experience
Certified Registered Nurse Anesthetist	Horigan, Eden	CRNA, RN	IL CRNA 209-006256, 10 years exp., ACLS
Advanced Practice Nurse	James, Evelyn	RN, APN, CNM	IL APN 209-012888, 10 years exp., BLS
Infection Control Licensed Nurse	Jeffery, Shannon	RN	IL RN 041-385188, 11 years exp., ACLS
Patient Representative	LaBellarte, Tammy		16 years experience, BLS

Personnel (continued)

POSITION AND/OR CLASSIFICATION	NAME	LICENSE NUMBER, REGSITRATION, CERTIFICATION, AND YEARS EXPERIENCE
Patient Representative	Madej, Colleen MA, LCSW	5 years experience
Administrator	Maracich, Diana BA	34 years experience
Licensed Nurse	Moore, Donella RN	IL RN 041-322127, 15 years exp., ACLS
Phone Room Specialist / Patient Rep.	Moreira, Vanessa	9 years experience, BLS
Advanced Practice Nurse	Nankin, Sue RN, APN, CNM	IL APN 209-006325, 9 years exp., BLS
Medical Assistant	Pena, Roseane MA	8 years experience, BLS
Insurance Representative I	Perez, Mariola	26 years experience
Manager	Phipps, Kathryn BA	13 years experience, BLS
Operations Manager	Rivera, Linda	33 years experience
Ancillary Back Office Staff	Rondero, Elenita CNA	25 years experience, BLS
Medical Assistant	Seymore, Shannon MA	4 years experience, BLS
Licensed Nurse	Sower, Kari RN	IL RN 041-379859, 8 years exp., ACLS
Ancillary Back Office Staff	Stevenson, Norma	26 years experience, BLS
Ancillary Back Office Staff	Tobicoe, Cynthia	12 years experience, BLS
Assistant Manager	Washington, Beverly	25 years experience, BLS
Certified Nurse Midwife	Wodell, Deborah RN, CNM	IL APN 209-002683, 34 years exp., BLS

Updated May 2015

CURRICULUM VITAE

I PERSONAL INFORMATION

E. Steve Lichtenberg, MD, MPH
Work address: 5086 North Elston Avenue, Chicago, Illinois 60630
Work Phone (773) 725-0200
Work Fax: (773) 725-6152
E-mail: [redacted]
Citizenship: United States of America
Birthplace: [redacted]

II EDUCATION:

Bachelor of Arts:	Cornell University Ithaca, New York Phi Beta Kappa	1963-1967
Medical School:	University of Pennsylvania Philadelphia, Pennsylvania	1967-1971
Master of Public Health in Epidemiology	University of California Berkeley, California	1972-1973

III GRADUATE MEDICAL EDUCATION

Internship	St. Luke's Hospital San Francisco, California	1971-1972
Residency in Obstetrics and Gynecology	University of California San Francisco, California	1979-1982

IV POSTDOCTORAL RESEARCH TRAINING

None

V BOARD CERTIFICATION AND CURRENT MEDICAL LICENSURE

American Board of Obstetrics and Gynecology 1985
California
Illinois

VI MILITARY SERVICE

None

VII FACULTY APPOINTMENTS

Professor of Clinical Obstetrics and Gynecology, Northwestern University Feinberg School of Medicine, effective September 1, 2015	2015-
Associate Professor of Clinical Obstetrics and Gynecology, Northwestern University Feinberg School of Medicine, Chicago, Illinois	2010-2015
Assistant Professor of Clinical Obstetrics and Gynecology, Northwestern University Feinberg School of Medicine, Chicago, Illinois	2001-2010
Instructor and Visiting Attending Physician, Department of Obstetrics and Gynecology, Rush-Presbyterian-St. Luke's Medical Center, Chicago, Illinois	1997-2001

VIII HOSPITAL APPOINTMENTS

Obstetrics and Gynecology, Pacific-Presbyterian Medical Center (Children's Hospital), San Francisco, California	1982-1984
Obstetrics and Gynecology, Kaiser-Permanente Hospital, Sacramento, California	1984-1986
Obstetrics and Gynecology, San Vicente Hospital, Los Angeles, California	1986-1988
Obstetrics and Gynecology, Augustana Hospital, Chicago, Illinois	1988-1990
Courtesy Staff, General Surgery, Edgewater Hospital, Chicago, Illinois	1990-2001
Obstetrics and Gynecology, Northwestern Memorial Hospital, Chicago, Illinois	2001-

IX ADMINISTRATIVE APPOINTMENTS

J.P. Shively, M.D., Inc., General Practice, San Francisco, California	1972-1975
Planned Parenthood San Francisco/Alameda, Medical Director and Clinician, San Francisco, California	1976-1979
Finkelstein and Novikoff, Inc., Group Private Practice, San Francisco, California	1982-1983
OB-GYN Associates of Davis, Group Private Practice, Davis, California	1983-1984
Kaiser-Permanente, HMO Group Practice, Sacramento, California	1984-1986
CIGNA Health plans of California, HMO Group Practice, Glendale, California	1986-1987
Family Planning Associates Medical Group, Senior Staff Physician, Group Practice, Long Beach, California	1986-2005
Albany Medical-Surgical Center, Medical Director, FPA of Illinois Chicago, Illinois	1988-

X COMMITTEE SERVICE

None

XI AWARDS, HONORS AND DISTINCTIONS

1. *Ortho Women's Health Best Scientific Paper:* "Randomized Double-Blind, Placebo-Controlled Trial of 7 Versus 3 Day Oral Doxycycline Prophylaxis Following Elective First Trimester Surgical Abortion" at the National Abortion Federation Annual Meeting, Boston

Massachusetts, May 6, 1997. Authors: **E. Steve Lichtenberg, MD, MPH**, Susan Shott, PhD.

2. *Freedom of Choice Award* presented to Family Planning Associates (FPA) Medical Group of Illinois "in recognition of courageous efforts to make reproductive choice a reality for every woman" by the Chicago Abortion Fund, May 1, 2003.
3. House of Representatives, State of Illinois, Certificate of Recognition for "...extraordinary contribution to the health and well-being of women...". October 20, 2006.
4. *Ortho Women's Health and Urology Scientific Poster Award Winner*: "Non-vaginal Routes of Misoprostol Administration for Pregnancy Termination up to 63 Days' LMP" at the National Abortion Federation Annual Meeting, Boston, Massachusetts, April 24, 2007. Authors: Ilana Dzuba, MHS, Beverly Winikoff, MD, MPH, Linda Prine, MD, Michael Molaei, MD, **E. Steve Lichtenberg, MD, MPH**, Robert Hanson, MD, Alisa Goldberg, MD, Mitchell Creinin, MD, Thomas Britton, MD.
5. *Best Scientific Paper Award*: "Preliminary Results of the Role of Semi-Quantitative Pregnancy Tests in Medical Abortion Provision" at the National Abortion Federation Annual Meeting, Philadelphia, Pennsylvania, April 27, 2010. Authors: Lynd K, Blum J, Winikoff B, **Lichtenberg ES**, Fischer R, Ngoc NN, Howe M, Ali R, Casseday S, Ricci R, Blumenthal P.
6. *Best Scientific Paper Award:* "Pain Control in First Trimester Medical Abortion: A Randomized Trial" at the National Abortion Federation Meeting, New York, New York, April 30, 2013. Authors: Raymond EG, Weaver MA, Louie KS, Dean G, Porsch L, **Lichtenberg ES**, Ali R, Arnesen M.

XII PROFESSIONAL SOCIETY MEMBERSHIPS

American College of Obstetrics and Gynecology	1985-
Association of Reproductive Health Professionals	1991-
National Abortion Federation	1991-
Physicians for Reproductive Health	1995-
The Society of Family Planning (Charter Member)	2005-

XIII PROFESSIONAL and SCIENTIFIC SERVICE

American Civil Liberties Union of Illinois	Board Member 1999-2004
Association of Reproductive Health Professionals	Board Member 2010
National Abortion Federation	Board Member 1999-2005

National Medical Committee of the Planned Parenthood Federation of America		2002-2012
	Vice Chair	2008-2010
	Chair	2010-2012
Society of Family Planning	Scientific Committee	2008-

Journal reviewer:
American Journal of Obstetrics and Gynecology
Journal of Reproductive Medicine

International Journal of Gynaecology and Obstetrics
Obstetrics and Gynecology (Ranked among the top 10% of reviewers for 6 years (2002-6 and 2013).

XIV TEACHING EXPERIENCE

UNDERGRADUATE EDUCATION PORTFOLIO

MEDICAL STUDENT TEACHING

- Preceptor, Medical Students for Choice Introduction to Abortion Program (2001 – present)
- Preceptor and Mentor, 3rd Year OB-GYN Clerkship (2001 – present)
- Preceptor and Mentor, 4th Year Women's Health Elective (2001 - present)
- Site Preceptor, Summer Scholars Program (2001)

OTHER CONTRIBUTIONS

- Oral Examiner, 3rd Year OB-GYN Clerkship Oral Examination

GRADUATE EDUCATION PORTFOLIO

RESIDENT TEACHING

- Preceptor, First and Second Trimester Abortion [Offsite training of house staff in first and second trimester abortion at Family Planning Associates, Ltd. of Illinois]
  - First and Second Trimester Surgical Abortion – 2001 - present
  - First Trimester Medical Abortion – 2008- present
- Resident Research Advisor
  - 2000-2002 -- Allison Cowett: Ultrasound evaluation of the endometrium after medical termination of pregnancy. Obstet Gynecol 2004;103:871-5.
  - 2008-2010 -- Sloane York: Characteristics of presumptive idiopathic disseminated intravascular coagulation during second trimester induced abortion. Contraception 2012;85:489-95. Epub 2011 Nov 30.
  -

OTHER CONTRIBUTIONS

FELLOWSHIP EDUCATION PORTFOLIO

FELLOWSHIP TEACHING

- Site Director, Family Planning Associates, Ltd. [FPA of Illinois provides the majority of 2nd trimester abortion training cases for Northwestern fellows. Dr. Lichtenberg helped found and organize the fellowship at Northwestern and continues to serve as director of this key clinical site.]
- Research Advisor/Mentor

- Hanna Lintu, 2003-2005: Misoprostol at the same time (MAST) Trial Group [Published in Obstet Gynecol 2007;109:885-94.]

- Research Advisor/Mentor
  - Sloane York, 2010-12: Characteristics of presumptive idiopathic disseminated intravascular coagulation during second trimester induced abortion. Contraception 2012;85:489-95. Epub 2011 Nov 30.

OTHER CONTRIBUTIONS

Post Doctoral Fellows Trained and Current Positions

- Allison Cowett MD, MPH — Completed Fellowship 2004
  Assistant Professor of OB-GYN
  Director, Ryan Program in Family Planning
  University of Illinois Chicago
  Chicago, Illinois

- Hanna Lintu MD, MPH — Completed Fellowship 2005
  Assistant Professor of OB-GYN
  University of Helsinki
  Helsinki, Finland

- Melissa Simon, MD, MPH — Completed Fellowship 2006
  Assistant Professor of OB-GYN
  Women's Reproductive Health Research Scholar
  Northwestern University
  Chicago, Illinois

- Kelly Culwell MD, MPH — Completed Fellowship 2007
  WHO/UNFPA Strategic Partnership Program
  World Health Organization
  Geneva, Switzerland, 2008-2011
  Assistant Professor of OB-GYN
  University of California, Davis
  School of Medicine
  Davis, California

- Jessica Kiley, MD, MPH — Completed Fellowship 2008
  Assistant Professor of OB-GYN
  Northwestern University
  Chicago, Illinois

- David Eisenberg, MD, MPH — Completed Fellowship 2009
  Assistant Professor of OB-GYN
  Washington University

St. Louis, Missouri

- Sheila Krishnan Mody, MD MPH — Completed Fellowship 2010
  Assistant Professor of OB-GYN
  University of California, San Diego
  San Diego, California

- Lori Gowron, MD, MPH — Completed Fellowship 2012
  Assistant Professor of OB-GYN
  University of Utah Medical Center
  Salt Lake City, Utah

- Sloane York, MD, MPH — Completed Fellowship in 2013
  Ryan Residency Director, Rush
  St. Lukes, Presbyterian Hospital,
  Chicago Illinois

- Ellen Lorange, DO, MPH — Completed Fellowship in 2014
  Assistant Professor of OB-GYN
  Wake Forest Baptist Medical Center
  Winston-Salem, North Carolina

- Leanne Griffin, MD — Will complete Fellowship in 2015

- Clare Harney, MD — Will complete Fellowship in 2016

- Alex Golobof, MD — Will complete Fellowship in 2016

OTHER EDUCATIONAL POSTS AND PROJECTS

- Medical Education, National Abortion Federation
  - Curriculum Development, 1999-2005

- Scientific Committee, Society of Family Planning, 2008-

XV RESEARCH GRANTS/CONTRACTS

Anonymous Donor **Lichtenberg ES** and Paul M (PIs) 2002-2009
Second round of surveys of NAF-member clinics and clinicians conducted in 2002. his study was an expanded version of the original self-funded round of NAF-member clinics surveyed in 1996-1997.
Role: PI
$15,000.00

Anonymous Donor Jones H, O'Connell-White K, Paul M (PI), **Lichtenberg ES** (PI) 2012
Third cross-sectional survey of abortion providers in the United States and Canada

This study is an expansion of the prior survey listed above.
Role: PI
$116,289.00

XVI SCHOLARLY BIBLIOGRAPHY

Original peer-reviewed research articles:

Lichtenberg ES, Paul M, Jones H. *First trimester surgical abortion practices: A survey of National Abortion Federation members.* Contraception 2001;64;345-52.

Lichtenberg ES, Shott S. *A randomized trial of prophylaxis for vacuum abortion: three versus seven days of doxycycline.* Obstet Gynecol 2003;101:726-31.

Lichtenberg ES, Hill LJ, Howe M, Heber W, Peipert JF. *A randomized comparison of propofol and methohexital as general anesthetics for vacuum abortion.* Contraception 2003;68:211-17.

Lichtenberg ES, Henning C. *Conservative management of clostridial endometritis.* Am J Obstet Gynecol 2004;191:266-70.

Cowett AA, Cohen LS, **Lichtenberg ES**, Stika CS. *Ultrasound evaluation of the endometrium after medical termination of pregnancy.* Obstet Gynecol 2004;103:871-5.

Dzuba I, Britton T, Creinin MD, Goldberg A, Hanson R, **Lichtenberg ES**, Molaei M, Prine L, Winikoff B. The potential of two non-vaginal routes of misoprostol administration following mifepristone for medical abortion up to 63 days gestation. Contraception 2007;76:161-2.

O'Connell K, Jones HE, **Lichtenberg ES**, Paul M. *Second-trimester surgical abortion practices: a survey of National Abortion Federation members.* Contraception 2008;78:492-9.

Wiegerinck MMJ, Jones HE, O'Connell K, **Lichtenberg ES**, Paul M, Westhoff CL. *Medical abortion practices: a survey of National Abortion Federation members in the United States.* Contraception 2008;78:486-91.

O'Connell K, Jones HE, Simon M, Saporta V, Paul M, **Lichtenberg ES**. *First-trimester surgical abortion practices: a survey of National Abortion Federation members.* Contraception 2009;79:385-92.

Fjerstad M, Trussell J, Sivin I, **Lichtenberg ES**, Cullins V. Changes in Regimens for Medical Abortion and Reductions in Serious Infection. New Engl J Med 2009;361:145-51.

Fjerstad M, Sivin I, **Lichtenberg ES**, Trussell J, Cleland K, Cullins V. Effectiveness of medical abortion with mifepristone and buccal misoprostol through 59 gestational days. Contraception 2009;80:282-6.

Sivin I, Trussell J, **Lichtenberg ES**, Fjerstad M, Cleland K, Cullins V. Unexpected heaping in reported gestational age for women undergoing medical abortion. Contraception 2009;80:287-91.

Clark W, Bracken H, Tanenhaus J, Schweikert S, **Lichtenberg ES**, Winikoff B. Alternatives to a routine follow-up visit for early medical abortion. Obstet Gynecol 2010;115:264-72. ClinicalTrials.gov, www.clinicaltrials.gov, NCT00120224.

Bracken H, Clark W, **Lichtenberg ES**, Schweikert S, Tanenhaus J, Barajas A, Alpert L, Winikoff B. Alternatives to routine ultrasound for eligibility assessment prior to early termination of pregnancy with mifepristone-misoprostol. BJOG 2011;118:17-23.

Fjerstad M, Trussell J, **Lichtenberg ES**, Sivin I, Cullins V. Severity of infection following the introduction of new infection control measures for medical abortion. Contraception 2011;83:330-335

York S, **Lichtenberg ES.** Characteristics of presumptive idiopathic disseminated intravascular coagulation during second trimester induced abortion. Contraception 2012;85:489-95. Epub 2011 Nov 30.

Blum J, Shochet T, Lynd K, **Lichtenberg ES**, Fischer D, Arnesen M, Winikoff B, Blumenthal PD. Can at-home semi-quantitative pregnancy tests serve as a replacement for clinical follow-up of medical abortion? A United States study. Contraception 2012;86:757-62.

Winikoff B, Dzuba IG, Chong E, Goldberg AB, **Lichtenberg ES**, Ball C, Dean G, Sacks D, Crowden WB, Swica Y. Extending medical abortion services through 70 days of gestational age. Obstet Gynecol 2012;120:1070-6. ClinicalTrials.gov, www.clinicaltrials.gov, NCT00997347.

Lichtenberg ES, Paul M. Surgical abortion prior to 7 weeks gestation. SFP Clinical Guideline. Contraception 2013;88:7-17.

Raymond EG, Weaver MA, Louie KS, Dean G, Porsch L, **Lichtenberg ES**, Ali R, Arnesen M. Prophylactic Compared With Therapeutic Ibuprofen Analgesia in First Trimester Medical Abortion: A Randomized Controlled Trial. Obstet Gynecol 2013;122:558-64. ClinicalTrials.gov, www.clinicaltrials.gov, NCT01457521

Trussell J, Nucatola D, Fjerstad M, **Lichtenberg ES**. Reduction in infection-related mortality since modifications in the regimen of medical abortion. Contraception 2014;89:193-6.

Frye LJ, Chong E, Winikoff, NCT01799252 Trial Investigators, Ball C, Harris L, **Lichtenberg ES**, Marsh J, Middleton T, Murthy A, Prine L. What happens when we routinely give doxycycline to medical abortion patients? Contraception 2015;91:19-24.

Ramesh S, Roston A, Zimmerman L, Patel A, **Lichtenberg ES**, Chor J. Misoprostol dose a

three hours pre-procedure versus overnight osmotic dilators prior to early second trimester surgical abortion. Contraception (in press).
Goldberg AB, Fortin JA, Drey EA, Dean G, **Lichtenberg ES**, Bednarek PH, Chen BA, Dutton C, McKetta S, Maurer R, Winikoff B, Fitzmaurice GM. Cervical preparation before dilation and evacuation using adjunctive misoprostol or mifepristone compared with overnight osmotic dilators alone: A randomized controlled trial. Obstet Gynecol (in press).

Editorials, reviews, chapters, books, commentaries:

Paul M, **Lichtenberg ES**, Borgatta L, Grimes DA, Stubblefield PG, Eds. *A Clinician's Guide to Medical and Surgical Abortion.* Churchill Livingstone, Philadelphia, Pennsylvania, 1999.
- Chapter 10 - "Surgical Abortion after the First Trimester." Haskell WM, Easterling T, **Lichtenberg ES.**
- Chapter 15 - "Abortion Complications: Diagnosis and Management." **Lichtenberg ES**, Grimes DA, Paul M.

Lichtenberg ES. *Fentanyl reduced pain during first trimester surgical abortion.* Evidenced-based Obstet Gynecol 2002;4:74-5. [Commentary invited and peer-reviewed]

Lichtenberg ES. *Complications of osmotic dilators.* Obstet Gynecol Surv 2004;59:528-36.

Lichtenberg ES. *Intrauterine infusion of lidocaine was not useful for pain control during hysterosalpingography.* Evidence-based Obstet Gynecol 2004; 6:177-80. [Commentary invited and peer-reviewed]

Sokol AI, Sokol ER, Eds. *General Gynecology. The Requisites in Obstetrics and Gynecology.* Mosby Elsevier, Philadelphia, Pennsylvania, 2007.
- Chapter 10 "Pregnancy Loss and Termination." Cowett AA, **Lichtenberg ES**.

Paul M, **Lichtenberg ES**, Borgatta L, Grimes D, Stubblefield P, Creinin MD Eds. *Management of unintended and abnormal pregnancy. Comprehensive Abortion Care.* Wiley-Blackwell, Oxford, UK, 2009. Publication date April 26, 2009.
- Chapter 15 - "Surgical Complications: Prevention and Management" **Lichtenberg ES**, Grimes DA

Case reports, technical notes and letters:

Parer JT, **Lichtenberg ES**, Callen PW, Feduska N. *Iliac venous aneurysm in a pregnant patient with a renal transplant - a case report.* J Reprod Med 1984; 29(12):869-71.

Lichtenberg ES. *Angiography alone as treatment for a high cervical tear.* J Reprod Med 2003;48:287-9.

Lichtenberg ES. *Gestational trophoblastic tumor after medical abortion.* Obstet Gynecol

2003;101:1137-9.

Lichtenberg S. *Cystic teratoma provoked peritonitis after induced abortion.* J Obstet Gynaecol Can 2004;26:823-5.

Lichtenberg ES, Frederiksen MC. *Cesarean scar dehiscence as a cause of hemorrhage after midtrimester dilatation and evacuation.* Contraception 2004;70:61-64.

Proceedings and non-refereed papers:
None

Software and other teaching materials:
None

Patents:
None

XVII PRESENTATIONS

Federal Abortion Ban and *Induction Abortion* presented at Grand Rounds of the University of Puerto Rico School of Medicine, Department of Obstetrics and Gynecology, San Juan Puerto Rico, February 20, 2004.

Preliminary Survey Results of D&E Practices of NAF Member Providers presented at the Second Trimester Providers meeting during the Annual Clinical Meeting of the National Abortion Federation, New Orleans, Louisiana, April 19, 2004.

Osmotic Cervical Dilators: Virtues, Selection, Techniques and Complications presented at a luncheon conference at the Annual Clinical Meeting of the American College of Obstetrician-Gynecologists, May 3, 2004, Philadelphia, Pennsylvania.

Cervical Ripening with Misoprostol: Current Protocols and Practices presented at a luncheon conference at the Annual Clinical Meeting of the American College of Obstetrician-Gynecologists, May 4, 2004, Philadelphia, Pennsylvania.

Best Practices Workshop: Lectures on (1) Pain Management and *(2) Management of Complications* at the Annual Meeting of the National Abortion Federation, Montreal, Quebec, Canada, April 16, 2005.

Pain in the Fetus: A Primer. Panelist. Annual Meeting of the National Abortion Federation, Montreal, Quebec, Canada, April 17, 2005.

Cervical Ripening with Misoprostol: Current Protocols and Practices presented at a luncheon conference at the Annual Clinical Meeting of the American College of Obstetrician-Gynecologists, May 9, 2005, San Francisco, California.

How Safe is Misoprostol for Labor Induction in the Second Trimester for Women with a Prior Cesarean? Presented at a luncheon conference at the Annual Clinical Meeting of the American College of Obstetrician-Gynecologists, May 10, 2005, San Francisco, California.

Best Practices in Abortion Care presented at "Reproductive Health 2005" of the Association of Reproductive Health Professionals, September 7, 2005, St. Petersburg, Florida.

Cervical Ripening with Misoprostol: Current Protocols and Practices presented at a luncheon conference at the Annual Clinical Meeting of the American College of Obstetrician-Gynecologists, May 8, 2006, Washington, DC.

Cervical Ripening with Misoprostol: Current Protocols and Practices presented at a luncheon conference at the Annual Clinical Meeting of the American College of Obstetrician-Gynecologists, May 7, 2007, San Diego, CA.

How Safe is Misoprostol for Labor Induction in the Second Trimester for Women with a Prior Cesarean? Presented at a luncheon conference at the Annual Clinical Meeting of the American College of Obstetrician-Gynecologists, May 8, 2007, San Diego, CA.

Perspectives on Providing Second Trimester Abortion Care: A Panel Discussion. Presented at the Risk Management Meeting of the National Abortion Federation, October 16, 2007, Victoria, BC, Canada. Panelist.

Cervical Ripening with Misoprostol: Current Protocols and Practices presented at a luncheon conference of the Annual Clinical Meeting of the American College of Obstetrician-Gynecologists, May 6, 2008, New Orleans, LA.

Reducing Serious Infections during Medical Abortion presented at the Eighth International Congress of the International Federation of Abortion and Contraception Professionals (FIAPAC), October 25, 2008, Berlin, Germany.

Challenges in Abortion Care: "Stump the Professors" Case Presentations. Moderator of panel discussion presented at the Annual Meeting of the National Abortion Federation, April 26, 2009, Portland, OR.

Complications of Induced Abortion: Prudent Technique, Diagnosis and Management presented at a luncheon conference of the Annual Clinical Meeting of the American College of Obstetrician-Gynecologists, May 4, 2009, Chicago, IL.

New Measures for Infection Reduction during Medication Abortion presented at the Department of Obstetrics and Gynecology Grand Rounds of Prentice Women's Hospital (Northwestern University Feinberg School of Medicine), November 13, 2009, Chicago, IL.

Cervical Ripening and Induction with Misoprostol: Current Protocols and Practices presented at a luncheon conference of the Annual Clinical Meeting of the American College of Obstetrician-Gynecologists, May 18, 2010, San Francisco, CA.

Partnerships between Ryan Programs and NAF Clinics: Strengthening Clinical Skills for Residents and Fellows, panelist for a discussion presented at the Annual Meeting of the National Abortion Federation, April 12, 2011, Chicago, Illinois.

Cervical Ripening and Induction Incorporating Misoprostol (Cytotec): Current Protocols and Practices presented at a luncheon conference of the Annual Clinical Meeting of the American College of Obstetrician-Gynecologists, May 3, 2011, Washington, DC.

Cervical Ripening and Induction Incorporating Misoprostol (Cytotec): Current Protocols and Practices presented at a luncheon conference of the Annual Clinical Meeting of the American College of Obstetrician-Gynecologists, May 8, 2012, San Diego, CA.

Inspiring Networks of Public Service: Peer Health Exchange. Panelist at career development event at the University of California, Berkeley, Dwinelle Hall, April 10, 2013.

Second-Trimester D&E Symposium, panelist, Power Point presentation: "Case report of a partial high cervical tear". Moderator: Adam Jacobs, MD, co-panelists, Shelly Sella, MD, Fred Hopkins, MD, at the Annual Meeting of the National Abortion Federation, New York, New York, April 29, 2013.

Cervical Ripening and Induction Incorporating Misoprostol (Cytotec): Current Protocols and Practices presented at a luncheon conference of the Annual Clinical Meeting of the American College of Obstetrician-Gynecologists, May 7, 2013, New Orleans, LA

Updates in abortion care: New clinical guidelines from the Society of Family Planning and frequently asked questions- **E. Steve Lichtenberg, MD, MPH** and Jennifer Kerns, MD, MS, MPH. Annual meeting of Medical Directors of Planned Parenthood, March 1, 2014, Crested Butte, CO

Cervical Ripening and Induction Incorporating Misoprostol (Cytotec): Current Protocols and Practices presented at a luncheon conference of the Annual Clinical Meeting of the American College of Obstetrician-Gynecologists, April 28, 2014, Chicago, IL

One-hour buccal misoprostol compared with osmotic dilators for cervical preparation in early surgical abortion. Ramesh S, Roston A, Zimmerman L, Patel A, **Lichtenberg S,** Chor J. Poster presentation at the Annual Clinical Meeting of the American College of Obstetrician-Gynecologists, May 3-7, 2013, New Orleans, LA. [Obstet Gynecol, 2014 May; 123 Suppl 1:108S-10S. doi: 10.1097/01.AOG.0000447052.71717.7a.]

Medical Abortion in the United States and Canada: Why so Different? Presented as a lecture at the 11th International Federation of Professional Abortion and Contraception Associates (FIAPAC) meeting in Ljubljana, Slovenia, on October 4, 2014.

Abortion Providers' Resilience to Anti-choice Tactics in the U.S. and Canada. Paul M, O'Connell White K, Norman WV, Okpaleke C, Guilbert E, **Lichtenberg ES,** Jones HE, Foster

presentation at the 11th International Federation of Professional Abortion and Contraception Associates (FIAPAC) meeting in Ljubljana, Slovenia, on October 3-4, 2014.

Demographic Trends in women seeking termination of Pregnancy for fetal anomaly at a free-standing abortion clinic: A neglected population? Linton A, **Lichtenberg ES,** Gowron L. Poster presentation at the Forum on Family Planning and Contraception, October 11-13, 2014, Miami, Florida.

Does a history of prior uterine scarring increase the likelihood of intervention among women undergoing medication abortion? Anderson N, Dehlendorf C, Ali R, Steinauer J, **Lichtenberg S.** Poster presentation at the Forum on Family Planning and Contraception, October 11-13, 2014, Miami, Florida.

Abortion providers' resilience to anti-choice tactics in the U.S. and Canada. Jones HE, O'Connell White K, Norman WV, Okpaleke C, Guilbert E, **Lichtenberg ES,** Paul M. Poster presentation at the Forum on Family Planning and Contraception, October 11-13, 2014, Miami, Florida.

Medical abortion provision in the United States. Jones HE, O'Connell White K, **Lichtenberg ES,** Paul M. Poster presentation at the Forum on Family Planning and Contraception, October 11-13, 2014, Miami, Florida.

Abortion services in Canada: Results of the 2012 national survey. Norman WV, Guilbert E, Okpaleke C, **Lichtenberg ES,** Paul M, O' Connell White K, Jones HE. Poster presentation at the Forum on Family Planning and Contraception, October 11-13, 2014, Miami, Florida.

Cervical Ripening and Induction Incorporating Misoprostol (Cytotec): Current Protocols and Practices presented at a luncheon conference of the Annual Clinical Meeting of the American College of Obstetrician-Gynecologists, May 2, 2015, San Francisco, CA

First Trimester Abortion Practices in Canada: A national survey. Guilbert ER, Hayden A, Jones HE, While KO, **Lichtenberg ES,** Paul M, Norman WV. Presented at the Society of obstetricians and gynaecologists of Canada (SOGC), 71st annual clinical and scientific conference, June 9-12, 2015, Quebec City, QC.

First trimester surgical abortion practices in the United States. White KO, Jones HE, **Lichtenberg ES,** Paul M. Poster presentation at the Forum on Family Planning and Contraception, November 14-6, 2015, Chicago, IL.

Second trimester abortion practices in the United States. White KO, Jones HE, **Lichtenberg ES,** Paul M. Poster presentation at the Forum on Family Planning and Contraception, November 14-6, 2015, Chicago, IL.

Cervical ripening practices before second trimester surgical abortion in the United States. Garai JD, Jones HE, **Lichtenberg ES,** Paul M, White KO. Poster presentation at the Forum on Family Planning and Contraception, November 14-6, 2015, Chicago, IL.

Contraception counseling at the time of first trimester abortion: what do women want?
Catherine Cansino[1], E. **Steve Lichtenberg**[2], Lisa Perriera[3], Melody Hou[1], Juliana Melo[1], Mitchell D Creinin [1]University of California, Davis, Sacramento, CA, USA, [2]Northwestern University, Chicago, IL, USA, [3]Case Western Reserve University, Cleveland, OH, USA. Poster presentation at the Forum on Family Planning and Contraception, November 14-6, 2015, Chicago, IL.

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HOLLY BETH HINES

[redacted]

Jan 2006-present	FAMILY PLANNING ASSOCIATES Registered Nurse	Chicago, IL

- Provide post-operative patient care
- Supervise recovery staff
- Maintain medical supplies

Nov 2005-Jan 2006	NORTHWESTERN MEMORIAL HOSPITAL Staff Registered Nurse	Chicago, IL

- Provided direct patient care on a medical oncology unit.

Aug 99-Nov2005	PLANNED PARENTHOOD CHICAGO AREA Reproductive Health Assistant	Chicago, IL

- Counseled patients on pregnancy options, birth control, surgical abortion, medical abortion and ultrasound results; reviewed medical histories of abortion patients.
- Provided classroom and on-the-job training to new staff in options counseling and listening skills.
- Performed over two thousand vaginal ultrasounds.
- Followed up on abnormal pap smear and STI test results.
- Trained registered nurses from other Planned Parenthood clinics in vaginal ultrasound.
- Spoke to groups of health care providers, including medical students at the University of Chicago and medical residents at Illinois Masonic Medical Center, about abortion.
- Assisted with surgical abortions.
- Performed routine lab tests, including Rh-typing.

April 1998-July 1999	HORIZONS COMMUNITY SERVICES Lesbian and Gay Helpline Administrator	Chicago, IL

- Trained, supervised and scheduled approximately fifty volunteer telephone counselors.
- Provided leadership for design and implementation of computer call tracking system and resource database.
- Responsible for weekend and holiday phone counseling coverage.
- Performed crisis intervention.

Sept 1993-July 2001	EDGEWATER MEDICAL CENTER Nursing Unit Secretary	Chicago, IL

- Coordinated activities of nursing unit, including patient flow, services performed by other departments, physician consultations and patient transportation.
- Transcribed doctors' orders onto kardexes.
- Scheduled diagnostic procedures via computer.

May-Aug 1996	ILLINOIS AIDS HOTLINE Temporary Staff Counselor	Chicago, IL

- Fielded callers' questions regarding HIV transmission, testing, symptoms, treatment and risk reduction.
- Provided referrals and emotional support.

Jan 1990-Jan 1991	ENGLISH LANGUAGE SCHOOLS INTERNATIONAL Instructor	Taipei, Taiwan

- Created lesson plans.
- Conducted interactive, student-centered classes in English for Taiwanese business people in their places of work.

EDUCATION

Aug 2006-Dec 2007	University of Illinois at Chicago: graduate nursing coursework
May 2004-June 2005	Loyola University of Chicago: B.S., Nursing, 4.0 GPA
1995-1997	University of Illinois at Chicago: undergraduate coursework
1994	McCormick Theological Seminary. M.A., Theological Studies
1989	University of Illinois, Champaign-Urbana: B.S., Psychology

VOLUNTEER EXPERIENCE

Aug 1999-Aug 2000	HORIZONS COMMUNITY SERVICES Volunteer Helpline Administrator	Chicago, IL
Sept 1994-April 1998	HORIZONS COMMUNITY SERVICES Counselor, Gay and Lesbian Helpline	Chicago, IL
Sept 1994-Jan 1997	ILLINOIS AIDS HOTLINE Counselor	Chicago, IL
Jan-Aug 1991	HELPLINE OF THE MIDLANDS Crisis Intervention Counselor	Columbia, SC
Sept 1986-Aug 1989	CHAMPAIGN COUNTY MENTAL HEALTH CENTER CRISIS LINE Crisis Intervention Counselor	

COMPUTER SKILLS: Microsoft Word, Internet.

Americans United for Life

CURRICULUM VITAE

Diana Maracich

[redacted]

PROFESSIONAL EXPERIENCE

Chief Operating Officer

Family Planning Associates Medical Group, Chicago, Illinois
October 2005-Present

Promoted to oversee all financial strategy and execution for Family Planning Associates Medical Group, while also maintaining the responsibilities of Facility Administrator.

- Credited for developing ongoing contracts with most major insurance providers.
- Researched and incorporated new services and procedures as medical technology advanced, increasing profitability and safety.

Facility Administrator

Family Planning Associates Medical Group, Chicago, Illinois
1988-Present

- Responsible for supervising a staff of over 60 employees.
- Handled the daily operation of the facility and delegated responsibilities as needed.
- Served as the liaison between Family Planning Associates and the State of Illinois during quarterly state inspections, ensuring compliance with state licensing requirements.
- Oversaw the opening of two additional facilities due to increased demand.

Clinic Administrator

Family Planning Associates Medical Group, Fresno, California
1987-1988

- Responsible for supervising a staff of 40 employees.
- Handled the daily operation of the facility and delegated responsibilities as needed.
- Accountable for all hiring, training, and retention of the staff.

Clinic Administrator

Family Planning Associates Medical Group, Modesto, California
1985-1987

- Responsible for supervising a staff of 25 employees.
- Managed the daily operation of the facility and delegated responsibilities as needed.
- Accountable for all hiring, training, and retention of the staff.

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CLINICAL EXPERIENCE

Medical Assistant

Family Planning Associates Medical Group, Modesto, California
1980-1985

- Ensured the cleanliness, sterility and maintenance of all facilities, surgical rooms and equipment.
- Consistently praised for efficient handling of administrative duties including maintaining medical records and patient processing.
- Reacted calmly during emergent situations and consistently added a compassionate and calming touch when interacting with patients.

CERTIFICATIONS

BLS for Healthcare Providers

Current CPR Certification

ADDITIONAL ACTIVITES

National Abortion Federation Board Member, April 2007-Present

LECTURES

Family Planning Clinic Implementation of Medical Abortion using Mifepristone and Misoprostal (RU486) and Responsible Management of Unfavorable Surgical Complications
Presented at the National Abortion Federation Annual Meeting, San Jose, California
April 2002

Family Planning Clinic Implementation of Medical Abortion using Mifepristone and Misoprostal (RU486)
Presented to Family Planning Associates Medical Group Organizational Meeting, San Jose, California
January 2001

EDUCATION

University of the Pacific, Stockton, California
Bachelor of Arts, June 1985

San Joanquin Delta College, Stockton California
Attended 1981-1983

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SUPPLEMENT III

List Consulting Committee approved surgical specialties and procedures

Effective March 1, 1995, the Illinois Health Facilities Planning Board implemented a provision requiring a Planning Board permit for the addition of surgical specialties that had not been approved prior to March 1, 1995. Therefore, your application should not include specialties that require Planning Board approval. Surgical specialties can be added under your license once the Planning Board approval has been obtained.

ASTC Renewal Licensure Application Checklist

- ☒ Completed Application
- ☒ Articles of Incorporat on
- ☒ Administrator's Resume
- ☒ Medical Director's Resume
- ☒ Supervising Nurse's Resume
- ☒ List of Medical Staff
- ☒ Separate list of Personnel Staff
- ☒ Surgical Procedures and services provided
- ☒ Renewal fee of $300

ALBANY MEDICAL SURGICAL CENTER

5086 NORTH ELSTON AVENUE
CHICAGO, ILLINOIS 60630
(773) 725-0200

Exhibit V – ASTC Renewal Licensure

ASTC ID # 7000789

The procedures performed at Albany Medical Surgical Center include:

- First Trimester Abortion
- Second Trimester Abortion
- Laminaria Insertions
- Insertion and removal of Intrauterine Contraception Devices

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for Life

ALBANY Medical Surgical Center

5086 North Elston Avenue, Chicago, Illinois 60630 • (773) 725-0200

October 20, 2015

Nirav Shah, M.D., J.D.
Director
Illinois Department of Public Health
535 West Jefferson Street, 5th floor
Springfield, IL 62761-5058

Dear Dr. Shah,

Please be advised that Family Planning Management will no longer be managing Albany Medical Surgical Center, effective October 21, 2015. Also, be advised of the resulting personnel changes:
E. Steve Lichtenberg, M.D. M.PH is resigning as Medical Director, effective 11:59 p.m., October 21, 2015
Diana Maracich is resigning as Administrator, effective 11:59 p.m., October 21, 2015
Holly Hines, R.N. resigning as Supervising Nurse, effective 11:59 p.m., October 21, 2015

This letter is being sent based on the requirements outlined in the Illinois Department of Public Health Administrative Code, section 205.118, Conditions of Licensure.

If you have any questions please do not hesitate to contact me directly.

Sincerely,

[redacted]

E. Steve Lichtenberg, M.D., MPH

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

X ASTC HHA ☐ HMO HOSPICE HOSPITAL

NAME AND ADDRESS OF FACILITY: Apollo Surgical Center
2750 South River Road, Des Plaines, Illinois 60018

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
	On survey date 2/29/16 a licensure survey was conducted at Apollo Surgical Center in Des Plaines, Illinois. The Facility is in compliance with Illinois Administrative Code 77 Ill: Public Health Chapter I: Department of Public Health Subchapter b: Hospital and Ambulatory Care Facilities Part 205 Ambulatory Surgical Treatment Center licensing requirements. The Facility is a multi specialty center that includes: Gynecology; urology; gastroenterology; ophthalmology; orthopedics; podiatry; general surgery; cosmetic surgery; and pain management. Hours of operation are: 7:00 AM to 4:00 PM and operate only on Fridays. Average 10 cases per month.		

DATE OF SURVEY 2/29/16 BY 15168 (Surveyor)

(Provider's Representative)

NOTE: IF ILV, INDICATE DATE OF PRIOR SURVEY

APOLLO
Surgical Center

Phone: 847.255.7400 Fax: 847.398.4585
E-mail: Apollo@officegci.com Website: www.ApolloSurgicalCenter.com

Future Facility Address:
2750 South River Road
Des Plaines, IL 60018

Administration Office:
1640 N. Arlington Heights Rd.
Suite 110
Arlington Heights, IL 60004

March 13, 2014

Sent Via UPS Overnight

Karen Senger, RN, BSN
Supervisor of Central Office Operations Section
Division of Health Care Facilities and Programs
Illinois Department of Public Health
525 West Jefferson Street
4th Floor
Springfield, IL 62761-0001

Dear Ms. Senger,

On March 6, 2014 we received the Statement of Deficiencies from our IDPH Survey.

Enclosed please find our Plan of Correction. All items have been completed.

Sincerely,

[redacted]

Vera Schmidt
Administrator
Apollo Health Center, Ltd.

RECEIVED OHCR/DCF&P
2014 MAR 14 A 11:33

3/17/14
K65-51

Americans United for Life

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

ASTC

NAME AND ADDRESS OF FACILITY: Apollo Health Center, Ltd., 2750 So. River Rd., Des Plaines, IL 60018

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.230(a)(1)	Standards of Professional Work The membership of the consulting committee shall reflect the types of procedures performed. If the facility performs more than 50 procedures per month or more than 10% of the total procedures performed are in a specific specialty area then there shall be consulting physician of that specialty on the consulting committee. Based on document review and interview, it was determined for 1 of 3 surgical specialties (gastrointestinal) (GI) expected to perform approximately 33% of the surgical procedures, the facility failed to ensure a GI physician was on the consulting committee. Findings include:		

DATE OF SURVEY 2/11/14 BY 19843 (Surveyor) (Provider's Representative)

NOTE: IF REV, INDICATE DATE OF PRIOR SURVEY

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

ASTC

NAME AND ADDRESS OF FACILITY: Apollo Health Center, Ltd., 2750 So. River Rd., Des Plaines, IL 60018

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.230(a)(1) continued	1. The facility's Bylaws, undated, were reviewed on 2/11/14 at 1:00 PM. The Bylaws required, "7.1. The Consulting Committee is the organization components to which the Center's Board of Directors delegates responsibilities relating to, and exact accountability for the quality and appropriateness of patient care and professional performance… The Consulting Committee shall be made up of members of Administration, qualified surgeons, anesthesiologists, pathologists, and other consulting physicians consisting of not less than three (3) members who shall establish the required standards commensurate with the size, scope, extent and complexity of service programs and procedures for which the Center is licensed."		

DATE OF SURVEY 2/11/14 BY 19843 (Surveyor) _____ (Provider's Representative)

NOTE: IF REV, INDICATE DATE OF PRIOR SURVEY _____

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

ASTC

NAME AND ADDRESS OF FACILITY: Apollo Health Center, Ltd., 2750 So. River Rd., Des Plaines, IL 60018

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.230(a)(1) continued	2. On 2/11/14 at 9:00 AM, an interview was conducted with the Administrator. The Administrator stated the Governing Body was the same as the Consulting Committee and the Governing Body meeting minutes were the same as the Consulting Committee's. The Administrator stated that a GI physician had not participated in the Governing Body/Consulting Committee meetings. 3. On 2/11/14 at 10:00 AM, the Governing Body (Consulting Committee) meeting minutes for the past 12 months were reviewed. Meetings were held on 3/20/13, 1/27/14, and 2/5/14. There was no GI physician in attendance during the meetings.	205.230(a)(1) See Consulting Committee Minutes. Vera Schmidt, Chief of Operations, will ensure that all physicians receive notice of meetings and that each specialty is represented as the meetings.	3/14/2014

DATE OF SURVEY 2/11/14 BY 19843 (Surveyor) (Provider's Representative)

NOTE: IF PLAN, INDICATE DATE OF PRIOR SURVEY

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

ASTC

NAME AND ADDRESS OF FACILITY: Apollo Health Center, Ltd., 2750 So. River Rd., Des Plaines, IL 60018

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.230(a)(1) Continued	4. On 2/11/14 at 11:00 AM, an interview was conducted with the Medical Director. The Medical Director stated the ASC would be performing obstetric, GI, and urology procedures and expected each specialty to do approximately one third of the surgical cases.		

DATE OF SURVEY 2/11/14 BY 19843 (Surveyor)

(Provider's Representative)

NOTE: IF PLAN INDICATE DATE OF PRIOR SURVEY _____

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

ASTC

NAME AND ADDRESS OF FACILITY: Apollo Health Center, Ltd., 2750 So. River Rd., Des Plaines, IL 60018

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.230(a)(2)	The consulting committee shall review development and content of the written policies and procedures of the center, the procedures for granting privileges, and the quality of the surgical procedures performed. Evidence of such review shall be recorded in the minutes. Based on document review and interview, it was determined the consulting committee failed to review the procedures for granting privileges and the quality of the surgical procedures performed. (The facility is currently licensed as a pregnancy termination facility.) This affected all past and future surgical patients. Findings include:		

DATE OF SURVEY 2/11/14 BY 19843 (Surveyor)

(Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

ASTC

NAME AND ADDRESS OF FACILITY: Apollo Health Center, Ltd., 2750 So. River Rd., Des Plaines, IL 60018

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.230(a)(2) continued	1. On 2/11/14 at 9:00 AM, an interview was conducted with the Administrator. The Administrator stated the Governing Body was the same as the Consulting Committee and the meeting minutes were the same. 2. On 2/11/14 at 10:00 AM, the Governing Body (Board of Directors) meeting minutes for the past 12 months were reviewed. Meetings were held on 3/20/13, 1/27/14, and 2/5/14. There was no discussion of the procedures for granting privileges or the quality of the surgical procedures currently being performed. There were no separate Consulting Committee meeting minutes.	205.230(a)(2) See Consulting Committee Minutes. The Consulting Committee has reviewed and discussed the procedures. Vera Schmidt will ensure procedures for granting privileges and the quality of the surgical procedures are discussed at the Consulting Committee. The Board of Directors approves the Consulting Committee's minutes.	3/14/2014

DATE OF SURVEY 2/11/14 BY 19843 (Surveyor) _____ (Provider's Representative)

NOTE: IF N.V. INDICATE DATE OF PRIOR SURVEY _____

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

ASTC

NAME AND ADDRESS OF FACILITY: Apollo Health Center, Ltd., 2750 So. River Rd., Des Plaines, IL 60018

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.230 (b)(2)	Standards of Professional Work The Medical Director shall be responsible for the implementation of medical policies and procedures contained in the facility's policy and procedure manual (Section 250.240) governing the professional personnel involved directly in the care of patients undergoing surgical procedures, including their preoperative and postoperative care and follow-up. Based on document review and interview, it was determined, the facility failed to ensure the surgical count policy was accurate, affecting all future surgical patients.		

DATE OF SURVEY 2/11/14 BY 19843 (Surveyor) (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

ASTC

NAME AND ADDRESS OF FACILITY: Apollo Health Center, Ltd., 2750 So. River Rd., Des Plaines, IL 60018

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.230 (b)(2) continued	1. Facility policy titled, "Counts of Sponges, Needles and Knife Blades (invasive)", with no date, was reviewed on 2/11/14 at 11:15 AM. The policy required, "E. If an item cannot be found… An X-ray should be taken to determine if the item is in the patient." 2. An interview was conducted with the Administrator on 2/11/14 at 11:00 AM. The Administrator stated the facility did not have an X-ray machine and the patient would have to be sent out of the facility if needles did not match the count.	205.203(b)(2) 1. & 2. See Consulting Committee Minutes. The policy has been changed and approved by the Committee (See Enclosure). The Medical Director will be responsible to keep clinical policy and procedures current and relevant to the surgical cases.	3/14/2014

DATE OF SURVEY 2/11/14 BY 19843 (Surveyor) (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

ASTC

NAME AND ADDRESS OF FACILITY: Apollo Health Center, Ltd., 2750 So. River Rd., Des Plaines, IL 60018

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.310 (b)	Personnel Policies The ambulatory surgical treatment center shall check the status of all applicants with the Health Care Worker Registry prior to hiring. Based on document review and interview it was determined for 10 of 10 (E# 1 - 10) non registered nurse files reviewed, the facility failed to check the status of the employees on the Health Care Worker Registry. Findings include: 1. The facility policy titled "Personnel - Employment Application" (approved 1/27/14), required, "Surgery center regulations require that ALL employees be screened through the Illinois Nurses' Aide Registry."	205.310(b) See Consulting Committee Minutes. All non-licensed healthcare workers have been screened through the Illinois Nurses' Aide Registry. Vera Schmidt, Chief of Operations, will ensure ongoing compliance.	3/14/2014

DATE OF SURVEY 2/11/14 BY 19843 (Surveyor) (Provider's Representative)

NOTE: IF PLAN INDICATE DATE OF PRIOR SURVEY

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

ASTC

NAME AND ADDRESS OF FACILITY: Apollo Health Center, Ltd., 2750 So. River Rd., Des Plaines, IL 60018

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.310 (b) continued	2. The personnel files of 10 non registered nurses staff members (E#1 - #10) were reviewed on 2/11/14. The 10 employees gave permission to have their status checked on the registry; however, there is no documentation of this occurring. 3. During an interview on 2/11/14 at approximately 11:00 AM, the Administrator stated, "we have not done any status checks because the staff are not nursing assistants."		

DATE OF SURVEY 2/11/14 BY 19843 (Surveyor) (Provider's Representative)

NOTE: IF PLAN INDICATE DATE OF PRIOR SURVEY

Special Meeting of the Consulting Committee
Apollo Health Center, Ltd.

March 12, 2014

Present:	Vera Schmidt, Administrator	Vinod Goyal, M.D. - Medical Director/GYN
	Nisha Patel, M.D.	Gordon Gluckman, M.D. - Urology
	Vijay Goyal, M.D.	Arun Ohri, M.D. – Gastroenterology

I. Call to Order

Meeting called to order at 1:30pm by Vera Schmidt.

II. Reading of the Notice Calling the Meeting

This special meeting of the Consulting Committee is being held to address the findings of the February 11, 2014 IDPH Statement of Deficiencies.

IV. Transaction of Business for which the Meeting was Called

The Consulting Committee has reviewed the Policy and Procedure Manual for the surgical center and has implemented the following:

1. Membership of the Consulting Committee shall reflect the types of procedures performed. The following current surgical specialties (Gastroenterology, Urology, and Gynecology) must be represented at the meetings.

2. The Center's policy and procedure for granting privileges has been found to be complete and appropriate. The following physicians have been granted privileges:
   a. Vinod Goyal, M.D. – GYN, Medical Director
   b. Gordon Gluckman, M.D. – Urology
   c. Arun Ohri, M.D. – Gastroenterology
   d. Paul Fahrenbach, M.D. – Gastroenterology
   e. Sampath Chennamaneni, M.D. – Anesthesiology
   f. Nisha Patel, M.D. – Family Practice
   g. Vijay Goyal, M.D. – General Practice
   h. Nichole Williams, M.D. – Uro-Gynecology

3. The Center's list of approved surgical procedures has been reviewed and accepted.

4. The Center's Nursing Policy and Procedure manual has been updated to reflect the approved surgical procedures.
   Regarding Nursing Policy: "Counts of Sponges, Needles, and Knife Blades"
   Section XI.A, Procedure E.3: "An X-ray should be taken to determine if the item is in the patient."
   The Center does not perform X-rays. Vera Schmidt has researched this matter and has found the following:

i. Research shows that the smallest needle that could be visualized on an X-ray is 5-0 suture and that a 6-0 suture is very difficult to visualize. (Macilquham MD, Riley RG, Grossberg P. Identifying lost surgical needles using radiographic techniques. AORN J 2003 Jul; 78(1):73-8.)
ii. A review of our current list of procedures demonstrates that our "invasive" procedures are actually minimally invasive; incisions are superficial and small and do not require any large incisions and/or open wounds.
iii. A discussion with the surgeons found that when there is a discrepancy in the count, they did not feel the need for mandatory X-ray follow-up the type of procedures they will perform.

This research justifies the removal of Procedure E.3 in this policy.

5. Per IDPH recommendations, all employees will be screened through the Illinois Nurses' Aide Registry. Vera Schmidt had previously investigated whether or not medical assistants needed to be screened and was told by the Registry that it was only for Nurses' Aides. Nevertheless, all non-licensed healthcare workers have been screened and no negative finds were found. The Nurses' Aide Registry screening has been added to the Personnel section of the Policy and Procedures Manual.

III. Adjournment

Having no further business, the meeting is adjourned

Approval of Minutes:

[redacted]

Vera Schmidt, Administrator

[redacted]

Vinod K. Goyal, M.D., Medical Director

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COUNTS OF SPONGES, NEEDLES AND KNIFE BLADES

POLICY:

Sponge, needle and knife blade counts are at the discretion of the physician to account for all items used during a procedure.

PROCEDURE:

A. Counts shall be made as follows: once prior to incision, as added to case, and before closure of incision.

B. The scrub person and circulating person carry out counts concurrently. The circulating personnel documents and signs for the counts.

C. Once the first count is taken, nothing should be removed from the operating room until after the final count.

D. The circulating person informs the surgeon of the count status.

E. If an item cannot be found:

1. Inform the surgeon.
2. A complete inspection of the sterile area and operating suite is performed.
3. The surgeon shall perform a visual and manual search of the wound to try and locate the missing item.
4. The surgeon will determine how to follow up with the patient.
5. Initiate an incident report

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CREDENTIALING POLICY FOR PERSONNEL

POLICY:

A review of all credentials and references for all new personnel shall be performed.

OBJECTIVE:

A. The assurance that patient care is by qualified competent staff.

B. The assurance that state licensing requirements, when applicable, have been met by the employee.

PROCEDURE:

A. Licensed Staff will have their license verified by IDFPR License Look-Up Verification. The report from License Look-Up and copies of the employees' current licenses shall be placed in their personnel file.

B. Non – Licensed healthcare workers will be screened through the Illinois Nurse's Aide Registry and the result of the report shall be placed in their personnel file.

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Special Meeting of the Board of Directors
Apollo Health Center, Ltd.

March 7, 2014

Present: Vera Schmidt, Administrator
Nisha Patel, M.D.
Vinod Goyal, M.D. - Medical Director
Vijay Goyal, M.D.

I. Call to Order

Meeting called to order at 1:00pm by Vera Schmidt.

II. Reading of the Notice Calling the Meeting

This special meeting of the Board of Directors is being held to address the findings of the February 11, 2014 IDPH Statement of Deficiencies and to establish the Consulting Committee.

IV. Transaction of Business for which the Meeting was Called

Membership of the Consulting Committee must reflect the types of procedures performed.

The following members have been appointed to the Consulting Committee:

- Vera Schmidt, Chief of Operations
- Vinod Goyal, M.D., Medical Director - Gynecology
- Gordan Gluckman, M.D.- Urology
- Arun Ohri, M.D. - Gastroenterology

Other Professional staff may also participate in the Consulting Committee as needed.

The Consulting Committee will meet at least quarterly or as needed.

The appointed Consulting Committee will meet on March 12, 2014 to address the findings of the IDPH survey. The Plan Of Correction must be submitted within 10 day (received on March 6, 2014).

III. Adjournment

Having no further business, the meeting is adjourned

Approval of Minutes:

[redacted]

Vera Schmidt, Administrator

[redacted]

Vinod Goyal, M.D., Medical Director

Special Meeting of the Board of Directors
Apollo Health Center, Ltd.

March 13, 2014

Present: Vera Schmidt, Administrator
Nisha Patel, M.D.
Vinod Goyal, M.D. - Medical Director
Vijay Goyal, M.D.

I. Call to Order

Meeting called to order at 1:00pm by Vera Schmidt.

II. Reading of the Notice Calling the Meeting

This special meeting of the Board of Directors is being held to approve the minutes of the Consulting Committee.

IV. Transaction of Business for which the Meeting was Called

The Consulting Committee Minutes of the March 12, 2014 meeting have been reviewed and accepted.

The IDPH Plan of Corrections has been completed and is ready to send to IDPH today.

III. Adjournment
Having no further business, the meeting is adjourned

Approval of Minutes:

[redacted]
Vera Schmidt, Administrator

[redacted]
Vinod Goyal, M.D., Medical Director

Americans United for Life

Illinois Department of
PUBLIC HEALTH

Pat Quinn, Governor

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.idph.state.il.us

December 11, 2013

Ms. Vera Schmidt, Administrator
Apollo Health Center Ltd
2750 South River Road
Des Plaines, IL 60018-

Initial Licensure Survey

Re: Apollo Health Center Ltd
Des Plaines
New ASTC
IDPH No: 9763

Dear Ms. Schmidt:

On December 10, 2013, an initial licensure follow up inspection was conducted for the purpose of determining compliance with the requirements of the "Ambulatory Surgical Treatment Center Licensing Requirements" (77 Ill. Adm. Code 205) and the 2000 Edition of NFPA 101, Life Safety Code.

At this time, it has been determined that the above listed facility is in compliance with the physical environment requirements of the Act and Codes. It will be necessary for a nursing survey to be conducted prior to receiving the license. This recommendation has been forwarded to the Central Office Operations Section for the scheduling of the nursing survey. A license must be issued prior to treating patients.

If you have any questions about this approval, please do not hesitate to call us at 217-785-4264 The Department's TTY number is 800/547-0466, for use by the hearing impaired.

Sincerely,

[redacted]

Henry Kowalenko, Division Chief
Division of Life Safety and Construction

Cc: Mr. David Schaefer
David A. Schaefer Architects PC
2500 S. Highland Avenue, Suite 340
Lombard, IL 60148-

Toni Colón - Deputy Director - IDPH

Karen Senger, Supervisor - Central Office Operations Section, IDPH

OMNIBUS BILL OF SALE AND ASSIGNMENT

THIS OMNIBUS BILL OF SALE AND ASSIGNMENT (this **"Instrument"**), dated as of October 31, 2016, is made and delivered pursuant to, and subject to the terms of, that certain Asset Purchase Agreement, dated as of August 5, 2016 (the **"Purchase Agreement"**), by and among APOLLO SURGICAL CENTER, LLC, an Illinois limited liability company (**"Seller"**), and each member of Seller, and UROPARTNERS SURGERY CENTER, LLC, an Illinois limited liability company (**"Purchaser"**). Capitalized terms not otherwise defined in this Instrument will have the meanings given to such terms in the Purchase Agreement.

Recitals:

WHEREAS, pursuant to the Purchase Agreement, Seller has agreed to sell, assign, transfer, convey and deliver to Purchaser, and Purchaser has agreed to purchase, acquire and receive from Seller, the Acquired Assets.

WHEREAS, Purchaser and Seller now desire to evidence and effectuate the transfer and conveyance of the Acquired Assets from Seller to Purchaser.

NOW THEREFORE, in consideration of the mutual covenants set forth in the Purchase Agreement and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, Purchaser and Seller hereby covenant and agree as follows:

1. Assignment and Sale. As of the Closing, Seller does hereby sell, convey, transfer, assign and deliver to Purchaser all of the Acquired Assets. Purchaser acknowledges that neither Seller, nor any member of Seller, makes no representation or warranty with respect to the Acquired Assets except as specifically set forth in the Purchase Agreement.

2. Excluded Assets. Notwithstanding anything to the contrary in this Instrument, the Purchase Agreement or in any other document delivered in connection herewith or therewith, the Acquired Assets being transferred pursuant to this Instrument expressly excludes (a) the Excluded Assets and (b), notwithstanding anything in the Purchase Agreement to the contrary, the Lease Agreement between EverBank Commercial Finance and Seller, dated on or about August 28, 2014.

3. Further Documents and Instruments. From time to time, as and when requested by Purchaser, Seller will execute and deliver, or cause to be executed and delivered, all such documents and instruments and will take, or cause to be taken, all such further or other actions, as Purchaser or its successors and permitted assigns may reasonably deem necessary or desirable to sell, transfer, convey and assign more effectively to Purchaser the Acquired Assets.

4. Successors and Assigns. This Instrument will be binding upon and inure to the benefit of the parties hereto and their respective successors and assigns.

5. Inconsistencies. To the extent that any provision of this Instrument is inconsistent or conflicts with the Purchase Agreement, the Purchase Agreement will control. Nothing in this

Agreement is intended to supersede any of the terms, agreements, representations or warranties of the Parties set forth in the Purchase Agreement.

6. Amendments. No amendment of any provision of this Instrument will be valid unless the same will be in writing and signed by Seller and Purchaser.

7. Severability. If any provision of this Instrument or the application of any such provision to any person or circumstance will be held invalid, illegal or unenforceable in any respect by a court of competent jurisdiction, such invalidity, illegality or unenforceability will not affect any other provision hereof.

8. Counterparts. This Instrument may be executed in two or more counterparts (including via facsimile or other electronic means), each of which will be deemed an original, but all of which together will constitute one and the same instrument.

9. Notices. All notices, requests, demands, claims and other communications hereunder will be delivered to the parties as provided in the Purchase Agreement.

10. Governing Law. This Instrument will be governed by and construed in accordance with the internal laws of the State of Illinois applicable to agreements made and to be performed entirely within such State, without regard to conflicts of laws principles (whether of the State of Illinois or any other jurisdiction) that would cause the application of the laws of any jurisdiction other than the State of Illinois.

[SIGNATURE PAGE FOLLOWS]

Americans United for Life

IN WITNESS WHEREOF, this Omnibus Bill of Sale and Assignment is duly executed and delivered as of the date and year first above written.

APOLLO SURGICAL CENTER, LLC, an Illinois limited liability company

By: [redacted]
Vera Schmidt, a Manager

UROPARTNERS SURGERY CENTER, LLC, an Illinois limited liability company

By: _____
Richard G. Harris, M.D., Manager

IN WITNESS WHEREOF, this Omnibus Bill of Sale and Assignment is duly executed and delivered as of the date and year first above written.

APOLLO SURGICAL CENTER, LLC, an Illinois limited liability company

By:_____
Vera Schmidt, a Manager

UROPARTNERS SURGERY CENTER, LLC, an Illinois limited liability company

[redacted]

By:_____
Richard G. Harris, M.D., Manager

Americans United for Life

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

Pat Quinn, Governor
LaMar Hasbrouck, MD, MPH, Director

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

January 31, 2014

Erin King, MD, Administrator
Hope Clinic for Women, Ltd., The
1602 21st Street
Granite City, IL 62040-

Re: Hope Clinic for Women, Ltd., The
Granite City
Licensure survey

Dear Erin King, MD:

On 04/28/12 a life safety code inspection was conducted for the purpose of determining compliance with the requirements of the "Ambulatory Surgical Treatment Center Licensing Requirements" (77 Ill. Adm. Code 205) and NFPA 101, Life Safety Code, 2012 Edition. Based on the Life Safety Code Monitoring visit on 01/29/14, we find that the previously cited deficiencies have been corrected and the facility is no longer under monitoring for physical environment.

If you have any questions about this approval, please do not hesitate to call us at 217-785-4247 The Department's TTY number is 800/547-0466, for use by the hearing impaired.

Sincerely,

[redacted]

Henry Kowalenko, Division Chief
Division of Life Safety and Construction

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTHCARE FACILITIES AND PROGRAMS
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

☐ AHC X ASTC ☐ FEC ☐ HHA ☐ HMO ☐ HOSPICE HOSPITAL ☐ OTHER _____

NAME AND ADDRESS: Hope Clinic for Women
OF FACILITY: 1602 21st Street, Granite City 62040

LICENSE #: 7001084

RULE/REGULATION	REQUIREMENT SUMMARY AND DESCRIPTION OF NONCOMPLIANCE	PLAN OF CORRECTION	COMPLETION DATE (MM/DD/YY)
	A Licensure survey was conducted 4/22-4/24/19. The Hope Clinic for Women was found to be in compliance with The Illinois Administrative Code Title 77: Public Health, Chapter 1: Subchapter b, Part 205 Ambulatory Surgical Treatment Center Licensing Requirements, for this survey.		

DATE OF SURVEY 4/22-4/24/19

BY 25926, 25927
(Surveyor)

(Provider's Representative)

NOTE: IF R.V. INDICATE DATE OF PRIOR SURVEY

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525 535 West Jefferson Street · Springfield, Illinois 62761 0001 · www.dph.illinois.gov

December 21, 2018

Ms. Erin King, MD
The Hope Clinic for Women Ltd
1602 - 21st Street
Granite City, IL 62040

Re: The Hope Clinic for Women Ltd
Repair work

Dear Ms. King:

Based on the narrative received on 12/20/18, a plan review is not required. The project consists of repairs due to storm damage and Interim Life Safety measures have been implemented to safeguard patients, staff and visitors.

Should the scope of the project change, it will be necessary to resubmit a narrative for a redetermination. The facility and its consultants are responsible for compliance with the Licensing Act/Code and NFPA 101, Life Safety Code, 2012 edition.

If you have any questions regarding this matter, please feel free to contact our office at 217-785-4247. The Department's TTY number is 800-847-0566, for use by the hearing impaired.

Sincerely,

[redacted]

Henry Kowalenko, Division Chief
Division of Life Safety and Construction

Americans United for Life

The Hope Clinic for Women Ltd.

December 20, 2018

Illinois Department of Public Health
Division of Life Safety and Construction
dph.design.standards@illinois.gov

To whom it may concern:

In response to the inquiry made by the Illinois Department of Public Health- Division of Life Safety and Construction on 12/19/18, please find a summary of repair work done at the Hope Clinic for Women in December 2018.

Initial Event:
Storm 6/28/18 with high winds: resulting in water leak secondary to decreased integrity of flashing on roof and awning on first floor by front door

Inquiry re: repair work being done in December 2018

Timeline:

- 12/8/18 3pm to 12/18/18 5pm:
  - First Floor repairs: half of First Floor repair work including front entry-hall
  - NO PATIENTS IN BUILDING during this time as front hall, although accessible for an emergency, had repair equipment and personnel working; all staff entered and exited through side entrance located in covered garage
  - access to all exits of building; all doors to outside accessible; no changes to or disruptions of electric, plumbing, fire alarm system or sprinkler system

- 12/19/18 8am to (*projected*) 1/7/19 5pm:
  - Alternate half of first floor, not including front entry; Patients/Visitors entering through Front Door; going up immediately adjacent stairs/elevator to second floor
  - NO SURGICAL CARE; patients being seen for outpatient office type visits only (such as post-op follow up or medication abortion) on second floor
  - access to all exits of building; all doors to outside accessible; no changes to or disruptions of electric, plumbing, fire alarm system or sprinkler system

General Information:

- All work reviewed continuously to ensure compliance:
  - Repairs to affected areas which include: cleaning, finishes including drywall repair, priming and repainting; replacement of ceiling tiles; replacement of floor covering where damaged
  - No changes in electrical, plumbing or HVAC systems completed

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- No changes to fire safety systems including no interruption of electrical to systems or alterations/changes to sprinkler systems
- Air filtration devices (scrubbers) used
- All cleaning done and reconstruction carefully planned to not necessitate any permanent barriers be constructed, no changes to the electric systems, the alarm system or the sprinkler system.
- No changes or disruptions of emergency electricity back up, emergency lighting or emergency systems such as alarms or sprinklers;
- all exit routes easily accessible; if barrier used to limit debris, air scrubbers used and temporary barriers of clear polyethylene with zippers or tape allow complete egress at all times
- repair work December 8, 2018 to January 7, 2019 affects surgical patient care areas (operating suites, sterile areas and recovery room) and no surgical care is planned until all repairs are completed
- All work done with appropriate barriers, personal protective equipment, HEPA-filtration devices
- end of repairs/cleaning, the HVAC will also have undergone thorough cleaning of air handling units, associated ductwork and have new filters installed

As always, patient safety is our utmost concern. We have been diligent, careful, and responsible while working on this repair process. If there is additional information that you need, please contact me at any time.

Sincerely,

[redacted]

Erin King, MD
Executive Director
618-451-5722 (phone)
618-451-9092 (fax)
erking@hopeclinic.com

Americans United for Life

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

May 8, 2018

Ms. Erin King, MD, Administrator
Hope Clinic for Women, Ltd., The
1602 21st Street
Granite City, IL 62040-

Re: Hope Clinic for Women, Ltd., The
Granite City
Licensure survey

Dear Ms. King, MD:

On 03/21/18 a life safety code inspection was conducted for the purpose of determining compliance with the requirements of the "Ambulatory Surgical Treatment Center Licensing Requirements" (77 Ill. Adm. Code 205) and NFPA 101, Life Safety Code, 2012 Edition. Based on POC received with the evidence of complaince, we find that the previously cited deficiencies have been corrected and the facility is no longer under monitoring for physical environment.

If you have any questions about this approval, please do not hesitate to call us at 217-785-4247 The Department's TTY number is 800/547-0466, for use by the hearing impaired.

Sincerely,

[redacted]

Dennis Schmitt, Supervisor
Design and Construction Section
Division of Life Safety and Construction

ok
per DS -

The Hope Clinic for Women Ltd.

May 1, 2018

Dennis Schmitt, Supervisor
Design and Construction Section
Division of Life Safety and Construction
Illinois Department of Public Health
525 W. Jefferson, 4th Floor
Springfield, IL 62761

RECEIVED-OHCR
MAY 02 2018
LIFE SAFETY & CONSTRUCTION

Dear Mr. Schmitt:

In reference to the Life Safety Survey conducted 3/21/18 and Plan of Correction (POC) returned on 3/27/18, I am following up with confirmation of the completion of the items in the POC.

See revised POC with completed dates and appendices attached.

If I may be of further assistance, or if you have further comments, please do not hesitate to phone 618-451-5722 or email: erking@hopeclinic.com

Sincerely,

[redacted]

Erin King, MD
Executive Director

Americans United for Life

Where There's Choice, There's Hope.

1602 21st Street ■ Granite City, Illinois 62040 ■ Ph: 618-451-5722 ■ Fax: 618-451-9092 ■ hopeclinic.com

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL1084	A. BUILDING. 01 - MAIN BUILDING B. WING _____	03/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE CLINIC FOR WOMEN LTD THE	1602 - 21ST STREET GRANITE CITY, IL 62040

(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
L 000	Initial Comments The Illinois Department of Public Health (IDPH) conducted a Life Safety Code inspection on 3/21/18. The facility is an Ambulatory Surgery Center (ASTC) located at 1602 21st Street, Granite City, IL. The following facility staff accompanied the surveyor during the walk through. Purchasing Coordinator (PC) The building was built in approximately 1998 and is a two story facility. The facility is fully sprinkler protected and is a Type II (000) construction. The Surgery Center is located on the ground floor of the building and was inspected under the Illinois ASTC Licensing Requirements and the Life Safety Code (2012). The upstairs of the building contains a waiting room, business offices and outpatient exam rooms. The following deficiencies were identified by document review, staff interview or direct observation.	L 000		
L 021	Doors/Firewalls 20.2.2.3, 21.2.2.3 Any door with a required fire protection rating, such as stairways, exit passageways, horizontal exits, smoke barriers, or hazardous area enclosures, if held open, is arranged to close automatically by the actuation of the manual fire alarm system and either smoke detectors arranged to detect smoke on either side of the opening or a complete automatic sprinkler system. 20.2.2.3, 21.2.2.3 This Regulation is not met as evidenced by: Based on an observation the facility failed to	L 021		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL1084	A. BUILDING 01 - MAIN BUILDING B. WING _____	03/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE CLINIC FOR WOMEN LTD THE	1602 - 21ST STREET GRANITE CITY, IL 62040

(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
L 021	Continued From page 1 maintain hazardous content separations. This deficient practice could affect patients, staff and visitors if fire and smoke from a hazardous area were allowed to impede exiting from the facility. Finding include: On 3/21/18 at 1:30 PM while in the company of PC it was determined that the door to the Dirty Linen room failed to close and latch to the frame when tested. This does not comply with NFPA 101, 2012 Edition, Section 21.3.2 and 39.3.2.	L 021	20.2.2.3, 21.2.2.3 Self closing mechanism of the cited door to the soiled linen storage will be adjusted to close completely without assistance after being released. This door and others with a required fire protection rating will be adjusted immediately if not closing appropriately. Completion estimated by 4/15/18 COMPLETED 4/2/18	
L 046	20.2.9.1/21.2.9.1 Emergency Illumination Emergency lighting shall be provided in accordance with 7.9 and 21.2.9.2. This Regulation is not met as evidenced by: Based on document review the facility failed to test and properly document the battery operated emergency lighting. This deficient practice could affect patients, staff and visitors if during a fire event the system failed to operate properly and the exit pathway was not illuminated. Finding include: On 3/21/18 at 11:30 AM it was determined during document review that the facility failed to test and document the battery operated emergency lighting for 90 minutes over the last 12 months. This does not comply with NFPA 101, 2012 Edition, Section 7.9.3.1.1 (3).	L 046	20.2.9.1/21.2.9.1 Emergency lighting will be tested for at least 90 *minutes* annually. Testing will be documented including date, time performed and number of minutes of testing. Completion estimated by 4/15/18 COMPLETED 5/1/18	
L 130	as indicated OTHER REFERENCED REQUIREMENTS Other Referenced Requirements: NFPA 70 - 2002 NFPA 13 -1999 NFPA 25 - 1998	L 130	see appendix A	

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL1084	A. BUILDING 01 - MAIN BUILDING B. WING _____	03/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE CLINIC FOR WOMEN LTD THE	1602 - 21ST STREET GRANITE CITY, IL 62040

(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
L 130	Continued From page 2 Illinois State Plumbing Code Illinois Accessibility Code As Indicate below: This Regulation is not met as evidenced by: Based on direct observations during the survey walk through and document review the facility failed to test and properly document the fire sprinkler system. Failure to install and maintain the system could result in the failure of the fire suppression system. This deficient practice could affect patients, staff and visitors if during a fire event the system failed to operate properly. Findings include: A. On 3/21/18 at 11:50 AM during document review it was determined that the facility conducted only one sprinkler inspection within the last 12 months. Per NFPA 25, 2011 Edition, Section 5.2.5 waterflow alarm and supervisory alarm devices shall be inspected quarterly. B. On 3/21/18 at 1:20 PM during a facility walkthrough with the PC it was determined that the sprinkler system was installed with gauge that was not identified with a date of installation. Further document review could not identify when the guage was last replaced or recalibrated. This does not comply with NFPA 25, 2011 Edition, Section 5.3.2.	L 130	5.2.5 Sprinkler inspection will be completed quarterly. Inspections will be documented. Completion estimated by 5/1/18 COMPLETED 4/23/18 see appendix B 5.3.2 Sprinkler system maintenance company will evaluate and determine date of installation of gauge. The company will calibrate and/or replace the gauge and provide documentation of these actions. Completion estimated by 5/1/18 COMPLETED 4/23/18 see appendix C	
L 178	205.1780 Emergency Power 205.1780 Emergency Electrical Service a) An emergency source of electricity shall be provided.	L 178		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL1084	A. BUILDING 01 - MAIN BUILDING B. WING _____	03/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE CLINIC FOR WOMEN LTD THE	1602 - 21ST STREET GRANITE CITY, IL 62040

(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
L 178	Continued From page 3 b) Ambulatory surgical treatment centers that do not administer inhalation anesthetics in any concentration, or that have no patients requiring electrical life-support equipment, shall be permitted to use a battery system for emergency power. The following is required: 1) Illumination of means of egress as required in the NFPA Life Safety Code. 2) Illumination of procedure and recovery rooms. 3) Illumination of exit and exit directional signs. 4) Fire alarm and alarms required for nonflammable medical gas systems, if nonflammable medical gas systems are installed. c) Ambulatory surgical treatment centers in which inhalation anesthetics are administered in any concentration to patients or that have patients requiring electrically operated or mechanical life support devices must be provided with an emergency generator. This generator must supply a limited amount of lighting and power service that is essential for life safety and orderly cessation of a procedure during the time normal service is interrupted for any reason. The maximum time of automatic transfer is 10 seconds. The following is required:	L 178		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL1084	A. BUILDING: 01 - MAIN BUILDING B. WING _____	03/21/2018

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HOPE CLINIC FOR WOMEN LTD THE	1502 - 21ST STREET GRANITE CITY, IL 62040

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L 178	Continued From page 4 1) Task illumination that is related to the safety of life and that is necessary for the safe cessation of procedures in progress. 2) All anesthesia and resuscitative equipment used in areas where inhalation anesthetics are administered to patients must include alarms and alerting devices. 3) Illumination of means of egress as required in the NFPA Life Safety Code. 4) Illumination of exit and directional signs. 5) Fire alarm and nonflammable medical gas system alarms, if nonflammable medical gas systems are installed. 6) General illumination and selected receptacles in the vicinity of the generator set. (Source: Amended at 18 Ill. Reg. 17250, effective December 1, 1994) This Regulation is not met as evidenced by: Based on direct observations, record review and interview, the facility failed to provide proper normal electrical power outlets in treatment locations. This deficient practice could affect patients, staff and visitors if the emergency generator failed to transfer power to the listed areas and normal power outlets were not provided.	L 178	205.1780 Electrical outlets in operating rooms will be evaluated. If normal power outlets are identified already in existence, they will be clearly marked with a different color outlet or some equally obvious method. If none are identified, the power outlets will be reconfigured so that at least one normal power outlet will be available in each operating room and be clearly marked/identifiable. Completion estimated by 5/1/18 — COMPLETED 4/11/18 see appendix D	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL1084	A. BUILDING 01 - MAIN BUILDING B. WING _____	03/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE CLINIC FOR WOMEN LTD THE	1602 - 21ST STREET GRANITE CITY, IL 62040

(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
L 178	Continued From page 5	L 178		

Findings include: On 3/21/2018 at 1:45 PM while accompanied by PC an observation determined that the following treatment locations did not contain a normal electrical power outlet.

1. Operating room 1
2. Operating Room 2

This does not comply with NFPA 70, 2011 Edition, Section 517.18.

appendix A

Annual Emergency and Exit Lighting Inspection Documentation Log

(page 1)

Date: 5/1/18 FSDA → 920A

Emergency Lights 90 minute test and inspection

Location/Light #	Pass /Fail	Good Condition	Testing By
First Floor			
OR 1	P	✓	DD
OR 2	P	✓	DD
OR 3	P	✓	DD
OR 4	P	✓	DD
Back corridor	P	✓	DD
Nurses station RR	P	✓	DD
Second Floor			
Front Desk	P	✓	DD

notes: generator power off
turned off circuit breaker to areas above
Confirmed lights r x 90 min
battery only.

Americans United for Life

Revised 4/18

appendix B

GATEWAY FIRE PROTECTION SYSTEMS, INC.

1862 Borman Court • St. Louis, MO 63146 • (314) 892-7622

REPORT OF INSPECTION • SET 1 OF 2

REPORT TO HOPE CLINIC
STREET 1602 21ST STREET
CITY & STATE GRANITE CITY IL ZIP 62040
ATTN

Inspection Quarterly
Emergency Service
Repairs
DATE 4/23/2018

24-Hour Service
(314) 892-7622

		Yes	N.A. ‡	No*
1.	**GENERAL**			
	(To be answered by the Owner or Owner's representative)			
a.	Have there been any changes in the occupancy classification, machinery or operations since the last inspection?			✓
b.	Have there been any changes or repairs to the fire protection systems since the last inspection?			✓
c.	If a fire has occurred since the last inspection, have all damaged sprinkler system components been replaced?		✓	
d.	Have the piping in all dry systems been checked for proper pitch within the past five years?		✓	
	Date last checked (checking is recommended at least every 5 years)			
e.	Has the piping in all systems been checked for obstructive materials?			✓
	Date last checked (checking is recommended at least every 5 years)			
f.	Have all fire pumps been tested to their full capacity through the use of hose streams or flow meters within the past 12 months?		✓	
g.	Are gravity, surface or pressure tanks protected from freezing?			
h.	Are any of the sprinklers 50 years old or older? (testing and/or replacement is recommended for such sprinklers)			✓
i.	Are any extra high temperature solder sprinklers regularly exposed to temperatures near 300°F?			✓
	(To be answered by the inspector)			
a.	Have the sprinkler systems been extended to all visible areas of the building?	✓		
b.	Does there appear to be proper clearance between the top of all storge and the sprinkler deflector?	✓		
c.	Are the building areas protected by a wet system, heated, including its blind attics and perimeter areas, where accessible?	✓		
d.	Are all visible exterior openings protected against the entrance of cold air?	✓		
2.	**CONTROL VALVES**			
a.	Are all sprinkler system main control valves and all other valves in the appropriate open or closed position?	✓		
b.	Are all control valves sealed or supervised in the open position?	✓		

Control Valves	No of Valves	Type	Easily Accessible		Signs		Valve Open		Secured? If yes, how?		(sealed?) (Locked?) (Supvd.?)	Supervision Operational?	
	* ON BACKFLOW		Yes	No	Yes	No	Yes	No	Yes	No		Yes	No
CITY CONNECTION *	2	2" BALL VALVE	✓		✓		✓		✓		Supvd	✓	
TANK													
PUMP													
SECTIONAL													
SYSTEM	SAME AS ABOVE												
ALARM LINE													

3. **WATER SUPPLIES**
a. Water supply source? City 4" Wg Gravity Tank ~~Pressure Fire Pump & Tank~~ ~~Pressure Fire Pump & City~~ ~~Pressure Fire Pump & Pond~~

Waterflow Test Results Made During This Inspection

Test Pipe Located	Size Test Pipe	Static Pressue Before	Flow Pressure	Static Pressure After	Test Pipe Location	Size Test Pipe	Static Pressue Before	Flow Pressure	Static Pressure After
AT RISER	1¼"	50	35	40					

		Yes	N.A. ‡	No*
4.	**TANKS, PUMPS, FIRE DEPT. CONNECTIONS**			
	Do fire pumps, gravity, surface or pressure tanks appear to be in good external condition?		✓	
	Are gravity, surface and pressure tanks at the proper pressure and/or water levels?		✓	
	Are fire dept. connections in satisfactory condition, couplings free, caps or plugs in place and check valves tight?	✓		
	Are fire dept. connections visible and accessible?	✓		
5.	**WET SYSTEMS**			
	No. of systems ONE Make & Model			
	Are cold weather valves in the appropriate open or closed position?			
	If closed, has piping been drained?			
	Has the owner or owner's representative been advised that cold weather valves are not recommended by NFPA?			✓
	Have all the antifreeze systems been tested?			✓
	Date antifreeze systems were tested			
	The antifreeze tests indicate protection to:			
	system 1 2 3 4 5 temperature			
	Did alarm valves, waterflow alarm indicators and retards test satisfactorily?	✓		

‡ Not Applicable
* Explain (No) Answers on Back of Sheet

GATEWAY FIRE PROTECTION SYSTEMS, INC.

1862 Borman Court • St. Louis, MO 63146 • (314) 892-7622

REPORT OF INSPECTION • SET 2 OF 2

HOPE CLINIC (2)

	Yes	N.A. ‡	No*
6. DRY SYSTEMS	▨	▨	▨
No. of systems 0 Make & Model	▨	▨	▨
Date last trip tested	▨	▨	▨
Are the air pressure and priming water levels normal?		▨	
Did the air compressor operate satisfactorily?			
Were all low points drained during this inspection? N/A		▨	
Did all quick opening devices operate satisfactorily?			
Did all the dry valves operate satisfactorily during this inspection?			
Do dry valves appear to be protected from freezing?		▨	
Is the dry valve house heated?			
7. SPECIAL SYSTEMS	▨	▨	▨
a. No. of systems 0 Make & Model	▨	▨	▨
Type			
b. Were valves tested as required: N/A			
Did all heat responsive systems operate satisfactorily?			
c. Did the supervisory features operate during testing?			
Heat Responsive Devices: Type ____ Type of test ____			

Valve No. ____ 1 .... 2 .... 3 .... 4 .... 5 .... 6 .... Valve No. ____ 1 .... 2 .... 3 .... 4 .... 5 .... 6 ....

Valve No. ____ 1 .... 2 .... 3 .... 4 .... 5 .... 6 .... Valve No. ____ 1 .... 2 .... 3 .... 4 .... 5 .... 6 ....

Valve No. ____ 1 .... 2 .... 3 .... 4 .... 5 .... 6 .... Valve No. ____ 1 .... 2 .... 3 .... 4 .... 5 .... 6 ....

Valve No. ____ 1 .... 2 .... 3 .... 4 .... 5 .... 6 .... Valve No. ____ 1 .... 2 .... 3 .... 4 .... 5 .... 6 ....

Auxiliary equipment: No. ____ Type ____

Location ____

Test results ____

	Yes	N.A. ‡	No*
8. ALARMS			
a. Did the water motors and gong operate during testing?		✓	
b. Did the electric alarms operate during testing: CODE - 1111 OR USE KEY	✓		
c. Did the supervisory alarms operate during testing?	✓		
9. SPRINKLERS - PIPING			
a. Do sprinklers generally appear to be in good external condition?	✓		
b. Do sprinklers generally appear to be free of corrosion, paint, or loading and visible obstructions?	✓		
c. Are extra sprinklers available on the premises?	✓		
d. Does the exterior condition of piping, drain valves, check valves, hangers, pressure gauges, open sprinklers and strainers appear to be satisfactory?	✓		
e. Does the hand hose on the sprinkler system appear to be in satisfactory condition?		✓	

10. EXPLANATION OF "NO" ANSWERS (For Sections 1 B thru 9):

11. THE INSPECTOR SUGGESTS THE FOLLOWING NECESSARY IMPROVEMENTS. HOWEVER, THESE SUGGESTIONS ARE NOT THE RESULT OF AN ENGINEERING SURVEY:

12. ADJUSTMENTS OR CORRECTIONS MADE: REPLACED PRESSURE GUAGE ON RISER, NFPA 25-2011(5.3.2)

13. LIST CHANGES IN THE OCCUPANCY HAZARD OR FIRE PROTECTION EQUIPMENT, AS ADVISED BY THE OWNER IN SECTION 1A:

14. INSPECTION AND SUGGESTED IMPROVEMENTS WERE DISCUSSED WITH THE UNDERSIGNED OWNER OR OWNER'S REPRESENTATIVE?

Signature of owner or owner's representative ____ Date 4/22/2018

DUPLICATE TO ____

STREET ____

CITY & STATE ____ ZIP ____

ATTN ____

‡ Not Applicable

* Explain (No) Answers on Back of Sheet

appendix C

GATEWAY FIRE PROTECTION SYSTEMS, INC.

1862 Borman Court. • St. Louis, MO 63146
(314) 892-7622 • FAX (314) 892-7448

SALESMAN		CUST. P.O. NO.	% COMP.	EST. COMP. DATE	WEEK ENDING	INVOICE DATE
			100%	Apr 23, 2018	Apr 27, 2018	

INVOICE TO:

JOB LOCATION / SHIP TO:
Hope Clinic
1602 81ST Street
Granite City IL 62040

WORK DESCRIPTION
Quarterly Fire Sprinkler Inspection
Replaced pressure gauge

TERMS OF THIS AGREEMENT ARE: (SEE BELOW FOR EXPLANATION OF TERMS)
1. ☑ TIME AND MATERIAL 2. ☐ FIXED PRICE OF $ _____ 3. ☐ PRICE NOT TO EXCEED $ _____

PSN	LAB	P.O.	F.O.	IR	ITEM DESCRIPTION OR EMPLOYEE NAME	QUANTITY	U/M	UNIT PRICE	EXTENDED PRICE	PERCENT	UNIT COST	EXTENDED COST
F26S					D. Ellis	2	ST					
Truck					50 Amm 10 Gal	5x						
manual					3 gal water pump	1x						
					can del							

AUTHORIZED CUSTOMER SIGNATURE:
X [illegible]

TITLE OF PERSON SIGNING:
Asst Facility Dir

CUSTOMER TELEPHONE NO.
618-451-5722

NO. 84824 DATE OF ORDER 4/23/2018

LABOR AND OTHER SUBTOTAL	
MATERIAL SUBTOTAL	MATERIAL
LOCAL TAX	LABOR
STATE TAX	OTHER
TOTAL DUE THIS INVOICE	TOTAL

WHITE - PROCESSING COPY YELLOW - ORIGINAL CUSTOMER INVOICE PINK - CUSTOMER'S ORDER COPY

appendix D

Bel-Clair
ELECTRIC, INC.
Phone 618-539-5200 Fax 618-539-5201

April 11, 2018

The Hope Clinic for Women
1602 21st St.
Granite City, IL 62040

Re: Operating Room Receptacle

To whom it may concern,

On April 3, 2018, Bel-Clair Electric, Inc. was requested for a service call to evaluate the presence of receptacles fed from normal electrical power (non-generator power) in the four operating rooms within the space. Upon evaluation, it was confirmed that all of the receptacles in these rooms are fed from the generator. To conform to the Illinois Department of Public Health's request, one receptacle, ivory in color, from the normal electrical power source, was added in each of the four operating rooms.

Sincerely,

[redacted]

Eric Smith
Bel-Clair Electric, Inc.

Americans United for Life

11 Southgate Center BCE Freeburg, IL 62243

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

February 6, 2017

Erin King MD
The Hope Clinic for Women, Ltd
1602 21st Street
Granite City, IL 62040

Re: Violation of regulations based on license application, license 7001084

Dear Dr. King:

It has come to the Department's attention that your agency's Corporation membership is not in compliance with 210 ILCS 55 Ambulatory Surgical Treatment Center Licensing Act and Title 77 Il Adm. Code 205 Ambulatory Surgical Treatment Center Licensing Requirements.

Per ILCS 210 6.1. Notwithstanding any other provision of this Act, any corporation operating an Ambulatory Surgical Treatment Center devoted primarily to providing facilities for abortion must have a physician, who is licensed to practice medicine in all of its branches and is actively engaged in the practice of medicine at the Center, on the board of directors as a condition to licensure of the Center.

Section 205.118 Condition of Licensure

d) *Any corporation operating an ambulatory surgical treatment center devoted primarily to providing facilities for abortion must have a physician who is licensed to practice medicine in all of its branches and is actively engaged in the practice of medicine at the* ambulatory surgical treatment *center, on the Board of Directors as a condition to licensure of the* ambulatory surgical treatment *center.* (Section 6.1 of the Act)

Section 205.210 Ownership, Control and Management

a) The ASTC shall have a governing body that assumes full responsibility for determining, implementing and monitoring policies governing the facility's operation:

As such, The Hope Clinic for Women, Ltd. is not in compliance with the Code and its authorizing statute the Ambulatory Surgical Treatment Center Act (210 ILCS 5/1 *et seq.*) (hereinafter "Act"). The Department thereby requires The Hope Clinic for Women Ltd to identify the names and positions of the

corporation board members who meets all requirements prescribed by the Act and Code **within 10 business days** of receipt of this letter.

Please send the names Board of Directors that includes an actively licensed physician and other members of the Board who are responsible for the operations of this ASTC to the attention of Karen Senger, Division Chief, Division of Health Care Facilities and Programs, 525 West Jefferson St., 4th Floor Springfield, IL 62761 **within 15 business days** of receipt of this letter.

Nothing herein shall be considered a waiver of any enforcement rights the Department may have against the facility, including, but not limited to, the assessment of fines and/or adverse licensure action.

If you have any questions, please contact me at 217-782-0381 or karen.senger@illinois.gov.

Sincerely,

[redacted]

Karen Senger, RN BSN
Division Chief
Division of Health Care Facilities and Programs

Americans United for Life

7016 0340 0001 1775 9841

The Hope Clinic for Women Ltd.

February 14, 2017

Karen Senger, RN BSN
Division Chief
Division of Health Care Facilities and Programs
525 West Jefferson St
4th Floor
Springfield, IL 62761

Dear Karen Senger,

I am writing in response to your letter to The Hope Clinic for Women, Ltd. dated February 6, 2017.

Re: Section 205.118
The Hope Clinic for Women, Ltd. current board members:
Sally Burgess, MBA
Hector Zevallos, MD
Your letter has brought to our attention that the current board structure does not meet complete compliance with this section of the Ambulatory Surgical Treatment Center Licensing Act.
Secondary to changes in employment and leadership that have occurred in 2016, The Hope Clinic for Women, Ltd is already actively in the process of changing the board membership. Erin King, MD (myself) is being added to the board with a goal date of completion March 1, 2017. This will also immediately make the corporation compliant with Section 205.118. We will notify the Illinois Department of Public Health as soon as this has been completed.

Re: Section 205.210
The Hope Clinic for Women, Ltd. has an active Governing Body that meets all licensing requirements set forth in the Licensing Act. Please see attached documentation which includes the Governing Body structure and list of responsibilities, as well as an example of notes from a quarterly meeting in which the Governing Body is actively engaged in governing the operations of the facility. We plan to continue with the same structure and membership of the Governing Body for 2017.
Current Governing Body members: Executive Director (Interim – Erin King, MD) and Medical Director (Yogendra Shah, MD).
Both members of the Governing Body are licensed to practice medicine in all of its branches and are actively engaged in the practice of medicine at the ambulatory surgical treatment center.

Please contact me if you need further information or have any questions.

Sincerely,

[redacted]

Erin King, MD
Interim Executive Director
618-451-5722
erking@hopeclinic.com

Americans United for Life

Hope Clinic for Women
Governing Body

Members: *Executive Director*
Medical Director

1. Shall review and approve organizational plan.
2. Shall ensure ASTC policies and programs provide quality health care in a safe environment.
3. Shall have oversight and accountability for Quality Assessment and Performance Improvement Program and shall evaluate its effectiveness at least annually
4. Shall approve an infection control program designed to prevent, identify and manage infections and communicable diseases.
    a. Responsible for appointing qualified infection control professional; to direct the infection control program
    b. Shall evaluate effectiveness of the program at least annually
5. Shall establish, protect and promote patients rights including respect for patient's property and privacy, patient safety, the confidentiality of clinical records, and the exercise of patient rights.
    a. Designate a grievance officer
    b. Establish a documented system by which allegations will be reported, investigated and responded to.
6. Shall develop and maintain a written Disaster Preparedness Plan.
    a. Review reports and recommendations at least annually

Americans United for Life

Approved 12/1/14

Hope Clinic for Women
Consulting Committee Meeting
2016 Quarter 1
5/1/16

Committee Members:
Yogendra Shah, MD – Medical Director
Erin King, MD – Interim Executive Director
Katie Luzecky, RN
Margaret Baum, MD – Hope Clinic physician
Sally Burgess, MBA – Clinic Consultant

Updates: Reviewed
Medical AB: changed criteria include EGA up to 70 days; implemented approved protocols from last CC meeting; includes distribution of new Danco medical AB materials/consent

NEW physician: Margaret Baum, MD started 4/19/16; trained and proficient in first trimester procedures, US, moderate sedation, laminaria placement; plans to continue training/advancing skills for increasing EGA

Changes personnel: resignation of Executive Director/Director of Nursing
Interim Executive Director: Erin King, MD
Director of Nursing position OPEN: hiring now

NOTE: all shifts will have a Supervising Nurse assigned; this person shall meet all qualifications (active RN license and experience in surgical nursing) and will direct and supervise the nursing personnel and the nursing care of patients

Consulting Committee changes: secondary to personnel changes, Katie Luzecky RN to join at least this meeting for Supervising RN role at CC
Sally Burgess present given recent changes and historical knowledge of clinic operations
When hiring completed new Consulting Committee Roles will be assigned
Organizational Plan INTERIM review/discuss/edit per Governing Body with input from CC members Reviewed and approved

In review of records since change in personnel: recommend the following be done:
DONE
Review/update Grievance Policy - Governing Body with input from CC members
Review/update QAPI - Governing Body with input from CC members
Thorough review of processes will take place this quarter by GB and any new update/revisions will be brought to attention of GB/CC for review at next mtg

Americans United for Life

Example of complete involvement of Governing Body in all operations; Page 1 of notes from Consulting Committee Meeting Quarter 1

The Hope Clinic for Women Ltd.

March 2, 2017

Karen Senger, RN, BSN
Division Chief
Division of Health Care Facilities and Programs
525 West Jefferson St.
4th Floor
Springfield, IL 62761

Dear Karen Senger,

I am writing to update our response to your letter to The Hope Clinic for Women, Ltd. dated February 6, 2017.

Re: Section 205.118
As of February 27, 2017, the current board members have been elected:
Erin King, MD
Sally Burgess, MBA

With the change in board members, the addition of Erin King, MD (myself) makes the corporation immediately complaint with section 205.118

I have attached the corporate meeting minutes that have gone out to the meeting participants.

Please contact me if you need further information or have any questions.

Sincerely,

[redacted]

Erin King ,MD
Interim Executive Director
618-451-5722
erking@hopeclinic.com

Americans United for Life

She thereupon called for the nomination of the directors and the following persons were nominated for directors of this corporation to serve for the corporation's ensuing year, or until a successor may be chosen:
Sally Burgess
Erin King Eisenberg

No further nominations being made, the nominations were closed and the shareholders proceeded to vote on the nominees. The shareholders present at the meeting, having voted, the Chairman announced that the aforesaid nominees had been unanimously elected to be the directors of the corporation until the next annual meeting of the shareholders in accordance with the term provided by the By-Laws.

The Chairman stated that it was necessary to elect officers of the corporation to serve for the term provided by the By-Laws. She thereupon called for the nominations of officers, and the following persons were nominated for officers of the corporation to serve until the next annual meeting of the directors in accordance with the term provided by the By-Laws:

President	Erin King, MD
Secretary	Sally Burgess
Treasurer	Erin King, MD

It was noted that Erin King, MD is licensed to practice medicine in all of its branches and is actively engaged in the practice of medicine at the Hope Clinic for Women meeting 210 ILCS 55 Ambulatory Surgical Treatment Center Licensing Act and Title 77 Il Adm. Code 205 Ambulatory Surgical Treatment Center Licensing requirements.

No further nominations being made, the nominations were closed and the directors proceeded to vote: and the vote having been counted, the Chairman announced that the aforesaid nominees had been unanimously elected to the offices set opposite their respective names, to serve for the corporation's ensuing year, or until successor(s) may be chosen.

There being no further business to come before the special meeting, it was, upon motion duly seconded and carried, adjourned.

[redacted]

Sally Burgess, Director
Chairman/Secretary

[redacted]

Hector Zevallos, MD
Stockholder

Americans United for Life

Minutes of Special Meeting of Stockholders and Directors of Hope Clinic for Women, Ltd.

A special meeting of the board of directors and shareholders of the corporation was held February 27, 2017 in the corporation's offices in Granite City, IL.

The sole Director was present in person and the Stockholder was present by phone.

Sally Burgess was chosen as Chairman and Secretary of the meeting.

The Secretary presented and read the following Waiver of Notice of the meeting, signed by the Director and Stockholder.

Waiver of Notice of Meeting

The undersigned, being sole Director and Stockholder of The Hope Clinic for Women, Ltd , hereby waives notice of the time, place and purpose of a special joint meeting of the Director and Stockholder of the said corporation, and do fix the 27th day of February, 2017, at 10.00am, in the offices of the corporation in Granite City, Illinois as the time and place of such meeting.

We hereby waive all the requirements of the State of Illinois, both as to time and place of said meeting and to the publication thereof, and consent to the transaction of such business as may come before said meeting.

Dated February 27, 2017

[redacted]

Hector Zevallos, MD
Stockholder

[redacted]

Sally Burgess
Director

The Chairman stated that the first item of business to come before the meeting was to increase the number of directors to TWO She proposed that the By-Laws were amended accordingly to reflect this change Article III, section 2 "Number, Tenure, and Qualifications"; "The number of directors of the corporation shall be two."

The Chairman stated it was necessary to elect the directors to serve for the term provided by the By-Laws

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

X ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ CBRR

NAME AND ADDRESS OF FACILITY: Hope Clinic for Women
1602 21st Street, Granite City, IL 62040

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
	An annual licensure survey was conducted on 11/23/16 in conjunction with complaint investigation COI161429. The Hope Clinic For Women was in compliance with Illinois Administrative Code, Title 77, Chapter I, Subchapter b, Part 205 Ambulatory Surgical Treatment Center Licensing Requirements, for this survey.		

DATE OF SURVEY 11/21/16 to 11/23/16

BY 31195, 29526, 34824
(Surveyor)

(Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH CARE FACILITIES AND PROGRAMS
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

X ASTC ☐ HHA ☐ HMO ☐ HOSPCIE ☐ HOSPITAL

NAME AND ADDRESS OF FACILITY	**Hope Clinic for Women · 1602 21st Street Granite City**

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
	A complaint investigation was conducted 9/8/14 through 9/10/14. Complaint # 141414 was unsubstantiated. No deficiencies cited. The Hope Clinic for Women is in substantial compliance with the Illinois Administrative Code 205 Ambulatory Surgical Center Treatment Licensing Requirements as of 9/10/14.		

DATE OF SURVEY 9-8-9/10/14 BY 31195
SURVEYOR

If PLV, INDICATE DATE OF PRIOR SURVEY:

IDPH FILE COPY

PROVIDER'S REPRESENTATIVE

DATE

Revised: 09/20/06:rac

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

X ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ CBRR

NAME AND ADDRESS OF FACILITY: Hope Clinic for Women
1602 21st Street, Granite City, IL 62040

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
	An annual licensure survey was conducted on 11/23/16 in conjunction with complaint investigation COI161429. The Hope Clinic For Women was in compliance with Illinois Administrative Code, Title 77, Chapter I, Subchapter b, Part 205 Ambulatory Surgical Treatment Center Licensing Requirements, for this survey.		

DATE OF SURVEY 11/21/16 to 11/23/16

BY 31195, 29526, 34824
(Surveyor)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

_____
(Provider's Representative)

_____

700184

The Hope Clinic for Women Ltd.

RECEIVED OHCR HCF&P

2016 APR 29 A 10:04

Illinois Department of Public Health
Attn: Supervisor, Central Office Operations Section
Division of Health Care Facilities and Programs
525-535 West Jefferson Street
Springfield, IL 62761-0001

Re: New Medical Staff Member

Dear Supervisor:

Please be advised that there is a change in personnel at the Hope Clinic for Women, Ltd.. Effective April 19, 2016, Margaret Baum, MD will be added to the medical staff. She has met the credentialing criteria of this facility and has been approved by the consulting committee members. Please see attached credentialing information.

Signed,

[redacted]

Tamara Threlkeld, RN, BSN
Executive Director

Americans United for Life

Hope Clinic for Women, Ltd.

PHYSICIAN CREDENTIALS AND PRIVILEGES

Attending Physician: Margaret Baum, MD
Privileges Granted: preliminary for 6 months

Appointment date: ***pending*** 4/19/16 ge

Privileges will be granted for Dr. Baum once she has met all of the following requirements, which are outlined in Hope Clinic for Women policy as mandatory for maintaining surgical privileges.

1) Has a current Illinois medical and controlled substance licenses as well as an unencumbered DEA license.
2) Is board certified in Ob/Gyn with an active maintenance of certification.
3) Has hospital privileges at an Illinois Hospital. **(PENDING)** 4/18/16 ge

During the preliminary privileging period, Dr. Baum will initially work under the supervision of the other surgical providers. Once she has adequate training and demonstrates necessary skills for surgical and medical abortion care, the Medical Director and Executive Director will approve Dr. Baum working on her own. She will be approved for surgical and medical procedures consistent with her training and skill level. During this preliminary privileging period, the following will be assessed:

1) Complication rate will need to be within the expected range of Hope Clinic physicians and other physicians providing abortion care. Any complications will be reviewed by the Medical Director and Executive Director.
2) Dependability will be evaluated. She will need to be punctual in keeping with the surgical schedule.
3) Any accusations of inappropriate behavior against Dr. Baum will be investigated. Dr. Baum's behavior must be professional and respectful toward patients and staff.

By signing below, the members of the Consulting Committee of Hope Clinic for Women, Ltd. do hereby grant Margaret Baum, MD preliminary surgical privileges for the next six months.

[redacted]
Tamara Threlkeld RN, BSN — Executive Director

[redacted]
Yogendra Shah, MD — Medical Director

[redacted]
Erin King, MD — Associate Medical Director

[redacted]
Tessa Madden, MD — Consulting Committee Member

GATEWAY REGIONAL MEDICAL CENTER

April 19, 2016

Margaret Elizabeth Baum, MD
1602 21st St.
Granite City, IL 62040

Dear Dr. Margaret Baum:

On behalf of the Board of Trustees, it is my pleasure to inform you that your appointment to the Medical Staff has been approved. You have been granted membership on the Active staff with clinical privileges in Obstetrics & Gynecology for up to two (2) years beginning 04/18/2016.

Clinical privileges have been granted as specified on the enclosed Delineation of Privileges form. Please review these carefully, as you have only been granted privileges to perform those procedures outlined on your Delineation of Privileges form.

According to the Medical Staff Bylaws and Peer Review Policy, your clinical activity will be reviewed under Focused Professional Performance Evaluation (FPPE) for a specified period of time as outlined in the Medical Staff Bylaws.

As a member of the Medical Staff, you are required to abide by all hospital policies and the Code of Ethical Conduct. Your appointment is subject to the terms and conditions of the Medical Staff Bylaws, Rules and Regulations and all other Medical Staff Policies and Procedures that are in force during the term of your appointment.

Prior to seeing any patients in the facility, you must contact Niki Wann, Medical Staff Credentialing Specialist, at (618) 798-3260 in order to schedule an appointment for Physician/Practitioner Orientation. Orientation must be completed prior to seeing any patients.

Should you have any questions regarding your appointment or your current privileges, please do not hesitate to contact the Medical Staff Office at (618)798-3260 for assistance.

We appreciate your continued support and value your contribution as a member of the Medical Staff.

Sincerely,

[redacted]

M. Edward Cunningham
Chief Executive Officer

Gateway Regional Medical Center

Delineation Of Privileges

Provider Name: Baum, Margaret E., MD - Active
Appointment: 04/18/2016 - 04/18/2018

Privilege Status	
Obstetrics/Gynecology	
Approved	Abdominal pregnancy
Approved	Ablation, endometrial, electrosurgical, hysteroscopic
Approved	Ablation, endometrial; electrosurgical; non-hysteroscopic
Approved	Ablation, endometrial; thermal; non-hysteroscopic
Approved	Abortion, inevitable or incomplete; suction and evacuation
Approved	Cystoscopy
Approved	D&C: diagnostic, therapeutic, including retained placenta
Approved	Ectopic pregnancy - salpingectomy or salpingotomy; laparoscopy or laparotomy
Approved	Ectopic pregnancy, non-surgical management
Approved	Evacuation of hematoma, vaginal
Approved	Evacuation of hematoma, vulvar
Approved	Evacuation of pelvic abscess
Approved	Excision of vulvar lesion, not at delivery
Approved	Excision, ovarian cyst
Approved	Excision, vaginal lesion
Approved	Excision, vulvar, perineal lesion
Approved	Exploratory laparotomy
Approved	Hemorrhage associated with pregnancy
Approved	Hysterectomy, abdominal (with or without adnexae), total, subtotal, including cancer staging procedures
Approved	Hysterosalpingography
Approved	Hysteroscopy, diagnostic or operative
Approved	Insertion/removal of IUD
Approved	Laceration repair, cervical, obstetrical
Approved	Laceration repair, perineal, obstetrical, gynecological
Approved	Laceration repair, rectal, obstetrical, gynecological
Approved	Laceration repair, uterine, obstetrical
Approved	Laceration repair, vaginal, obstetrical, gynecological
Approved	Laparoscopic approach, surgical interventions

Applicant's Initials: _____ Approving Physician Initials: _____

Printed on Tuesday, April 19, 2016

Gateway Regional Medical Center

Delineation Of Privileges

Provider Name: Baum, Margaret E., MD - Active
Appointment: 04/18/2016 - 04/18/2018

Privilege Status	
Approved	Oophorectomy
Approved	Other life-threatening maternal disease in pregnancy
Approved	Pain management
Approved	Pelvic exam under anesthesia
Approved	Removal of foreign body from vagina and uterus
Approved	Salpingectomy - total or partial
Approved	Salpingo-oophorectomy
Approved	Salpingostomy
Approved	Treatment of complicated pelvic inflammatory disease
Approved	Treatment of uncomplicated pelvic inflammatory disease
Approved	Tubal ligation, laparoscopy or laparotomy (bilateral)
Approved	Ultrasonography - obstetrics, gynecological
Approved	Uterine/vaginal packing
Approved	Order Diagnostic Services
Approved	Order Therapeutic Services
Approved	Make referrals and request consultations
Approved	Render care within the scope of training in a medical emergency
Approved	Perform History and Physical examination
Approved	Hysterectomy, abdominal (with or without adnexae), total, subtotal

Applicant's Initials: _____ Approving Physician Initials: _____

American Board of Obstetrics and Gynecology
2915 Vine Street
Dallas, TX 75204
Phone: (214) 871-1619
Fax: (214) 871-1943

March 31, 2016

RE: Certification Status of Margaret E. Baum, M.D.

To Whom It May Concern:

Margaret E. Baum, M.D. is a Diplomate of the American Board of Obstetrics & Gynecology (ABOG).

Obstetrics and Gynecology Certification

ABOG ID Number: 9009318
Original Certification Date: 11/8/2007
Certification Status: Valid through: 12/31/2016
Meeting Requirements of Maintenance of Certification: Yes

A physician becomes a Diplomate of the ABOG when he/she has fulfilled all requirements, has satisfactorily completed the written and oral examinations and has been awarded ABOG's certifying diploma.

Physicians certified by the ABOG in Basic Obstetrics and Gynecology prior to 1986 or subspecialty certified prior to November, 1987 hold non-time-limited (non-expiring) certificates. They are not required to participate in Maintenance of Certification.

Sincerely,

[redacted]

Larry C. Gilstrap, III, M.D.
Executive Director

A101900

The Hope Clinic for Women Ltd.

7001084

Illinois Department of Public Health
Attn: Supervisor, Central Office Operations Section
Division of Health Care Facilities and Programs
525-535 West Jefferson Street
Springfield, IL 62761-0001

RECEIVED OHCR HCF&P
2016 MAY 10 A 7:03

Re: Changes in personnel

Dear Supervisor:

Please be advised that there is a change in personnel at the Hope Clinic for Women, Ltd..

1. Effective April 29, 2016, Erin King, MD became the ***Interim Executive Director***. Dr. King has been the Associate Medical Director of the clinic for over five years and has been a physician on the medical staff of Hope Clinic since 2010. Her resume is attached.
2. Effective April 29, 2016, Katherine Luzecky, RN became the ***Interim Supervising Nurse***. Katherine has been working with Hope Clinic as an RN for over three years. During this time she has been in a supervisory role of other nursing and clinical staff. She has significant surgical and critical care experience. Her resume is attached.
3. The Executive Director and Director of Nursing (Supervising RN) positions were formerly held by Tamara Threlkeld, RN.
4. The "interim" status indicates that qualified candidates for these positions are being actively recruited. Once permanent hiring occurs, the department will be immediately notified.
5. Personnel changes and an updated organizational chart were approved by the Governing Body in consultation with the Consulting Committee and clinic consultant on May 1, 2016.

Sincerely,

[redacted]

Erin King, MD
Interim Executive Director

Americans United for Life

Where There's Choice, There's Hope.

1602 21st Street ■ Granite City, Illinois 62040 ■ 618-451-5722 ■ EMAIL askhope@hopeclinic.com ■ hopeclinic.com

Erin King, MD, FACOG

erking@hopeclinic.com

EDUCATION

Washington University School of Medicine – St. Louis, MO
M.D., May 2003

Stanford University – Stanford, CA
B.A., Human Biology, June 1997 (conferred with honors)

GRADUATE MEDICAL EDUCATION

McGaw Medical Center – Northwestern University – Chicago, IL
Residency Training Obstetrics & Gynecology 2003-2007

BOARD CERTIFICATION

American Board of Obstetrics and Gynecology; Status: Active 1/14/11

MEDICAL LICENSURE

Illinois: *November 2006 to present*
Missouri: *February 2011 to present*

PUBLICATIONS AND PRESENTATIONS

Yee LM, Farner KC, King E, Simon MA (2015) What do Women Want? Experiences of Low-Income Women with Postpartum Contraception and Contraceptive Counseling. J Preg Child Health 2: 191. doi:10.4172/2376-127X.1000191

King EL, Redline RW, Smith SD, Kraus FT, Sadovsky Y, Nelson DM. Myocytes of Chorionic Vessels From Placentas With Meconium-Associated Vascular Necrosis Exhibit Apoptotic Markers. Human Pathology 2004; 35(4):412-417

King E, Shackelford G, Hamvas A. High-Frequency Oscillation and Paralysis Stabilize Surfactant Protein-B Deficient Infants. J Perinatology 2001; 21:421-25 (also abstract poster presentation at American Thoracic Society Conference, 5/97)

Cole F, Hamvas A, Rubinstein P, King E, Trusgnich M, Nogee L, deMello D, Colten H. Population-Based Estimates of Surfactant Protein B Deficiency. Pediatrics 2000; 105(3):538-41

WORK EXPERIENCE / FACULTY APPOINTMENTS

Generalist in Obstetrics and Gynecology at Affinia Healthcare (formerly Grace Hill Health Centers); medical staff privileges at Barnes Jewish Hospital; St. Louis, MO; *2/11 to present*

Gynecology and medical consulting services provider (Associate Medical Director 2/11 to present); The Hope Clinic for Women; Granite City, IL; *2/10 to present*

Part-time gynecology services provider Planned Parenthood of Illinois; Chicago, IL; *6/07 to present*

Clinical Instructor in the Feinberg School of Medicine - Northwestern University; Chicago, IL; *9/07 to 9/11*

Generalist in Obstetrics and Gynecology at Progressive Care for Women, contributed services faculty at Northwestern Memorial Hospital; Chicago, IL; *9/07 to 7/10*

Senior Analyst; Kaiser Permanente Northern California Regional Offices (TPMG): quality and access consulting for M.D. Department Chiefs, *7/00 to 6/01*

Research Technician; Washington University Department of Pediatrics: research resulting in 2 publications noted above, *6/96-9/96; 6/97-9/98*

HOSPITAL AFFILIATIONS

Barnes Jewish Hospital; St. Louis, MO; *6/11 to present*

Gateway Regional Medical Center; Granite City, IL; *4/10 to present*

HONORS/AWARDS

Leadership Training Academy Completion; Physicians for Reproductive Health; 6/15 to present

Fellow; American College Obstetrics & Gynecology; (7/12 to present)

Honored in "Contraception/Family Planning" category of poster presentations; ACOG Annual Meeting (5/08)

Excellence in medical student teaching, Feinberg School of Medicine Northwestern University (5/04 and 5/09)

First Place: Chicago TAP Debate "Comparing sexual function after total versus supracervical hysterectomy" (9/05)

Fourth Year Medical Student Achievement Award in Obstetrics&Gynecology, Washington University (6/03)

Honors conferred for thesis in Human Biology, Stanford University (6/97)

Americans United for Life

Katherine C. Luzecky

[redacted]

Career Objective – To serve as a Registered Nurse at Barnes-Jewish Hospital where I can further develop excellent patient care knowledge and clinical skills.

Education

Goldfarb School of Nursing at Barnes-Jewish College, Graduated: Apr. 2013, St. Louis, MO
Bachelor of Science in Nursing, Accelerated Program, GPA 3.95

- Dean's List, every academic semester
- Institutional Scholarship recipient, July 2012
- Swaziland Immersion Trip, Feb.– Mar. 2013
- Selected as both Peer Leader and Peer Mentor, Fall 2012 – Spring 2013

University of Wisconsin-Madison, Graduated: Dec. 2009, Madison, WI
Bachelor of Arts in Psychology and Certificate in Gender and Women's Studies, GPA 3.4

Employment Experience

St. Anthony's Medical Center, July 2013-present, St. Louis, MO

- Staff RN on Observation Unit and Medical-Telemetry Floor
  - Provide excellent nursing care to diverse group of patients with multi-systemic diseases
  - Ensure quick, accurate assessment of patients from admission through discharge
  - Manage time effectively and promote teamwork in fast-paced environment
  - NIH Stroke Scale Certified, Dec. 2013

Hope Clinic for Women, Feb. 2010 – present, Granite City, IL

- Circulating RN
  - Lead the surgical team to provide specialized patient care in fast-paced environment
  - Utilize critical thinking skills to assess patients throughout entire perioperative period
  - Closely collaborate with physician during perioperative period to ensure safe patient care

Related Experience

International Institute of St. Louis, June 2010 – Sept. 2011, St. Louis, MO

- Volunteer English Literacy Tutor for adult refugees living in the United States
- Volunteer on Global Farm for adult refugees

Student Nurses Association, member, 2012 – 2013
Sigma Theta Tau Honor Society of Nursing, member, 2013
Basic Life Support Certified, renewed Mar. 2014

Areas of Interest

1. Medicine
2. Neuro
3. Cardiovascular

Americans United for Life

The Hope Clinic for Women Ltd.

May 1, 2016

This writing shall serve as documentation that the following persons have been appointed by the Executive Director of the Hope Clinic for Women, Ltd to serve as the **Consulting Committee** effective May 1, 2016. These appointments shall remain in effect unless formally changed in writing by the Executive Director:

Erin King, MD - Interim Executive Director
Yogendra Shah, MD – Medical Director
Margaret Baum, MD - Staff Physician
Tessa Madden, MD - Qualified Consulting Gynecologist
Katherine Luzecky, RN – Interim Supervising Nurse

Signed,

[redacted]

Erin King, MD
Interim Executive Director

5/4/16
Date

Americans United for Life

Where There's Choice, There's Hope.

1602 21st Street ■ Granite City, Illinois 62040 ■ 618-451-5722 ■ EMAIL askhope@hopeclinic.com ■ hopeclinic.com

The Hope Clinic for Women Ltd.

May 1, 2016

This writing shall serve as documentation that the following persons will serve as the **Governing Body** of the Hope Clinic for Women, Ltd. effective May 1, 2016.

Interim Executive Director - Erin King, MD
Medical Director - Yogendra Shah, MD

Sincerely,

[redacted]

Erin King, MD
Interim Executive Director

5/4/16
Date

Americans United for Life

Where There's Choice, There's Hope.

1602 21st Street ■ Granite City, Illinois 62040 ■ 618-451-5722 ■ EMAIL askhope@hopeclinic.com ■ hopeclinic.com

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
7002777	30195	7/17/19

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Michigan Avenue Center for Health, Ltd.	2415 S. Michigan Ave., Chicago, IL 60616

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIOI DATE
000	A licensure survey was conducted on 7/17/19. The Facility was in compliance with TITLE 77: PUBLIC HEALTH CHAPTER I: DEPARTMENT OF PUBLIC HEALTH SUBCHAPTER b: HOSPITAL AND AMBULATORY CARE FACILITIES PART 205 AMBULATORY SURGICAL TREATMENT CENTER LICENSING REQUIREMENTS SECTION 205.710 PREGNANCY TERMINATION SPECIALTY CENTERS for this survey.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
7002777	32820	7/11/18

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Michigan Avenue Center for Health	2415 S. Michigan Avenue Chicago, Illinois 60616

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
000	An investigation was conducted on 7/11/18 for complaint #182478. The Facility is in compliance with TITLE 77: PUBLIC HEALTH CHAPTER 1: DEPARTMENT OF PUBLIC HEALTH SUBCHAPTER b: HOSPITAL AND AMBULATORY CARE FACILITIES PART 205 AMBULATORY SURGICAL TREATMENT CENTER LICENSIING REQUIREMENTS SECTION 205.710 PREGNANCY TERMINATION SPECIALTY CENTERS for this survey.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
7002777	30195	8/24/16

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Michigan Avenue Center for Health	2415 S. Michigan Ave, Chicago, IL, 60616

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
T000	A licensure survey was conducted on 8/24/16. The Facility was in compliance with TITLE 77: PUBLIC HEALTH CHAPTER I: DEPARTMENT OF PUBLIC HEALTH SUBCHAPTER b: HOSPITAL AND AMBULATORY CARE FACILITIES PART 205 AMBULATORY SURGICAL TREATMENT CENTER LICENSING REQUIREMENTS SECTION 205.710 PREGNANCY TERMINATION SPECIALTY CENTERS for this survey.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

March 14, 2016

Ms. Aimee Dillard, Administrator
Michigan Avenue Center for Health, Ltd.
2415 Michigan Ave
Chicago, IL 60616-

Re: Michigan Avenue Center for Health, Ltd.
Chicago
Licensure survey

Dear Ms. Dillard:

On March 14, 2016, a life safety code desk audit of the facility's Plan of Correction and additional information received was conducted. Based on this information, all previously cited deficiencies, from the February 10, 2016, life safety code licensure survey, have been corrected, therefore, the facility is no longer under monitoring.

If you have any questions, please do not hesitate to call us at 217/785-4247. The Department's TTY # is 800/547-0466, for use by the hearing impaired.

Sincerely,

[redacted]

Henry Kowalenko
Division Chief
Division of Life Safety and Construction

PRINTED: 02/23/2016
FORM APPROVED

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7002777	A. BUILDING: 01 - MAIN BUILDING B. WING _____	02/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIGAN AVENUE CENTER FOR HEALTH LTI	2415 MICHIGAN AVENUE CHICAGO, IL 60616

(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
L 000	Initial Comments The Illinois Department of Public Health (IDPH) conducted an onsite Life Safety Code inspection on 2/10/16. Michigan Ave. Center for Health, Ltd. is a Pregnancy Termination Center (PTC) located at 2415 Michigan Ave., Chicago, IL. Surveyor #31586 met with the facility representative to identify the purpose of the visit prior to touring the facility. The building is a one story facility with a partial basement that is only accessible from the back alley. This partial basement space is being utilized as a file storage space. The building is fully sprinkler protected and appears to be Type I (332) construction. The PTC is the only occupant in the building, and was inspected under the Illinois Ambulatory Surgical Treatment Center (ASTC) Licensing Requirements and the Life Safety Code (2000). The following deficiencies were identified by document review, staff interview or direct observation. The findings listed below include the code section(s) of the deficiency for your convenience.	L 000		
L 050	21.7.1.2 FIRE DRILLS Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift, using the fire alarm system, except at night. The staff is familiar with procedures and is aware that drills are part of established routine. 21.7.1.2 This Regulation is not met as evidenced by: Based on record review it was determined that the facility failed to maintain provide fire drills as	L 050		

RECEIVED-OHCR
FEB 24 2016
LIFE SAFETY & CONSTRUCTION

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7002777	A. BUILDING: 01 - MAIN BUILDING B. WING _____	02/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIGAN AVENUE CENTER FOR HEALTH LTI	2415 MICHIGAN AVENUE CHICAGO, IL 60616

(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
L 050	Continued From page 1 required. Fire drills are to be held at unexpected times under varying conditions, at least quarterly on each shift per NFPA 101, Section 21.7.1.2. This deficient practice could affect patients, staff and visitors if proper training of staff is not completed. The following items were identified as deficient. Findings include: On 02/10/2016 at 11:45 AM during the quarterly fire drills report inspection it was determined that the facility was not transmitting a fire alarm signal to the monitoring company for verification. This does not comply with NFPA 101, 2000 edition, section 21.7.1.2.	L 050	The manager has been educated on how to properly perform a Fire Drill with alarm activation. She has also been instructed to perform these drills at different times of the day. A Fire Drill with alarm activation via pull station took place on February 19, 2016. The alarm monitoring company was called to verify the signal.	2/19/2016
L 130	as indicated OTHER REFERENCED REQUIREMENTS Other Referenced Requirements: NFPA 70 - 2002 NFPA 13 -1999 NFPA 25 - 1998 Illinois State Plumbing Code Illinois Accessibility Code As Indicate below: This Regulation is not met as evidenced by: Based on record review and interview, the facility failed to provide proper maintenance, required clearance at devices, quarterly inspections or required multi-year tests of the sprinkler system in accordance with NFPA Sections 9.7.1 and 19.3.5 NFPA 13 and NFPA 25. This deficient practice could affect patients, staff and visitors if proper sprinkler system maintenance is not completed. Findings include: On 02/10/2016 at 12:20 PM during the review of sprinkler system	L 130	The administrator will be responsible, to ensure that alarm activated drills are performed quarterly at different times.	

PRINTED: 02/23/2016
FORM APPROVED

Illinois Department of Public Health

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MICHIGAN AVENUE CENTER FOR HEALTH LTI	2415 MICHIGAN AVENUE CHICAGO, IL 60616

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L 130	Continued From page 2 maintenance records it was determined that the facility has not completed a 5 year internal investigation of the Fire Department Connection check valve. This does not comply with NFPA 25, 1998 edition, section 9-4.2.1.	L 130	We have scheduled the 5 year sprinkler inspection for March 1, 2016. Enclosed, please find the proposal. The Administrator will be responsible for ensuring that this testing is performed every 5 years.	3/1/2016

FIRE DRILL CRITIQUE

Date: 2/19/20 Location: MAM

Method Fire Drill Initiated/Triggered: Pull Station - Front Entrance
System taken off line 12:47pm

CHECKLIST:

Station pulled - Alarm sounded 12:48pm	
~~Overhead Intercom "CODE F, CODE F" (Location)~~	✓
Evacuated Patients and Visitors instructed to evacuate	✓
Close all doors	✓
Check previously closed doors (i.e. bathrooms)	✓
Shut off Oxygen valves	✓
Assure corridor and exits are clear	✓
Evacuate employees	✓
Head count performed	✓
Station Deactivated System Reset 12:52pm	✓
~~Overhead Intercom "All Clear, All Clear"~~	✓
Called to put system online 12:53pm	

Daily Logs:
- ☑ Staff Sign-In
- ☑ Patient Sign-In
- ☑ Recovery Room Log

Completion Time: 2min 40sec

Other: EM24 (monitoring Co) Contacted at 12:47pm. Operator #48 took System offline for Drill. Alarm pull station activated at 12:48pm. Drill performed. At 12:53pm EM24, Contacted again. Operator #65 confirmed signal received & put system back online.

Attendees: Kristen Briagas, [illegible] Gaillard
Crystal Vera
Darnell Williams

Number of Patients/Visitors: 0

Verified By: Aimee Gaillard

Americans United for Life

SimplexGrinnell
BE SAFE.

SimplexGrinnell LP
91 N. Mitchell Ct.
Addison, IL 60101
Tel: 630-948-1209
Fax: 630-948-1284
License number: 127-001155
www.simplexgrinnell.com
flunsford@simplexgrinnell.com

PROPOSAL AND SERVICE AGREEMENT

SimplexGrinnell Contract # 2042585	Salesperson: Fae Lunsford (175898) License No. 127-001155	Date: 02-11-16

Customer: Michigan Ave. Center for Health Attn: Vera Schmidt P (847) 255-7400 E veras@atticagci.com Invoice To (if different from Customer): AA Realty Management 1640 N. Arlington Heights Rd. STE 110 Arlington Heights, IL 60004	Job Location: Michigan Ave. Center for Health 2415 S. Michigan Ave. Chicago, IL 60616 Customer P.O. #

SimplexGrinnell LP ("Company"), for and in consideration of the prices herein named, proposes to furnish the work, and/or materials hereinafter described, subject to th
this Agreement.
SCOPE OF WORK:

1) 5 year test per NFPA 25 code (1) wet sprinkler system, to include the following:
Provide a 5 year obstruction inspection and a 5 year internal inspection, including removing the end of one crossmain and the branch line for the purpose of looking for obstructions.

2) 5 year test per NFPA 25 code (1) FDC check valve to include the following:
Provide a 5 year internal inspection, including opening and verifying internal check valve components operate properly and mx

Total - $1,645.00

Quote does not include applicable taxes, overtime labor, lift rental or any other fees associated with the above listed repair.
Service Request# 32959208.

Scope of Work continued on attached Amendment.

Payment	NET 10 ☐	NET 30 ☒	C.O.D. ☐	DEPOSIT: $
Time and Material ☐	Price Not to Exceed $	Fixed Price of $1,645.00		BALANCE DUE: $

CUSTOMER ACCEPTANCE
In accepting this Agreement, Customer agrees to the terms and conditions contained herein including those on the following pa ge(s) of this Agreement and any addita
attached hereto that contain additional terms and conditions. It is understood that these terms and conditions shall prevail over any variation in terms and conditions
other document that the Customer may issue. Any changes in the system requested by the Customer after the execution of this Agreement shall be paid for by the C
changes shall be authorized in writing. ATTENTION IS DIRECTED TO THE LIMITATION OF LIABILITY, WARRANTY, INDEMNITY AND OTHER CONDITIONS C
AGREEMENT. This offer shall be void if not accepted in writing within thirty (30) days from the date first set forth above.

2/23/16

SIMPLEXGRINNELL LP

tyco SimplexGrinnell

Safer. Smarter. Tyco.™

SERVICE REQUEST

FORWARD TO YOUR ACCOUNTS PAYABLE DEPARTMENT

91 N. Mitchell Court
Addison, IL 60101-5008
P 630-649-1200
Reg#

TASK 5 10 4 10 | 9590 |

SR #

LICENSE #

SYSTEM LEFT IN SERVICE ☑ Y ☐ N
FIRE DEPT NOTIFIED ☑ Y ☐ N
PERMIT ☐ Y ☐ N
PERMIT #

NAME [illegible] MEDICAL MAIN CENTER FOR HEALTH

ADDRESS (OR ATTENTION OF)

ADDRESS 2415 S. MICHIGAN AVE

CITY CHICAGO STATE IL ZIP 60616

LABOR - REG.	LABOR - OT	LABOR - DT

TRAVEL - REG.	TRAVEL - OT	TRAVEL - DT	MILES

TR ARRIVAL DATE 3/1/16

CUSTOMER PURCHASE ORDER

SST

TIME ARRIVAL

DEPART

56923

NAME (BILL TO)

ADDRESS

CITY STATE ZIP

I authorize SimplexGrinnell to proceed with the work as agreed to and outlined below:

Customer signature Date 3-1-16

PAYMENT TERMS

☐ Time and Material ☐ Price Not to Exceed $ ☐ Fixed Price of $

IMMEDIATE ☐ COD ☐ NET 10 ☐

DEPOSIT $ BALANCE DUE $

☐ BILLABLE ☐ NON-BILLABLE

SCOPE OF WORK / PROBLEM CODE 5IK OBSTRUCTION ON A WET SYSTEM
FIRE DEPARTMENT CHECK VALVE.

WORK PERFORMED / RESOLUTION CODE BACK FLUSH OF DRY SYSTEM, OPEN
FIRE DEPARTMENT CHECK VALVE. FLUSH THRU LOOPS GOOD AT
THIS TIME OF DRY SYSTEM + CALL ALARMS BACK ON
LINE

WE STRONGLY RECOMMEND IMMEDIATE CORRECTION OF ANY DEFICIENCIES/IMPAIRMENTS IDENTIFIED. REQUESTED REPAIRS MADE IF SET FORTH BELOW IN "WORK PERFORMED". ADDITIONAL REPAIRS OR COMPLETE INSPECTION MAY BE REQUIRED. WE URGE YOU TO NOTIFY THE LOCAL AUTHORITY HAVING JURISDICTION AND YOUR INSURANCE CARRIER WITHOUT DELAY.

SimplexGrinnell, for and in consideration of the prices herein named, proposes to furnish the work, and/or materials hereinafter described, subject to the terms and conditions outlined below

MATERIAL	QTY.	UOM	PRICE	EXPENSE	QTY.	UOM	PRICE

IMPORTANT NOTICE TO CUSTOMER

Customer acknowledges and agrees to the terms and conditions on the reverse side of this Service Request, agrees that the services have been completed to Customer's satisfaction and that the [illegible] and repair, unless services performed were of a temporary nature, in which case Customer acknowledges that part of customer's system may have been bypassed or is otherwise inoperable [illegible] **CUSTOMER'S ATTENTION IS DIRECTED TO THE LIMITATION OF LIABILITY, WARRANTY, INDEMNITY AND OTHER CONDITIONS ON THE REVERSE SIDE.**

CUSTOMER ACCEPTANCE

(Customer Acceptance)

(Print Name)

SIMPLEXGRINNELL LP

(SimplexGrinnell Representative)

(Print Name)

License #

CUSTOMER COPY

REPORT OF OBSTRUCTION INVESTIGATION AND INTERNAL CONDITION OF FIRE PROTECTION SYSTEM PIPING

SimplexGrinnell BE SAFE.

91 N Mitchell Court
Addison, Il 60101
24/7 Service 630-948-1200

Inspector Name:	DAVE STEVENSON	SR #:	
Customer Name:	MICHIGAN CENTER FOR HEALTH	Task #:	50409590
Customer Location:	2415 S MICHIGAN, CHICAGO IL	Date	3-1-16

5-Year Investigation and Prevention

	Y	N/A	N
System in service before conducting investigation	✓		
Pertinent parties notified before conducting investigation	✓		
Adequate drainage ensured before draining system	✓		
System impairment program implemented before conducting investigation	✓		
Flushing connection of one main and sprinkler of one branch line removed	✓		
Alternative nondestructive examination method utilized			✓
No foreign material indicated by nondestructive examination method	✓		
Interior of main, branch line, and sprinkler outlet checked for presence of foreign organic or inorganic material			
No significant foreign material observed	✓		
Interior of main, branch line, and sprinkler outlet checked for presence of tubercules or slime	✓		
No tubercules or slime observed			✓
Complete flushing program implemented where observed material sufficient to obstruct sprinklers date:			✓
TESTING FOR MICROBIOLOGICALLY INFLUENCED CORROSION (MIC):			
Tubercules or slime (if present) tested for indications of MIC date:			✓
Material test results do not indicate presence of MIC date:			✓
MIC abatement/monitoring program implemented (if "NO" on B.3.1) date:			✓
Pertinent parties notified of investigation conclusion.	✓		
ALARM PANEL CLEAR	✓		
SYSTEM RETURNED TO SERVICE	✓		
COMMENTS:			

F. D. CHECK VALVE
GOOD

Other Conditions Providing Cause for Investigation

Check all that apply:

- ☐ Defective intake for fire pump taking suction from open body of water
- ☐ Discharge of obstructive material during routine water flow test
- ☐ Evidence of foreign materials in fire pump
- ☐ Evidence of foreign material in system valve, i.e. dry pipe, preaction/deluge, alarm valve
- ☐ Evidence of foreign material in check valve
- ☐ Foreign material in water during drain test
- ☐ Plugged inspector's test connection
- ☐ Plugged sprinkler or drop
- ☐ Plugged sprinkler piping discovered during alterations
- ☐ Failure to flush yard piping or surrounding public main following new installation or repair
- ☐ A record of broken or public mains in vicinity
- ☐ Abnormally frequent false tripping of dry pipe valve
- ☐ A system returned to service after a shutdown of more than 1 year
- ☐ Indications that system contains sodium silicate
- ☐ Indications that copper system contains highly corrosive flux
- ☐ A system being supplied raw water via the FDC
- ☐ Pinhole leaks observed in system piping
- ☐ A 50-percent increase in water delivery time for a dry pipe system
- ☐ Other: (describe)

Inspector Signature:

Inspector Printed Name: DAVE STEVENSON

Owner or Owner's Representative: E Villarreal

Owner or Representative Printed Name: E Villarreal

Americans United for Life

REPORT OF OBSTRUCTION INVESTIGATION AND INTERNAL CONDITION OF FIRE PROTECTION SYSTEM PIPING

SimplexGrinnell BE SAFE.

91 N Mitchell Court
Addison, Il 60101
24/7 Service 630-948-1200

Inspector Name:	DAVE STEVENSON	SR #:	
Customer Name:	MICHIGAN CENTER FOR HEALTH	Task #:	5040 9530
Customer Location:	2415 MICHIGAN CHICAGO IL	Date	3-1-16

5-Year Investigation and Prevention

	Y	N/A	N
System in service before conducting investigation	✓		
Pertinent parties notified before conducting investigation	✓		
Adequate drainage ensured before draining system	✓		
System impairment program implemented before conducting investigation	✓		
Flushing connection of one main and sprinkler of one branch line removed	✓		
Alternative nondestructive examination method utilized			✓
No foreign material indicated by nondestructive examination method	✓		
Interior of main, branch line, and sprinkler outlet checked for presence of foreign organic or inorganic material			
No significant foreign material observed	✓		
Interior of main, branch line, and sprinkler outlet checked for presence of tubercules or slime	✓		
No tubercules or slime observed			✓
Complete flushing program implemented where observed material sufficient to obstruct sprinklers date:			✓
TESTING FOR MICROBIOLOGICALLY INFLUENCED CORROSION (MIC):			
Tubercules or slime (if present) tested for indications of MIC date:			
Material test results do not indicate presence of MIC date:			✓
MIC abatement/monitoring program implemented (if "NO" on B.3.1) date:			✓
Pertinent parties notified of investigation conclusion.	✓		
ALARM PANEL CLEAR	✓		
SYSTEM RETURNED TO SERVICE	✓		

COMMENTS:

WET SYSTEM
GOOD.

Other Conditions Providing Cause for Investigation

Check all that apply:

- ☐ Defective intake for fire pump taking suction from open body of water
- ☐ Discharge of obstructive material during routine water flow test
- ☐ Evidence of foreign materials in fire pump
- ☐ Evidence of foreign material in system valve, i.e. dry pipe, preaction/deluge, alarm valve
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- ☐ Plugged inspector's test connection
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- ☐ A system being supplied raw water via the FDC
- ☐ Pinhole leaks observed in system piping
- ☐ A 50-percent increase in water delivery time for a dry pipe system
- ☐ Other: (describe)

Inspector Signature: [signature]

Inspector Printed Name: DAVE STEVENSON

Owner or Owner's Representative: [signature]

Owner or Representative Printed Name: S. Villareal

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7003183	39802, 19843	6/11/19

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Western Diversey Surgical Center	2744 N. Western Ave., Chicago, IL 60647

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
000	A licensure survey was conducted on 6/11/19. The Facility was not in compliance with Title 77: Public Health, Chapter 1: Department of Public Health, Subchapter b: Hospital and Ambulatory Care Facility, Part 205: Ambulatory Surgical Treatment Center Licensing requirements, as evidenced by:			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE	TITLE	DATE
Julie Swanson 7/2/19	Administrator	

Illinois Department of Public Health

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000	A licensure survey was conducted on 6/11/19. The Facility was not in compliance with Title 77: Public Health, Chapter 1: Department of Public Health, Subchapter b: Hospital and Ambulatory Care Facility, Part 205: Ambulatory Surgical Treatment Center Licensing requirements, as evidenced by:	205.230	On June 26, 2019, 9:00AM - an emergency Consulting Committee meeting was conducted to formally document vote and elect for CEO and members of a Consulting Committee. see attachement A. (Quarterly Consulting Committee Minutes) On the minutes, responsibilities of the consulting committee are discussed and delineated. The minutes of the meeting format are also ammended which more in detail represents the entirity of the organization agenda covering aspects such as credentialing, aprroval of new and changes in policies and procedures, tissue review report, QA/PI report, Infection prevention and control, environment of care, and other organizational activities. The Consulting Committee will be responsible in the documentation and record keeping of the minutes of the meeting. The Consulting Committee will meet on a regular basis (quarterly) at a minimum. A quorum may be called upon 50% or more of the memebers are present. Attached: Consulting Committee Minutes, ByLaws of the Medical Staff, AHCC Organizational Structure	6/27/2019

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE: Julie Swanson

TITLE: Administrator

DATE: 7/2/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
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205.230 a) 2	Section 205.230 a) 2) Standards of Professional Work a) A qualified consulting committee shall be appointed in writing by the management or owner of the ambulatory surgical treatment center and shall establish and enforce standards for professional work in the facility and standards of competency for physicians. The qualified consulting committee shall meet not less than quarterly and shall document all meetings with written minutes. The minutes shall be maintained at the facility and shall be available for Department inspection. 2) The qualified consulting committee shall review the development and content of the facility's written policies and procedures, including the details of the quality assessment and performance improvement program, the infection control program, the patient rights plan, the disaster preparedness plan, the procedures for granting privileges, and the quality of the surgical procedures performed. The reviews shall be documented in the minutes. This Regulation is not met as evidence by: Based on document review and interview, it was determined that the Facility failed to ensure that detailed reviews of the quality assessment and performance program, the infection control program, the patient rights plan, the disaster preparedness plan, granting of privileges, and the quality of the surgical procedures performed were documented in the governing body meeting minutes. This could potentially affect the average 65 procedures performed at the Facility every month.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE	TITLE	DATE
Julie Swanson	Administrator	7/2/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
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205.230 a) 2	Section 205.230 a) 2 (continued) Findings include: 1. The Facility's bylaws regarding responsibilities of the Consulting Committee were requested from the Administrator (E#1) on 6/10/19, at approximately 2:00 PM. On 6/11/19, at approximately 10:20 AM, E#1 stated that there were no written bylaws regarding oversight by the Consulting Committee. E#1 stated that the Consulting Committee is the Governing Body and is responsible for oversight of all facility operations including quality assurance and performance improvement (QAPI), medical staff credentialing, infection control, patient rights, and disaster planning. 2. The quarterly Consulting Committee meeting minutes from January 2017 to April 2019 were reviewed on 6/10/19. The minutes failed to include documentation of any discussions regarding QAPI, credentialing, infection control program, patient rights plan, and the disaster preparedness plan. 3. An interview was conducted with the Administrator (E#1) on 6/10/19, at approximately 3:30 PM. E#1 reviewed the meeting minutes from January 2017 to April 2019 and could not find documentation of discussions, actions and/or activities made by the Governing Body during the quarterly meetings. E#1 stated that the meeting minutes used to be written on a more detailed template that included sections about credentialing, policies and procedures, QAPI, and infection control; however, the Medical Director (MD#1) and Office Manager (E#4) "thought it was okay" to not have the details for each section written out.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE	TITLE	DATE
Julie Swanson	Administrator	7/2/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
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205.550 b)	Section 205.550 b) Infection Control b) Each ASTC shall maintain a written, active and effective facility-wide infection control program. A system designed for the identification, surveillance, investigation, control, and prevention of infectious and communicable diseases in patients and health care workers shall be included in this program. This Regulation is not met as evidence by: A. Based on document review, observation, and interview, it was determined that for 1 of 2 Physicians (MD#1) observed, the Facility failed to ensure that personal clothing was not exposed in the restricted perioperative area (OR). Findings include: 1. On 6/10/19 at approximately 8:45 AM, the Facility's "Surgical Attire" policy was requested. The policy was not found. 2. On 6/11/19, at 12:15 PM, the "Association of periOperative Registered Nurses [AORN] 2018 Edition Guidelines for Perioperative Practice," was reviewed. The Guidelines included, "Guidelines for Surgical Attire... Recommendation I: Clean surgical attire should be worn in the semi-restricted and restricted areas of the perioperative setting... 1.b.5. Personal clothing that cannot be contained within the scrub attire either should not be worn or should be laundered in a health care accredited laundry facility..." 3. On 6/10/19 at 9:00 AM, an observational tour was conducted in the perioperative area (OR). The Surgeon (MD#1), who performed a pain procedure in OR suite #1, wore a tee shirt under his scrub shirt that was exposed at the neck level.	205.550 b)	On June 24, 2019, A Policy for Infection Control was drafted. Policy # 07.04.20 Titled Surgical Attire. The policy provides for guidance to perioperative personnel for surgical attire, including scrub attire, shoes, jewelry, head coverings, and surgical masks worn in the semi-restricted and restricted areas, which has an expected outcome that the patient will be free from signs and symptoms of infection. The drafted policy was cross referenced from ASHA, and AORN. (see attached Policy#07.04.20 Surgical Attire) The aforementioned Policy was presented and discussed in an emergency Consulting Committee meeting on June 26, 2019 was approved and inserviced to the staff on and other perioperative personnel for immediate implementation 6/27/19. (see attched Policy#07.04.20 Surgical Attire); Surgical Attire In-service Log.) see also attached tool used for Competency verification on Surgical Attire.	6/27/2019

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE: Julie Swanson

TITLE: Administrator

DATE: 7/2/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
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205.550 b)	Section 205.550 b) (continued) 4. On 6/10/19 at 3:55 PM, an interview was conducted with the Infection Control Officer (E #2). E #2 stated that the Facility follows AORN Guidelines and that MD #1's tee shirt should have been covered by the scrubs. B. Based on document review and interview, it was determined that for 1 of 1 sterilizer log reviewed, the Facility failed to ensure that daily biological indicator test (a process used to test the effectiveness of sterilization). This could potentially affect the average 65 procedures performed at the Facility every month. Findings included: 1. The Facility's Policy titled, "Sterilizer Monitoring" (revised 4/2/18), was reviewed on 6/10/19 and required, "...Spore [biological indicator] testing will be conducted daily when sterilizer is in use and on every load for implantable. (See accompanying inserts for manufacturers instructions for use).." 2. The manufacturer's guidelines for the biological indicator, were reviewed on 6/10/19 and required, "...Record the processed and control biological indicator results..."	205.550 b)	On June 21, 2019, Policy # 07.04.07 Titled: Sterilizer Monitoring was reviewed with the staff as part of an in-service under Infection Control Plan. see attached sign in log for in-service, Policy on Sterilizer Monitoring, 3M attest Biological IFU. To guarantee the success of Performance Improvement of such activities, the Sterilizer Monitoring activities will be included in the performance improvement activities which will be collected daily and evalauated monthly for improvement for the next 6 months. The Performance Improvement actities will also be reported to the consulting committee on a quarterly basis. (see attached Performance Activities Indicator)	6/21/2019

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE: Julie Swanson

TITLE: Administrator

DATE: 7/2/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7003183	39802, 19843	6/11/19

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Western Diversey Surgical Center	2744 N. Western Ave., Chicago, IL 60647

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Section 205.550 b) (continued)			
205.550 b)	3. The sterilization logs from 3/1/19 to 5/1/19, were reviewed on 6/10/19 and indicated: - On 3/22/19, two loads of surgical instruments were sterilized. Load #1 contained 2 video cases (camera equipment inserted in the body during surgery), a hand tray (surgical instruments used to repair the hand), and a laryngoscope blade (used to open the airway when viewing the throat). Load #2 contained an Arthrex Power Tray (instruments used to saw or drill bone) and an Arthrex hand instrument (surgical instrument used to repair the hand). The log lacked documentation of the results of the biological indicator tests for both loads. - On 3/27/19, one load of surgical instruments was sterilized. The load contained dilators (surgical instrument used to expand an opening or passage), forceps (a pair of pincers or tweezers used in surgery), curettes (surgical instrument used to remove material by a scraping action), and speculums (instrument used to dilate an opening or canal in the body to allow inspection). The log lacked documentation of the result of the biological indicator test. 4. An interview was conducted with a Surgical Technician (E#5) on 6/10/19, at approximately 1:15 PM. E#5 stated that biological indicator testing is required daily. E#5 verified that no results were marked for loads performed on 3/22/19 and 3/27/19 and stated, "It should have been documented, we have no record of the results for those days."			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE	TITLE	DATE
Julie Swanson	Administrator	7/2/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7003183	39802, 19843	6/11/19

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Western Diversey Surgical Center	2744 N. Western Ave., Chicago, IL 60647

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205.550 j)	Section 205.550 j) Infection Control - Hand Hygiene j) Thorough hand hygiene shall be required after touching any contaminated or infected material. This Regulation is not met as evidence by: Based on document review, observation, and interview, it was determined that for 1 of 1 Housekeeper (E#3) observed, the Facility failed to ensure that hand hygiene was performed after removing gloves. Findings include: 1. On 6/11/19, the Facility's "Infection Prevention Program and Plan," (undated), was reviewed. The Plan included, "...Hand Hygiene will be performed for... After removing gloves..." 2. On 6/10/19 at 9:00 AM, an observational tour was conducted in the operating area (OR). At 10:00 AM, a Housekeeper (E#3), in the Holding/ Post Operative Area, disposed of a cleaning cloth, removed gloves, did not disinfect hands, and left the room. 3. On 6/10/19 at 3:55 PM, an interview was conducted with the Infection Control Officer (E#2). E#2 stated that hand hygiene should be performed after gloves are removed.	205.550 (j)	On June 20, 2019, A facility wide in-service was conducted to all personnel. Title: Guideline Implementation: Hand Hygiene (see attached brochure) A post evaluation was also conducted at this time and Competency Verification was also conducted on June 24, 25, and 27 following the in-service. (see attached sample of tool used in comptency verification) (see also log of attendance on Hand Hygiene in-service)	6/27/2019

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE: Julie Swanson

TITLE: Administrator

DATE: 7/2/19

American Health Care Center

3412 W. Fullerton Ave., Chicago, IL 60647
773-235-8000

Quarterly Consulting Committee Minutes

Date: June 26, 2019

Emergency Meeting

Time: 9:00 am

Location: Fullerton-Kimball Medical and Surgical Center (conference room)

No of Pages: *(2)*

I Approval of the previous minutes of meeting

The minutes of the previous meeting (1st Quarter 2019) has been approved. A new format of agendas on the meeting is discussed which will be included in the subsequent meetings. The Medical Staff Bylaws has been amended, the Consulting Committee members and Chief Executive Officers has been voted on and listed hereinafter.

CEO- Dr. R. Xia
Members:
D. Ur – Medical Director
J. Swanson – Administrator
A. Sabater, RN – Clinical Nurse Manager
Sophia Demas – Office Manager
Andriy Khlopas – Nurse Practitioner

The meeting also delineates the other committees that reports to the Consulting Committee, namely Credentialing, Quality Improvement and Infection Control. (see attached ByLaws of the Medical Staff)

II Credentialing

The Credentials Committee has reported no new medical staff or LIPs under renewal and all members are up to date with their credentials. A review and discussion of the Medical Staff Bylaws and the steps to credentialing and re-credentialing were reviewed. Dr. R. Malcom has filed a leave of absence for the year commencing May 2019. Dr. H. Brown has resigned from the medical staff as of April 2019. Dr. T. Huang has been re-appointed as of June 01, 2019.

III Approval/review of Policies and Procedures

A new policy has been created and presented to the committee for approval: Policy #7.04.20 Title: Surgical Attire, the policy was approved for in-service and implementation.
Policy #7.04.17 STERILIZER MONITORING has been reviewed and in-service will be conducted for the staff on June 26, 2019.

IV Tissue Review Report

Tissue review reports for the 1st quarter 2019. No discrepancies were reported from the pre-operative and post-operative diagnosis basing on the tissue reports, all tissue reports are also received on a timely manner.

V **QA/PI Report**
Performance Improvement and Quality Assurance such as Medication monitoring (i.e., Look-Alike – Sound-Alike Medication and High Risk Medication List; Medication Cabinet Checklist; Outdated Supplies – has been assigned to S. Garcia to monitor on a weekly basis for the next two months and tapering off to monthly. The Sterilizers Biological Testing has been added to the Quality/Performance Improvement indicator daily monitoring for the next 6 months tapering to 3 months and eventually to monthly.

VI **Infection Prevention and Control**
A new policy was drafted and approved: Policy # 07.04.20 Surgical Attire
Hand Hygiene In-service and competency evaluation was conducted for the staff.
Sterilization Monitoring policy has been reviewed and in-serviced to the staff.

VII **Environment of Care**
The quarterly Fire Drill has been conducted on June. 19, 2019 at 2:30 PM, report has been filed to the Safety Coordinator. The Disaster Plan was also discussed and revision of the Plan is being looked into and details will further be discussed in the upcoming 2nd Quarterly Meeting.

VI **Census Report**
The census report for the quarter has been reported. (see attached report).

VII **Employee Related Agenda**
Nothing discussed.

VIII **Other Agendas and Announcements**
Aflac renewal is up-coming this July 2019, new enrollees will be welcomed.

Adjournment

Attendees: *(list of people in attendance, must have a sign in sheet)*

Attendees:

R. Xia, MD

D. Ur, MD

A. Sabater, RN

J. Swanson

K. Mazurek

S. Demas

A. Khlopas, NP

[redacted]

Americans United for Life

AMERICAN HEALTH CARE CENTER
MEDICAL STAFF BYLAWS

American Health Care Center is an organization under the state of Illinois whose purpose is to serve as a medical and ambulatory surgical center providing quality care for patients having outpatient procedures performed.

The Medical Staff of the American Health Care Center (AHCC) is responsible for the quality of medical care in all of its centers, and must accept and discharge this responsibility subject to the ultimate authority of the Consulting Committee (the "Board"). The physician, dentist and podiatrists who are granted privileges to care for the patients at AHCC by the Board hereby organize themselves into a Medical Staff in conformity with these Bylaws.

ARTICLE I
Medical Staff Name

The organized Medical Staff of the AHCC shall be known as the "Medical Staff of American Health Care Center."

ARTICLE II
Purpose

The Medical Staff of AHCC shall be accountable to the Board and shall be responsible for the quality of medical care provided to patients and for the ethical conduct and professional practice of its members and Allied Health Professionals who have been granted clinical privileges. In the proper discharge of these duties, the Medical Staff shall:

1. Recommend rules and regulations respecting clinical operations of the Center and the organization and operation of the Medical Staff to the Board for review and approval;
2. Conduct ongoing review and evaluation of its members and Allied Health Professionals and make recommendations to the Board respecting assignment and curtailment of clinical privileges and advancement and disciplinary action respecting such practitioners in accordance with these Bylaws and make recommendations to the Board respecting quality concerns and suggestions for improvement; and,
3. Ensure an appropriate liaison between the Medical Staff and the Board.

ARTICLE III
Medical Staff Membership

Section 1
Definition of Medical Staff Membership

Membership on the American Health Care Center is a privilege which shall be extended only to qualified, professional and competent physicians, dentists, and podiatrists who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and in the rules, regulations, policies and procedures of the Medical Staff and the Center. Allied Health Professionals are licensed or certified health practitioners other than physicians, dentists, or podiatrists who through their training, experience and demonstrated competence are eligible to provide certain patient care services at the Center as recommended by the Medical Staff and approved by the Board.

Section 2
Qualifications for Membership

1. Every practitioner who seeks or enjoys appointment to the Medical Staff, or rights to perform patient care services as an Allied Health Professional shall, at the time of initial appointment and continuously thereafter, be qualified for membership or status as an Allied Health Professional, as the case may be, and the exercise of the clinical privileges granted to him or her. At a minimum, such practitioners shall:

a. Hold a valid, current, and unrestricted license to practice medicine, dentistry, or podiatry in the state of Illinois or, in the case of an Allied Health Professional, a valid, current, and unrestricted license or certification from the state of Illinois sufficient in scope to provide the patient care services for which privileges have been sought;

b. Possess the professional education, training, experience, ability, demonstrated competence, and judgment necessary to exercise the clinical privileges being sought;

c. With respect to physicians, dentists, and podiatrists:

i. Have completed post-graduate study at an accredited institution in the practitioner's specialty sufficient to qualify the practitioner for examination by an appropriate medical, osteopathic, dental, podiatric or specialty board (if such board exists in the practitioner's specialty) or professional training and professional credentials equivalent thereto;

ii. To the extent available and required in connection with the privileges requested, possess a current, unrestricted, and valid Drug Enforcement Agency registration necessary to permit such practitioner to dispense and/or administer controlled substances within limits of practitioner's specialty.

iii. Have and maintain clinical privileges at an accredited hospital which is either Medicare certified or satisfies the requirements for emergency services under 42 CFR 482.2 and which is located within approximately 35 miles from the Center, or have an established coverage arrangement with a physician or group of physicians having such clinical privileges so that the emergency needs of Center patients may be addressed through emergency admission;

iv. Participate in continuing education which satisfies the continuing education requirements of the State of Illinois, the American Medical Association Physician Recognition Award, the American Osteopathic Association, the American Podiatry Association, the American Dental Association, the practitioner's specialty board, or their equivalent;

d. With respect to Allied Health Professionals:

i. Have adequate training, experience and demonstrated current competence commensurate with the duties and responsibilities associated with the privileges being requested; and

ii. Where required by the State of Illinois, have in effect an agreement with a supervising practitioner who is a member of the Medical Staff and which covers oversight of the Professional's activities within the Center;

e. Demonstrate a willingness and capacity to work with and relate to other Medical Staff members, Allied Health Professionals, Center staff, patients, visitors, and the community in a cooperative and professional manner;

f. Possess current and valid professional liability insurance coverage that covers services to be rendered at the Center with limits acceptable to the Board;

g. Not have any significant physical or behavioral impairment which would interfere with the practitioner's ability to exercise his or her clinical privileges, discharge his or her duties as a member of the Medical Staff, satisfy any of the conditions for Medical Staff membership or classification as an Allied Health Professional, or otherwise provide quality health care, excepting such physical or behavioral impairments which may be reasonably

accommodated so as to eliminate the foregoing;

h. Adhere to the highest ethical standards and levels of professional competence of his or her licensing Board and profession; and,

i. Not be excluded from participation in any Federal health care program.

Section 3
Duration and Condition of Appointments

1. Action. All initial appointments and reappointments to the American Health Care Center Medical Staff shall be made by the Consulting Committee/Board. The Board of Directors shall act on appointments, reappointments, revocation, limitation or suspension of appointments or privileges only after there has been a recommendation from the Medical Advisory Committee as provided in these Bylaws; provided, however, that in the event of unwarranted delay on the part of the Medical Advisory Committee, the Board of Directors may act without such recommendations on the basis of documented evidence of the applicant's or the staff member's professional and ethical qualifications obtained from reliable sources other than the Medical Staff.

2. Duration. Initial appointments shall be for a period of not more than two (2) years. Reappointments shall be for a period of not more than two (2) years.

3. Temporary Privileges. Temporary privileges may be granted by the Medical Director for a period of 60 days after a fully completed application has been presented to him or her and the following information has been obtained and verified:

a. An acceptable report from the National Practitioner Data Bank;

b. At a minimum, verbal verification of current, valid and unrestricted licensure or certification from the State of Illinois;

j. At a minimum, verbal verification of current medical staff privileges as required by Section II.ciii hereof;

k. Verification of professional liability insurance coverage as required by Section II.e hereof; and

l. Verification that the practitioner is not included on the List of Excluded Individuals/Entities maintained by the Office of Inspector General of the Department of Health and Human Services.

Temporary privileges may be extended for an additional period not to exceed 30 days for purposes of completion of the physician's credentials file or for a period not to exceed 60 days if the Medical Advisory Committee is not scheduled to meet with the first 30-day extension. In the event that the foregoing time periods are exceeded, the practitioner's temporary privileges shall terminate and his or her application will continue to be processed in due course.

1. Scope. The appointee will have and be permitted to exercise only those clinical privileges granted by the Board of Directors in accordance with these Bylaws.

2. Application. Every application for staff appointment shall be on a form approved by the Board, signed by the applicant and shall contain the applicant's specific acknowledgment of a Medical Staff Member's obligations to provide continuous care and supervision of his patients, to abide by the Medical Staff Bylaws, Rules and Regulations, the policies, procedures, rules and regulations of the Center and to accept committee assignments.

6. Condition of Appointments:

a. In order for a provider to maintain his or her medical staff appointment and clinical privileges at AHCC, he or she must perform at least four (4) surgeries per year at the Center. The exception to this bylaw is if the surgeon is an investor.

b. At the one-year mark, the Center will send a warning letter to physicians who are not maintaining the minimum number. At the end of the two-year reappointment period, failure of the provider to meet the above requirements will result in the provider's voluntary administrative resignation of clinical privileges and medical staff appointment to the Medical Staff of AHCC.

Section 4

Procedure for Appointment/Reappointment

1. Application packets for appointment or reappointment to the staff may be obtained from the AHCC upon request. Requests should be sent to:

American Health Care Center
c/o Medical Staff Services
3412 W. Fullerton Ave.,
Chicago, Illinois 60647

2. Physicians, dentists and podiatrists who wish to apply for appointment to the staff and for clinical privileges and Allied Health Professionals who wish to apply for rights to perform patient care services at the Center shall submit a written application on a form provided by the Center. The application form for physicians, podiatrists, and dentists shall contain a delineation of privileges for each specialty. There is a separate application for Allied Health Professional application forms and amendments to the forms shall be approved by the Board of Directors.

3. Completed application forms shall be submitted to AHCC Credentialing Department with a letter of reference from the applicant's Department Chairman in the primary hospital with which the application is presently affiliated. *NOTE: In the event the applicant works as Locum Tenens, a letter of reference from a physician with whom the applicant has worked on a consistent basis may be substituted.

4. The AHCC Credentialing Department shall be responsible for coordinating the gathering and verification of information necessary in the application process. The Medical Director shall be permitted to require the applicant to participate in the information gathering and verification process. Specifically, the applicant shall be responsible for updating all educational information, providing copies of proof of Illinois Licensure and DEA registration, providing all references required, completing appropriate Delineation of Privileges forms, and providing proof of professional liability insurance, (In addition, foreign graduates shall be required to supply copies of medical school transcripts and other materials necessary as set forth in the application form.) At all times during the application process the applicant shall have the burden of producing information in a timely fashion for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and membership requested, of resolving any doubts about these matters, and of satisfying requests for information. This burden may include submission to a medical or psychiatric examination, at the applicant's expense, if deemed appropriate by the Medical Advisory Committee, who may select the examining physician.

5. The Medical Director may request a personal interview with the applicant.

6. By applying for appointment or reappointment to the Medical Staff, each applicant thereby signifies his/her willingness to appear for interview in regard to his/her application, authorizes the AHCC to consult with members of the Medical Staffs or other

institutions with which the applicant has been associated, and with others who may have information bearing on his/her competence, character, and ethical qualifications, consents to the American Health Care Center's inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges that have been requested, and to query the National Practitioner's Data Bank.

7. After all information required in the application form has been gathered and verified, and Data Bank report and sanctions check completed, the Medical Director shall submit the application to the Medical Advisory Committee appointed by the Board of Directors.

8. The Medical Advisory Committee shall review the application and may interview the applicant. Following its review, the Medical Advisory Committee shall submit the application, together with its recommendations as to whether the applicant should be appointed or reappointed to the Medical Staff and the recommended scope and delineation of clinical privileges or rights to perform patient care services in the AHCC to the Board of Directors.

9. The Board shall consider the recommendation of the Medical Advisory Committee at its next regularly scheduled meeting; provided, however, that the Board, in its sole discretion, may defer action on any application and/or request such additional information as it deems appropriate, through the Medical Director, from the applicant.

10. In the event that the Board denies an application for appointment or reappointment, or privileges granted to an applicant to the Medical Staff by the Board are less comprehensive than those requested, and the reasons for the Board's decision is not based solely on the practitioner's inability to satisfy the threshold qualifications or criteria for Medical Staff membership or the privileges requested, then the decision shall be considered an Adverse Action for purposes of Article VI hereof.

11. In the event that an applicant is dissatisfied with the decision of the Board, he/she may appeal the recommendation or action pursuant to Article VI of the Bylaws. (The applicant shall have thirty (30) days from his/her notification of the recommendation or action to submit a written request for an appeal to the Medical Director. In the event of an appeal, the Board of Managers shall appoint an Ad Hoc hearing committee to hear the appeal and to make a report to the Medical Advisory Committee, or the Board of Directors depending upon whose recommendation or action is being challenged. The applicant also shall have the right to an appellate review by the Board of Directors of any adverse recommendation or action.

ARTICLE IV
Parliamentary Procedure

Sturgis– Standard Code of Parliamentary Procedure shall govern all meetings in all cases to which they are applicable and in which they are not inconsistent with the Bylaws or Rules and Regulations of the Medical Staff of AHCC.

ARTICLE V
Corrective Action

1. Corrective action will be initiated against a member of the Medical Staff or an Allied Health Professional whenever their activities or professional conduct:

   a. Is contrary to the standards or aims of the Medical Staff or Professional conduct; or

   b. Is disruptive to the operation of American Health Care Center; or

   c. Brings discredit upon the Medical Staff or AHCC; or

   d. Is contrary to the provisions of the Medical Staff Bylaws, Rules and Regulations, or civil law.; or

   e. Raises issues respecting the practitioner's competence or continued satisfaction of the qualifications described in Article III, Section 2 hereof; or,

   f. Is inconsistent with the efficient delivery of patient care at generally recognized professional levels of quality or is reasonably probable of being disruptive to Center operations; or,

   g. Is indicative of a mental or physical impairment that might interfere with quality of care.

A request for corrective action may be initiated by a Medical Staff member, the Medical Director, the Administrative Director, a Committee of the Medical Staff or Board, the Medical Advisory Committee, or the Board. All requests for corrective action shall be in writing and shall be submitted to the Medical Director and shall be supported by reference to the specific activities of conduct which constitutes grounds for the requested action.

2. If the Medical Director finds sufficient cause, he/she shall appoint an Ad Hoc

Committee, within ten (10) calendar days, of three members of the Medical Staff. To the extent possible, the Medical Director shall avoid appointing individuals to the committee who are in direct competition with the practitioner being reviewed. The Ad Hoc Committee will investigate the allegations and shall make recommendations to the Medical Director within fourteen (14) days of appointment.

3. After reviewing the report of the Ad Hoc Committee, the Medical Director will report in writing his/her own investigation and recommendations on the matter to the Medical Advisory Committee. To the extent that an ad hoc committee has not been appointed, the Medical Director will provide the Medical Executive Committee with a report of his or her investigation.

4. The Medical Director shall then arrange a meeting with the practitioner being investigated and the Medical Advisory Committee. At this meeting, the practitioner shall be given an opportunity to discuss, explain, or refute the circumstances giving rise to the request for correction action. The Medical Director, in conjunction with the Medical Advisory Committee, shall make their recommendations in writing to the Board within fourteen (14) days of this meeting. A copy of the Medical Advisory Committee's recommendations shall be provided to the practitioner.

5. The practitioner may submit a written response to the Medical Advisory Committee's recommendations to the Board.

After considering all recommendations and evaluating the information presented, the Board may take corrective action. Such action may include, but is not limited to, (1) issuing a warning or a letter of admonition, or a letter of reprimand; (2) imposing terms of probation or a requirement for consultation or monitoring; (3) reduce, suspend, revoke, or otherwise limit clinical privileges or rights to provide clinical services or (4) continue or modify an already imposed summary suspension of clinical privileges. The action so taken shall be communicated to the practitioner in writing within ten (10) days of the decision.

6. The practitioner may appeal any adverse action taken by the Board pursuant to Article VI hereof.

7. The Medical Director, the Medical Executive Committee, the Administrative Director or the Board may summarily suspend any practitioner if such person or body reasonably determines that:

a. Continued exercise of privileges by the practitioner would endanger the safety of patients or staff of the Center; or,

b. The practitioner has breached or failed to comply with the requirements of these Bylaws, the rules and/or regulations of the Medical Staff, or the rules, regulations, policies or procedures of the Center, and such breach or failure to comply was intentional or done with willful disregard; or,

c. The practitioner has acted beyond the scope of his or her delineated privileges and such action cannot be justified as the only recourse in response to an emergency situation.

A summary suspension described in this Section 7 shall be considered an Adverse Action for purposes of Article VI hereof, but notwithstanding any provision of Article VI hereof to the contrary, any appeal from a summary suspension shall be limited to the issue of whether the person or body imposing the suspension was arbitrary or capricious in making the determination that a summary suspension was warranted.

8. The clinical privileges of a practitioner shall be automatically suspended in the event that:

a. The practitioner's license is suspended or revoked or is restricted in such a way as to interfere with his or her legal ability to exercise the privileges he or she has been granted;

b. The practitioner is listed on the List of Excluded Individuals/Entities maintained by the Office of Inspector General of the Department of Health and Human Services;

c. The practitioner's professional liability insurance coverage no longer satisfies the requirements imposed by the Board; or

d. The practitioner's privileges or coverage arrangements as described in Article III, Section II(c)(iii) are terminated, suspended, or revoked.

A suspension pursuant to this Section 8 shall not be an Adverse Action for purposes of Article VI hereof; provided, however, that the practitioner who is the subject of the suspension shall have the right to provide to the Board evidence that the circumstances giving rise to the suspension did not, in fact, occur. Any suspension invoked pursuant to this Section 8 shall be effective for a period commencing with the occurrence giving rise to the suspension and shall continue until such time as: (a) the occurrence giving rise to the suspension ceases to be effective; (b) the

practitioner submits a completed application for appointment to the Medical Staff; and (c) the Board, after consideration of the recommendations of the Medical Advisory Committee, determines that the practitioner again qualifies for Medical Staff privileges, taking into account the occurrence giving rise to the suspension, any information respecting the practitioner's activities during the period of the suspension, and any remedial actions taken by the practitioner after such occurrence.

ARTICLE VI

Appeal

1. In the event that an Adverse Action (as hereinafter defined) is taken against a practitioner who is a member of the Medical Staff, said practitioner shall have 30 calendar days from the date of the Board's notice of such Adverse Action (or the notice of the Medical Director in the event of a summary suspension) in which to deliver a request for an appeal of such Adverse Action. Any such request must be in writing, forwarded by certified or registered mail, return receipt requested, and addressed to the Medical Director. Failure on the part of a practitioner to submit a request for a hearing in compliance with the requirements of this Paragraph 1 shall constitute a waiver of the practitioner's right to a hearing.

2. The Board shall have 30 days from the date of the practitioner's request for an appeal in which to appoint a hearing committee and a hearing officer. The hearing committee shall be composed of clinicians who may or may not be members of the Medical Staff who are not in direct economic competition with the practitioner requesting the hearing.

3. The Hearing Officer shall be responsible for establishing procedural protocols applicable to preparation for and the conduct of the hearing, including without limitation, establishing protocols for the provision of witness and exhibit lists. The Hearing Officer shall preside over the conduct of the hearing and shall be responsible for resolving disputes which arise during the hearing.

4. Each of the parties to the hearing shall have the right, at the hearing, to be represented by counsel, call and examine witnesses (including the practitioner who requested the appeal), introduce exhibits and present relevant evidence, cross-examine adverse witnesses, make opening and closing arguments, and submit a written statement at the close of the hearing. A stenographic transcript or its equivalent shall be made so that an accurate record of the proceedings is maintained.

5. The person or body who took the Adverse Action shall initially have the burden of showing that the action taken was supported by substantial evidence. The practitioner shall thereafter have the burden of showing by clear and convincing evidence that the grounds for the Adverse Action lack any factual basis or that such basis or the conclusions drawn therefrom are either arbitrary or capricious.

6. The Hearing Committee shall issue a written report of its findings within 10 days of final adjournment of the hearing and shall deliver such report to the Board. Within 30 days of its receipt of the report, the Board shall consider its contents and recommendations and affirm, modify, or reverse the hearing committee's recommendations. The decision of the Board shall be final. Written notice of the Board's decision shall be forwarded to the practitioner within 10 days.

7. For purposes of this Article VI, an "Adverse Action" is:

a. An action described in Article III, Section 4(11) or Article V, Section 7 hereof; and,

b. Any action by the Board which results in the limitation of, restriction on or revocation or suspension of the clinical privileges of a member of the Medical Staff which is based on the clinical competence of the practitioner; provided, however, that the following shall not be Adverse Actions hereunder:

i. Requirements that a practitioner's services within the Center be monitored , supervised, proctored, or reviewed unless such monitoring, proctoring supervision or review involves a requirement that the practitioner obtain permission prior to exercising his or her privileges;

ii. An action that is based on a practitioner's failure to satisfy established qualifications or criteria for privileges or membership on the Medical Staff or duly adopted modifications to such qualifications or criteria; or,

iii. An action abased on a practitioner's failure to follow established administrative rules, regulations, policies, or procedures and not based upon the clinical competence of the practitioner.

ARTICLE VII

Administration

Section I

Administration and Management of Operations

The Director of American Health Care is a full time, on site person who is responsible for the operation of the AHCC at all times. Under the direction of the Vice President of Physician Practices, the Director is responsible for the development, implementation, and administration of all policies and procedures relating to the daily operation and marketing of the AHCC.

The Medical Director is a board certified physician who reports to the Board of Directors of AHCC. The Medical Director is responsible for ensuring that appropriate, high quality medical patient care is delivered at AHCC.

Medical Advisory Committee

The Medical Advisory Committee shall be appointed by the Medical Director and the Board. This committee will meet on a quarterly basis. Quality Improvement activities will be reviewed on a quarterly basis. The Medical Advisory Committee shall be charged with:

1. **Credentialing** -- Review the credentials and qualifications of those practitioners requesting initial and renewed operating privileges at the Summit Surgery Center; and Allied Health Professionals requesting the right to provide clinical services at the Center and making recommendations respecting such requests to the Medical Advisory Committee.

2. **Quality Improvement** — Conduct of an ongoing quality assurance and improvement program designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care, and resolve identified problems. The Committee=s quality improvement activities shall be conducted pursuant to the Quality Assurance Plan adopted and modified from time to time by the Board. At a minimum, the Committee shall be responsible for:

    a. Peer review of the clinical performance of practitioners with clinical privileges and Allied health Professionals who provide clinical services at the Center;

    b. Surgical case and tissue review;

    c. Anesthesia services review, including the types of anesthesia utilized, the appropriateness of such anesthesia, and adherence to and proposed modifications of anesthesia policies and procedures and

standards of practice;

d. Review of nursing services and policies and procedures and standards of practice;

e. Review of arrangements for pharmaceutical, pathology, and radiology services, the appropriateness of such arrangements, and policies and procedures and standards of practice respecting or applicable to such services;

f. Review of the procedures performed in the Center and their necessity and appropriateness;

g. Review of the types of procedures which may be performed in the Center;

h. Review of reports of accidents, injuries and safety hazards;

i. Evaluation of data submitted as part of the quality assurance program.

The Committee shall make recommendations resulting from its activities to the Board, including without limitation, changes in policies and procedures, staffing and assignment changes, appropriate education and training, adjustments in clinical privileges, and modifications to the Center's equipment or physical plant. The Committee shall monitor the effectiveness of any measures implemented to resolve identified problems or concerns.

3. **Infection Control.** The Medical Advisory Committee will be responsible for:

a. The prevention, control and investigation of infection in the Center and for assuring the effectiveness of current procedural techniques in all areas of operation; and,

b. The designation of an individual responsible for developing and monitoring the infection control program and reporting back to the Committee respecting its development, implementation, and effectiveness, regulatory requirements and modifications thereto to the Board for approval.

The Medical Advisory Committee shall be appointed from time to time by the Board and shall consist, at a minimum, of the following: (a) the Medical Director, (b) the Vice President of Physician Practices; (c) the Chair of the Board; (d) the Administrative Director or representative; and (e) such other practitioners and administrative representatives as are deemed appropriate by the Board.

Section II
Additional Committees

The Medical Director shall be responsible for the appointment of any additional committees of the Medical Staff. The Medical Director, Administrative Director and Chairman of the Board of Managers shall be voting members of all committees. The appointment of these committees shall be January 1 to December 31. Special Committees may be appointed from time to time by the Medical Director in order to carry out properly the duties of the Medical Staff. Such committees shall meet as directed by their respective chairperson and shall confine their work to the purpose for which they were appointed and shall submit a report to the Medical Advisory/Credentials Committee.

ARTICLE VIII
Rules and Regulations

The Medical Advisory Committee shall recommend such Rules and Regulations as may be necessary for the proper conduct of the work of the Medical Staff of the American Health Care Center. Subject to the approval of the Board of Directors, such Rules and Regulations shall be part of these By-Laws and shall be amended as provided for in Article X.

ARTICLE IX
Adoption

These By-Laws and the Rules and Regulations of the Medical Staff will be initially adopted by the Board.

ARTICLE X
Amendments to By-Laws

These By-Laws, Rules and Regulations of the Medical Staff may be amended as follows:

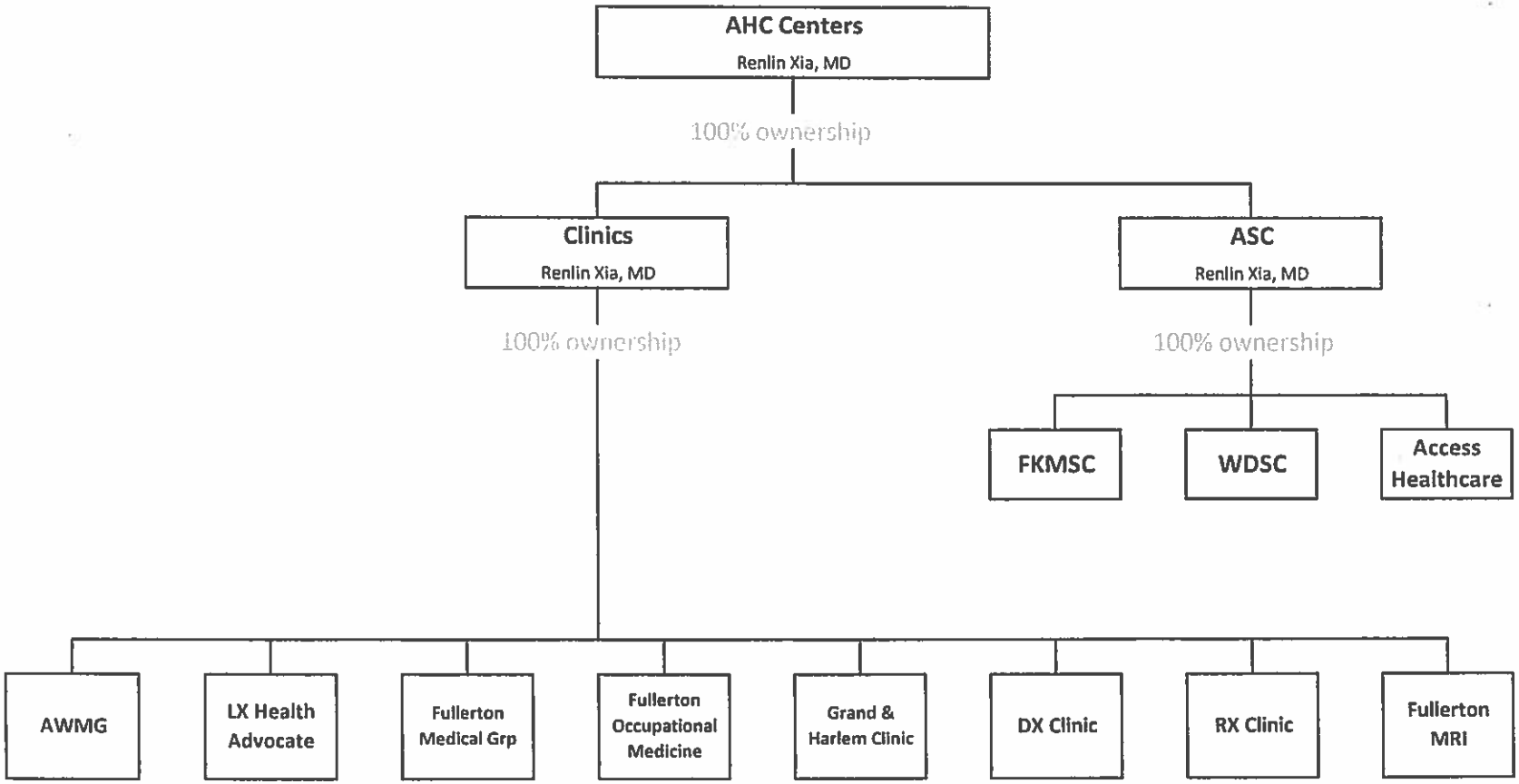
1. Proposed amendments should be presented to the Consulting Committee Meeting for review and to be entered into the minutes. Amendment and/or changes may be proposed by any member of the Medical Staff, Medical Director, Administrative Director, the Board of Managers, or the Medical Advisory Committee.
2. The Medical Director will review the proposed amendments and advise the Medical Staff on whether the proposed changes are in conformity with the provisions of the Federal and State Laws, and By-Laws, Rules and Regulations of American Health Care Center.
3. Proposed amendments will be distributed to the Medical Staff 30 days prior to the Consulting Committee meeting for comment and recommendations.
4. A proposed amendment will be adopted upon a two-thirds affirmative vote by the Consulting Committee.

Adopted: August 2008
Amended: June 25, 2019

Americans United for Life

AMERICAN HEALTH CARE CENTERS

STRUCTURE



Americans United for Life

updated: 04-2019

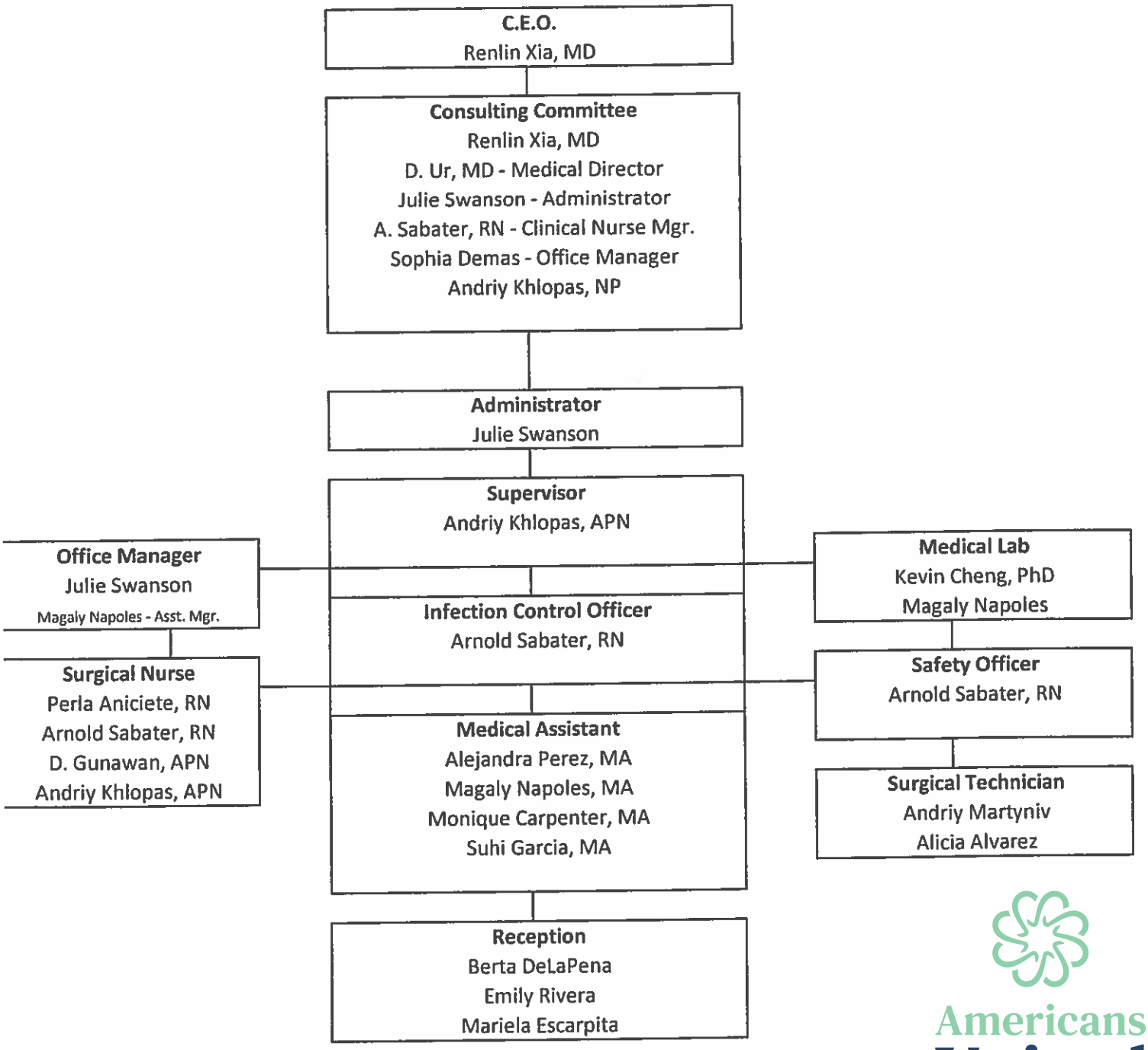
aps

AMERICAN HEALTH CARE CENTERS

Western-Diversey Surgical Center

2744 N. Western Ave., Chicago, IL 60647

ORGANIZATIONAL PLAN



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updated: 06-2019

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Policy and Procedure

Title: **Surgical Attire**
Section: **Infection Control**
Policy No. **07.04.20**
Date Adopted: **07-24-2019**
Date Revised:
No. of Pages: 4

Purpose

To provide guidance to perioperative personnel for surgical attire, including scrub attire, shoes, jewelry, head coverings, and surgical masks worn in the semi-restricted and restricted areas. Guidance is also provided for personal items and personal electronic devices taken into the semi-restricted and restricted areas. The expected outcome is that the patient will be free from signs and symptoms of infection.

Policy

It is the policy of **American Health Care Center** that:

- Clean surgical attire will be worn in semi-restricted and restricted areas.
- Individuals who enter semi-restricted and restricted areas will wear scrub attire that has been laundered at the health care-accredited laundry facility or wear single-use scrub attire provided by the facility and intended for use within perioperative areas.
  - Scrub attire will be laundered in the health care-accredited laundry facility after each daily use and when contaminated.
  - Personal clothing that is not covered by the scrub attire will be laundered in the health care-accredited laundry facility after each daily use and when contaminated.
  - Reusable head coverings will be laundered in the health care-accredited laundry facility after each daily use and when contaminated.
  - Reusable cover apparel will be laundered in the health care-accredited laundry facility after each daily use and when contaminated.
- Scrub attire that has been penetrated by blood, body fluids, or other potentially infectious materials must be removed immediately or as soon as possible and replaced with clean attire.
  - When extensive contamination of the body occurs, a shower or bath will be taken before the clean attire is donned.
  - Scrub attire contaminated with visible blood or body fluids must be laundered at the health care-accredited laundry facility.
  - Wet or contaminated scrub attire must not be rinsed or sorted in the location of use.
- Perioperative personnel will change into street clothes whenever they go outside of the building.
- Cover apparel (eg, lab coats) worn over scrub attire will be clean or single-use.
- Identification badges will be worn by all personnel authorized to enter perioperative areas.
- Jewelry that cannot be contained or confined within the scrub attire will not be worn in the semi-restricted or restricted areas.
- Shoes worn within the perioperative environment must
  - meet Occupational Safety and Health Administration standards for protective footwear;
  - be constructed to prevent exposures to blood, body fluids, and other potentially infectious materials; and
  - have closed toes and backs, low heels, and non-skid soles.
- Surgical masks, in combination with eye protection devices (eg, goggles, glasses with solid side shields, chin-length face shields), must be worn whenever splashes, spray, spatter, or droplets of

blood, body fluids, or other potentially infectious materials may be generated and eye, nose, or mouth contamination can be reasonably anticipated.
- Personnel entering the semi-restricted and restricted areas will cover the head, hair, ears, and facial hair.

Procedure Interventions

Scrub Attire

- Don clean scrub attire daily in the designated dressing area before entering the semi-restricted and restricted areas.
- Prevent clean scrub attire from contacting the floor or other contaminated surfaces while donning.
- Ensure all personal clothing is covered by the scrub attire.
- Tuck the top of the scrub suit into the pants if it does not fit close to the body.
- Wear scrub dresses over scrub pants or leggings that are laundered in the health care-accredited laundry facility after each daily use and when contaminated.
- Wear close-fitting long-sleeved jackets with the snaps closed and with the cuffs down to the wrists when
  - in the restricted areas,
  - performing preoperative patient skin antisepsis, and
  - performing preparation and packaging of items in the clean assembly section of the sterile processing area.
- Discard single-use scrub attire in a designated trash container or place reusable items in a designated laundry container.
- Leave reusable scrub attire at the health care facility for laundering.
- Do not store reusable scrub attire that has been worn in a locker for future use.
- People entering the semi-restricted or restricted areas for a brief time (eg, law enforcement officers, parents, biomedical engineers) will don either clean scrub attire, single-use scrub attire, or a single-use jumpsuit (eg, coveralls, bunny suit) designed to completely cover personal apparel.

Shoes

- Wear shoes that are clean and dedicated for use within the perioperative area.
- Wear shoe covers when gross contamination can reasonably be anticipated.
- Remove single-use shoe covers worn as personal protective equipment immediately after use, discard, and perform hand hygiene.

Surgical Masks

- Wear a mask when open sterile supplies and equipment are present.
- Don a fresh, clean surgical mask before performing or assisting with each new procedure.
- Cover the mouth and nose with the mask and tie it securely.
- Do not wear the mask hanging down from the neck.
- Replace and discard the mask whenever it becomes wet or soiled, or has been taken down.
- Remove the mask by handling only the mask ties and perform hand hygiene after removing the mask.

- Clean reusable protection devices worn with surgical masks, (eg, goggles, personal glasses supplemented with solid side shields) according to the manufacturer's instructions for use before and after performing or assisting with each new procedure.

Identification Badges

- Secure identification badges in a visible location on the scrub attire top or long-sleeved jacket.
- Do not wear lanyards around the neck.
- Clean identification badges with a low-level disinfectant regularly and when the badge becomes soiled.

Stethoscopes

- Do not wear stethoscopes around the neck.
- Do not use fabric covers for stethoscopes.
- Clean stethoscopes before and after each use with a low-level disinfectant.

Personal Items

- Clean briefcases, backpacks, and other personal items taken into the semi-restricted or restricted areas with a low-level disinfectant and do not place them on the floor.
- Clean cell phones, tablets, and other personal communication or hand-held electronic equipment according to the manufacturer's instructions for use with a low-level disinfectant before and after taking them into the semi-restricted or restricted areas.

Head Coverings

- Wear a clean surgical head cover or hood that confines all hair and completely covers the ears, scalp skin, sideburns, and nape of the neck.
- Do not remove the surgical head covering when wearing surgical attire and leaving the perioperative areas.
- Remove the surgical head covering when changing into street clothes and going outside the building.
- Remove single-use head coverings at the end of the shift or when contaminated and discard in a designated receptacle.

Competency

Perioperative personnel working in semi-restricted and restricted areas of the facility will receive education and complete competency verification activities on surgical attire worn in the perioperative areas.

Quality

Perioperative personnel working in semi-restricted and restricted areas of the facility will participate in quality assurance and performance improvement activities related to surgical attire worn in the perioperative areas.

Glossary

Scrub attire: Nonsterile apparel designed for the perioperative practice setting that includes two-piece pantsuits, scrub dresses, long-sleeved cover jackets, and head coverings.

Surgical attire: Nonsterile apparel designated for the perioperative practice setting that includes two-piece pantsuits, scrub dresses, cover jackets, head coverings, shoes, masks, and protective eyewear.

Surgical mask: A device worn over the mouth and nose by perioperative team members during surgical procedures to protect both the patient and perioperative team member from transfer of blood, body fluids, and other potentially infectious materials. Surgical masks prevent the transmission of large droplets (ie, greater than 5 microns). Surgical masks are evaluated for fluid resistance, bacterial filtration efficiency, differential pressure, and flammability.

References

Occupational Safety and Health Administration. 1910.136: Occupational foot protection. http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=9786. Accessed September 14, 2014.

Occupational Safety and Health Administration. 1910.1030: Bloodborne pathogens. http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051. Accessed September 14, 2014.

Petersen C, ed. *Perioperative Nursing Data Set*. 3rd ed. Denver, CO: AORN, Inc; 2011:254-276.

Guideline for surgical attire. In: *Guidelines for Perioperative Practice*. Denver, CO: AORN, Inc; 2015:97-120.

Americans United for Life

American Health Care Center
Competency Verification Tool—Perioperative Services
Surgical Attire

Name: _____ **Date:** _____

Competency Statement: The perioperative RN or team member has completed facility- or health care organization-required education and competency verification activities related to recommended surgical attire in the perioperative setting.[1]

1. Guideline for surgical attire. In: *Guidelines for Perioperative Practice*. Denver, CO: AORN, Inc; 2015:97-120.

Outcome Statement: The patient is free from signs and symptoms of infection.[2]

2. Petersen C, ed. Infection. In: *Perioperative Nursing Data Set*. 3rd ed. Denver, CO: AORN, Inc; 2011:254-276.

Competency Statements/Performance Criteria	Verification Method (Select applicable code from legend at bottom of page)						Not Met (Explain why)
	DEM/ DO/DA	KAT	S/SBT/ CS	V	RWM/ P&P	O	
1. Wears clean surgical attire in the semi-restricted and restricted areas.							
2. Wears scrub attire provided by the facility and intended for use in the perioperative areas.							
3. Wears scrub attire that is laundered in the health care-accredited laundry facility after each daily use and when contaminated including a. personal clothing not covered by the scrub attire,							
b. personal leggings worn under scrub dresses,							
c. reusable head coverings, and							
d. reusable cover apparel.							
4. Removes scrub attire that has been penetrated by blood, body fluids, or other potentially infectious materials immediately or as soon as possible and dons clean scrub attire and a. takes a shower or bath before donning clean attire if extensive contamination occurs,							
b. leaves contaminated scrub attire at the facility for laundering, and							
c. does not rinse or sort contaminated scrub attire in the location of use.							
5. Dons clean scrub attire daily in the designated dressing area before							

DEM/DO/DA = Demonstration/Direct Observation/Documentation Audit
S/SBT/CS = Skills Laboratory/Scenario-based Training/Controlled Simulation
RWM/P&P = Review of Written or Visual Materials/Policy/Procedure Review (Specify P&P #s _____)

KAT = Knowledge Assessment Test
V = Verbalization
O = Other: _____

American Health Care Center
Competency Verification Tool—Perioperative Services
Surgical Attire

Competency Statements/Performance Criteria	Verification Method [Select applicable code from legend at bottom of page]						Not Met (Explain why)
	DEM/ DO/DA	KAT	S/SBT/ CS	V	RWM/ P&P	O	
entering the semi-restricted and restricted areas.							
6. Prevents clean scrub attire from contacting the floor or other contaminated surfaces while donning.							
7. Ensures all personal clothing is covered by the scrub attire or is laundered after each daily use and when contaminated in the health care-accredited laundry.							
8. Wears close-fitting long-sleeved jackets with the snaps closed and with the cuffs down to the wrists when a. in the restricted areas,							
b. performing preoperative patient skin antisepsis, and							
c. performing preparation and packaging of items in the clean assembly section of the sterile processing area.							
9. Discards single-use scrub attire in a designated trash container or places reusable items in the designated laundry container.							
10. Leaves reusable scrub attire at the health care facility for laundering.							
11. Does not store reusable scrub attire that has been worn in a locker for future use.							
12. Ensures that people entering the semi-restricted or restricted areas for a brief time (eg, biomedical engineers) don either clean scrub attire, single-use scrub attire, or a single-use jumpsuit (eg, bunny suit) designed to completely cover personal apparel.							
13. Changes into street clothes when going outside of the building.							
14. Wears clean or single-use cover apparel (eg, lab coat).							
15. Wears identification badge in a visible location on the scrub attire top or long-sleeved jacket.							
16. Cleans identification badge with a low-level disinfectant regularly and when the badge becomes soiled.							
17. Does not wear stethoscopes around the neck.							
18. Does not use fabric covers for stethoscopes.							

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American Health Care Center
Competency Verification Tool—Perioperative Services
Surgical Attire

Competency Statements/Performance Criteria	Verification Method [Select applicable code from legend at bottom of page]						Not Met (Explain why)
	DEM/ DO/DA	KAT	S/SBT/ CS	V	RWM/ P&P	O	
19. Cleans stethoscopes before and after each use with a low-level disinfectant.							
20. Does not wear jewelry that cannot be contained or confined within the scrub attire in the semi-restricted and restricted areas.							
21. Cleans briefcases, backpacks, and other personal items taken into the semi-restricted or restricted areas with a low-level disinfectant and does not place them on the floor.							
22. Cleans cell phones, tablets, and other personal communication or hand-held electronic equipment according to the manufacturer's instructions for use with a low-level disinfectant before and after being taken into the semi-restricted or restricted areas.							
23. Wears shoes that are clean and a. dedicated for use within the perioperative area,							
b. meet Occupational Safety and Health Administration standards for protective footwear,							
c. are constructed to prevent exposures to blood, body fluids, and other potentially infectious materials, and							
d. have closed toes and backs, low heels, and non-skid soles.							
24. Wears shoe covers when gross contamination can reasonably be expected.							
25. Removes shoe covers worn as personal protective equipment immediately after use, discards, and performs hand hygiene.							
26. Wears surgical mask in combination with eye protection devices (eg, goggles, glasses with solid side shields, chin-length face shields) whenever splashes, spray, spatter, or droplets of blood, body fluids, or other potentially infectious materials may be generated and eye, nose, or mouth contamination can be reasonably anticipated.							
27. Dons a fresh, clean surgical mask before performing or assisting with each new procedure.							

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American Health Care Center
Competency Verification Tool—Perioperative Services
Surgical Attire

Competency Statements/Performance Criteria	Verification Method [Select applicable code from legend at bottom of page]						Not Met (Explain why)
	DEM/ DO/DA	KAT	S/SBT/ CS	V	RWM/ P&P	O	
28. Covers the mouth and nose with the mask and ties it securely.							
29. Does not wear the mask hanging down from the neck.							
30. Replaces and discards the mask whenever it becomes wet or soiled, or has been taken down.							
31. Removes the mask by handling only the mask ties and performs hand hygiene after removing the mask.							
32. Cleans reusable protection devices worn with surgical masks (eg, goggles, personal glasses with solid side shields) according to the manufacturer's instructions for use before and after performing or assisting with each new procedure.							
33. Covers head, hair, ears, and facial hair when entering the semi-restricted and restricted areas.							
34. Wears a clean surgical head cover or hood that confines all hair and completely covers the ears, scalp skin, sideburns, and nape of the neck.							
35. Does not remove the surgical head covering when wearing surgical attire and leaving the perioperative areas.							
36. Removes the surgical head covering when changing into street clothes and going outside the building.							
37. Removes single-use head coverings at the end of the shift or when contaminated and discards them in a designated receptacle.							
38. Verbalizes a review of facility or health care organization policies and procedures related to surgical attire.							
39. Participates in assigned quality improvement activities related to surgical attire.							

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American Health Care Center
Competency Verification Tool—Perioperative Services
Surgical Attire

Competency Statements/Performance Criteria	Verification Method [Select applicable code from legend at bottom of page]						Not Met (Explain why)
	DEM/ DO/DA	KAT	S/SBT/ CS	V	RWM/ P&P	O	
Concurrent competency verification of the following is recommended							
• Standard precautions,	• airborne precautions, and						
• droplet precautions,	• additional competencies related to surgical attire as determined by the facility or health care organization.						
• contact precautions,	•						

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Title: **Sterilizer Monitoring**
Section: **Infection Control**
Policy No: **07.04.17**
Date Adopted: **03/01/08**
Date Revised: **04/02/18**
Pages: 1 of 2

I POLICY

It is the policy of American Health Care Center to monitor the efficacy of the sterilizing process to insure the sterility of instruments, and to maintain a documented monitoring control system to meet national guidelines.

II PROCEDURES

A. Spore testing will be conducted ~~weekly~~ daily when sterilizer is in use and on every load for implantable.
(see accompanying inserts for manufacturers instruction for use (41482V)

~~1. Biological indicators are placed in a test pack representative of the load.~~
~~2. When removed, the vial (result test) is placed in a biological spore testing machine with a biological indicator vial (control test) that has not been placed in the sterilizer.~~
~~3. After the appropriate time has elapsed (48 hours), read the result.~~
~~The indicator in the result test should be negative (-); the control test should be positive (+).~~
~~4. Record the result of the test on the spore test log, and sign as confirmation of physical parameters being attained.~~

B. If the result of the spore test from the vial is positive, the sterilizer is not used, and the result is reported to the Surgical Coordinator.

1. The Surgical Coordinator will perform a second test. If the second test is positive, the sterilizer is repaired and not used until all tests are negative.
2. All instruments and packages processed with a positive test result are pulled from the shelves and re-sterilized.
3. The spore test log with a positive test will be compared to the surgical log. Patients indentified will be called and asked to come into the office to check for infection.
~~4. All loads will be sequestered and placed on hold for use until the biological indicator result turns negative.~~

C. Bowie-Dick Type test will be carried out on days sterilizer will be used.
(see manufacturers instruction for use)

~~Note: A rapid Biological Testing kit is in evaluation and will be used soon as after they have arrive and in-serviced.~~

3M™ Attest™ Super Rapid 5 Steam-Plus Challenge Pack 41482V

Product Description

The 3M™ Attest™ Super Rapid 5 Steam-Plus Challenge Pack 41482V is specifically designed for routinely challenging and conducting qualification testing of 270°F (132°C) and 275°F (135°C) dynamic-air-removal (pre-vacuum) steam sterilization processes in healthcare facilities. The challenge pack consists of multiple layers of medical index cards, some of which are die-cut to contain the monitoring products. The stacked cards are wrapped with a sterilization wrap. Each challenge pack has a process indicator on the pack label that changes from yellow to brown or darker when exposed to steam. This convenient disposable challenge pack presents a challenge to the sterilization process equivalent to the user-assembled biological indicator (BI) challenge test pack (towel PCD) recommended by the Association for the Advancement of Medical Instrumentation (AAMI). The challenge pack is a single use device.

Each challenge pack contains a 3M™ Attest™ Super Rapid Readout Biological Indicator 1492V (brown cap, hereinafter referred to as a 1492V BI), a 3M™ Comply™ SteriGage™ Steam Chemical Integrator, and a record keeping sheet. AAMI recommends that steam sterilization loads containing an implant be monitored with a process challenge device containing a biological indicator and an integrating indicator. Comply™ SteriGage™ Steam Chemical Integrators are Type 5 (Category i5) Integrating Indicators as categorized by ISO 11140-1:2014. Comply™ SteriGage™ Steam Chemical Integrators are single-use chemical indicators consisting of a paper wick and a steam and temperature sensitive chemical pellet contained in a paper/film/foil laminate. The chemical pellet melts and migrates as a dark color along the paper wick. The migration is visible through a window marked ACCEPT or REJECT; the extent of migration depends on steam, time, and temperature. The Comply™ SteriGage™ Steam Chemical Integrator offers an immediate Accept/Reject reading that allows for implant load early release in emergency situations as defined in AAMI ST-79.

The 1492V BI is a self-contained dual readout biological indicator specifically designed for rapid and reliable monitoring of the steam sterilization process when used in conjunction with the 3M™ Attest™ Auto-reader 490, hereinafter referred to as the 490 Auto-reader. When steam processed, the process indicator on the top of the 1492V BI cap changes color from pink to light brown or darker. 3M™ Attest™ 1492V biological indicator controls are provided with the challenge packs.

The 1492V BI utilizes the α-glucosidase enzyme system, which is generated naturally within growing cells of *Geobacillus stearothermophilus*. The α-glucosidase in its active state is detected by measuring the fluorescence produced by the enzymatic hydrolysis of a non-fluorescent substrate, 4-methylumbelliferyl-α-D-glucoside (MUG). The resultant fluorescent by-product, 4-methylumbelliferone (MU), is detected in the 490 Auto-reader. The presence of fluorescence within 1 hour of incubation of the 1492V BI in the 490 Auto-reader indicates a steam sterilization process failure.

The 1492V BI can also indicate the presence of *G. stearothermophilus* organisms by a visual pH color change reaction. Biochemical activity of the *G. stearothermophilus* organism produces metabolic by-products that cause the media to change color from purple to yellow which also indicates a steam sterilization process failure. Use of this indication method is optional and is typically restricted to special studies.

Readout Times

The 1-hour super rapid readout and the optional 48-hour visual pH color change incubation times have been correlated with a 7-day incubation period (at 56+/-2°C) following the FDA's Reduced Incubation Time protocol. Processed indicators were examined at 48 hours and 7 days for detection of a visual pH color change. The 1-hour fluorescence change readings and the 48-hour visual pH color change readings were compared to the 7-day visual pH color change readings to determine the readout time of the indicator.

1-hour Fluorescence Change Result

1492V BIs have 1-hour reduced incubation time results that correlate to the 7-day (168 hours) visual readout result ≥ 97% of the time.

48-hour Visual pH Color Change Result

1492V BIs have 48-hour reduced incubation time results that correlate to the 7-day (168 hours) visual readout result ≥ 97% of the time.

Due to the high reliability of the 1-hour fluorescent result, there is no advantage to incubating 1492V BIs beyond 1 hour.

1492V BIs meet ANSI/AAMI/ISO 11138-1:2006/(R)2010, ANSI/AAMI/ISO 11138-3:2006/(R)2010 and EN/ISO 11138-1:2006, EN/ISO 11138-3:2006.

Indications for Use

United States

Use the 3M™ Attest™ Super Rapid 5 Steam-Plus Challenge Pack 41482V in conjunction with the 3M™ Attest™ Auto-reader 490 to qualify or monitor dynamic-air-removal (pre-vacuum) steam sterilization cycles of 4 minutes at 270°F (132°C) and 3 minutes at 275°F (135°C). The 3M™ Attest™ Super Rapid Readout Biological Indicator 1492V contained in the challenge pack provides a final fluorescent result in 1 hour. An optional visual pH color change result is observed in 48 hours.

Outside the United States

Use the 3M™ Attest™ Super Rapid 5 Steam-Plus Challenge Pack 41482V in conjunction with the 3M™ Attest™ Auto-reader 490 to qualify or monitor 270°F (132°C) to 275°F (135°C) dynamic-air-removal (pre-vacuum) steam sterilization cycles.

Contraindications

None.

Warnings

There is a glass ampoule inside the plastic vial of the biological indicator. To avoid the risk of serious injury or death from flying debris due to a ruptured ampoule:

- Allow the biological indicator to cool for the recommended time period before activating. Activating or excessive handling of the BI before cooling may cause the glass ampoule to burst.
- Wear safety glasses when activating the biological indicator.
- Handle the biological indicator by the cap when crushing and flicking.
- Do not use your fingers to crush the glass ampoule.

Precautions

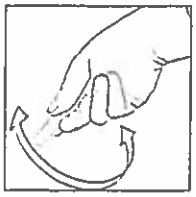
1. To ensure the challenge pack delivers the intended challenge:
   - DO NOT OPEN challenge pack prior to sterilization;
   - DO NOT reuse challenge pack.
2. DO NOT use the challenge pack to monitor sterilization cycles which it is not designed to challenge:
   a. Gravity-displacement steam sterilization cycles;
   b. 250°F (121°C) dynamic-air-removal (pre-vacuum) steam sterilization cycles;
   c. 270°F (132°C) dynamic-air-removal (pre-vacuum) steam sterilization cycles having exposure times <4 minutes or 275°F (135°C) dynamic-air-removal (pre-vacuum) steam sterilization cycles having exposure times <3 minutes;
   d. Dry heat, chemical vapor, ethylene oxide or other low temperature sterilization processes.
3. After 1492V BI activation, ensure media has flowed to the spore growth chamber.

Monitoring Frequency

Follow facility Policies and Procedures which should specify a biological indicator monitoring frequency compliant with professional association recommended practices and/or national guidelines and standards. As a best practice and to provide optimal patient safety, 3M recommends that every steam sterilization load be monitored with a biological indicator in an appropriate Process Challenge Device (i.e., BI challenge test pack).

Directions for Use

1. Place an Attest™ Super Rapid 5 Steam-Plus Challenge Pack 41482V flat, with the label side up, in a full load in the most challenging area for the sterilant to reach. This is generally on the bottom shelf, over the drain. Do not place objects (e.g. another pack) on top of the challenge pack. This will create too great of a challenge for air removal and steam penetration.
2. Process the load according to established procedures.
3. After completion of the cycle, while wearing heat resistant gloves, retrieve the challenge pack.
4. Check to see that the external process indicator on the outside of the challenge pack has changed from yellow to brown or darker. Open the challenge pack and allow the 1492V BI to cool outside the challenge pack for 10 minutes prior to activation.
5. Check the Comply™ SteriGage™ Steam Chemical Integrator. The dark color should have entered the ACCEPT window. If the dark color has not entered the ACCEPT window, this indicates a REJECT result which means the load was not exposed to sufficient steam sterilization conditions. This load should not be released for use but reprocessed. Record integrator result.
6. Check the process indicator on the top of the 1492V BI cap. A color change from pink to light brown or darker confirms that the biological indicator has been exposed to the steam process. This color change does not indicate that the steam process was sufficient to achieve sterility. If the process indicator is unchanged, check the sterilizer physical monitors.
7. Identify the processed 1492V BI by writing the sterilizer, load number, and processing date on the indicator label. Do not place another label or indicator tape on the biological indicator.
8. For a permanent record, fill out the required information on the record keeping card. Record the 1492V BI result when available.
9. Discard the challenge pack. Using the challenge pack more than once will invalidate subsequent test results.
10. To activate the 1492V BI, place it in a 490 Auto-reader incubation well which is color-coded brown (i.e., configured to incubate 1492V BIs). While wearing safety glasses, press the cap of the BI down firmly to close the cap and crush the glass ampoule. Immediately remove the BI and flick it (see picture at right). Visually verify that media has flowed into the growth chamber at the bottom of the vial. If the media hasn't filled the growth chamber, hold the BI by the cap and flick it until media fills the growth chamber. Return the activated 1492V BI to the incubation well and wait for the result. See the 490 Auto-reader Operator's Manual for further information related to its use.



11. Each day that a processed 1492V BI is incubated, activate and incubate at least one non-processed 1492V BI to use as a positive control. Follow the activation instructions provided in Step 10 above. Write a "C" (for "control") and the date on the BI label. The positive control should be from the same lot code as the processed biological indicator. The positive control BI helps confirm:
    - correct incubation temperatures are met;
    - viability of spores has not been altered due to improper storage temperature, humidity or proximity to chemicals;
    - capability of media to promote rapid growth; and
    - proper functioning of the 490 Auto-reader.
12. Incubation and Reading:

    Incubate the positive control and steam processed 1492V BIs at 56 ± 2°C in a 490 Auto-reader. See the 490 Auto-reader Operator's Manual for the proper use of this equipment. Positive 1492V BI results are available within 1 hour. The 490 Auto-reader will display a positive result as soon as it is obtained. The final negative 1492V BI reading is made at 1 hour. After the results are displayed and recorded, the 1492V BIs may be discarded.

Interpretation of Results:

Fluorescent Results

The positive control (unprocessed) 1492V BI must provide a positive fluorescent result (+ on the 490 Auto-reader LCD display). Processed 1492V BI results are not valid until the positive control reads fluorescent positive. The positive control should read positive (+ on the LCD display) at or before 1 hour. If the positive control reads negative (- on the LCD display) at 1 hour, check the 490 Auto-reader Operator's Manual Troubleshooting Guide. Retest the 490 Auto-reader with a new positive control.

With processed 1492V BIs, a positive (+ on the LCD display) result indicates a sterilization process failure. A final negative (- on the LCD display) result for the processed 1492V BI after 1 hour of incubation indicates an acceptable sterilization process.

Act immediately on any positive results for processed BIs. Determine the cause of the positive BI following facility policies and procedures. Always retest the sterilizer and do not use sterilizer for processing loads until qualification testing yields satisfactory results (typically three consecutive cycles with negative BI results and three consecutive cycles with passing Bowie-Dick test results).

Optional Visual pH Color Change Result

The 1492V BI is normally discarded after the fluorescent result has been recorded. If, however, special studies are desired, 1492V BIs may be further incubated for a visual pH color change result. After activation and during incubation, the white Nonwoven Material will absorb the bromocresol purple indicator, the pH-sensitive indicator dye in the growth media, and appear blue. In the case of the positive control BI a yellow color change of the growth media and/or Nonwoven Material will appear within 48 hours. Any observation of a yellow color within the vial indicates a positive result.

In the case of a processed 1492V BI, a media and/or Nonwoven Material color change from purple to yellow indicates a sterilization process failure. A negative pH color change result, i.e., media and Nonwoven Material remain purple/blue, can be assessed at 48 hours.

Storage

- Best stored under normal room conditions: 59-86°F (15-30°C), 35-60% relative humidity.
- Store away from direct sunlight. Do not store challenge packs near sterilants or other chemicals.
- After use, the Comply™ SteriGage™ Steam Chemical Integrator will not change visually within 6 months when stored at above conditions.

Disposal

Dispose of used 1492V BIs according to your health care facility policy. You may wish to steam sterilize any positive biological indicators at 270°F (132°C) for 4 minutes or at 275°F (135°C) for 3 minutes in a dynamic-air-removal steam sterilizer prior to disposal.

Explanation of Symbols

Caution, see instructions for use

Do not reuse

Use by date

LOT Batch code

Manufacturer

Date of manufacture

STEAM Product is designed for use with steam sterilization cycles.

REF Catalogue Number

Made in U.S.A. by
3M Health Care
2510 Conway Ave.
St. Paul, MN 55144
1-800-228-3957
3M.com/infectionprevention

Issue Date: 2016-02
34-8718-7365-8

Americans United for Life

Western-Diversey Surgical Center

REVIEW OF PERFORMANCE MEASUREMENT/MONITORING

YEAR:

Americans United for Life

Indicator	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Infection Control													
# of surgical patients with nosocomial infections													
OR cleaned prior to surgery													
Sterilization of Insturments													
Spore Testing													
Management of Information													
100% Review content, accuracy, legibility, adverse outcomes													
Random sample reviewed for appropriateness annually													
Medications													
Reagents, drugs, chemicals, checked for expiration													
Emergency equipment/medications checked proir to surgery													
# Of medications recalled													
# of incidents/controlled substances													
Human Resources													
No. of Staff New Hires - Orientation													
Competency reviewed													
Staff Training - Infection Control, BioHazards, Environment of Care													
Performance Evaluation/Appraisal													

AMERICAN HEALTH CARE CENTER

FKMSC
WDSC

IN-SERVICE

DATE: 03-21-2019

TOPIC/ SUBJECT: Sterilizer Monitoring (Biological Testing)

PRECEPTOR: A. Sabater, RN, BSN

Attendees:
(Print and Sign)

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ANDRIY KHLOBAS
Monique Carpenter
ALEJANDRA PEREZ
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Americans United for Life

American Health Care center
FKMSC
WDSC

In-Service Sign in Sheet

Date: June 27, 2019

n-Service Title: Surgical Attire (Infection Control

Preceptor: A. Sabater RN

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3.	Magaly Napoles	
4.	Yesika Napoles	
5.	ANDRIY KHLOPAS	
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9.	Marie Frukacz	
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IN-SERVICE LOG

DATE: 06-20-2019

TOPIC/ SUBJECT: Guideline Implementation: Hand Hygiene

PRECEPTOR: A. Sabater, RN, BSN – Infection Control Coordinator

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Guideline Implementation: Hand Hygiene 1.1 CE

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JUDITH L. GOLDBERG, DBA, MSN, RN, CSSM, CNOR, CHL, CRCST

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The contact hours for this article expire February 29, 2020. Pricing is subject to change.

Purpose/Goal

To provide the learner with knowledge specific to implementing the AORN "Guideline for hand hygiene."

Objectives

1. Discuss hand hygiene considerations related to maintaining healthy fingernails in the perioperative setting.
2. Explain methods perioperative personnel can use to prevent dermatitis.
3. Describe proper hand hygiene practices.
4. Discuss considerations for surgical hand antisepsis.
5. Discuss the implications of wearing jewelry on the hands and wrists in the perioperative setting.
6. Describe ways to engage patients in hand hygiene initiatives.

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Approvals

This program meets criteria for CNOR and CRNFA recertification, as well as other CE requirements.

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Judith L. Goldberg, DBA, MSN, RN, CSSM, CNOR, CHL, CRCST, has no declared affiliation that could be perceived as posing a potential conflict of interest in the publication of this article.

The behavioral objectives for this program were created by Liz Cowperthwaite, BA, senior managing editor, and Helen Starbuck Pashley, MA, BSN, CNOR, clinical editor, with consultation from Susan Bakewell, MS, RN-BC, director, Perioperative Education. Ms Cowperthwaite, Ms Starbuck Pashley, and Ms Bakewell have no declared affiliations that could be perceived as posing potential conflicts of interest in the publication of this article.

Sponsorship or Commercial Support

No sponsorship or commercial support was received for this article.

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http://dx.doi.org/10.1016/j.aorn.2016.12.010

Guideline Implementation: Hand Hygiene 1.1 CE

www.aornjournal.org/content/cme

JUDITH L. GOLDBERG, DBA, MSN, RN, CSSM, CNOR, CHL, CRCST

ABSTRACT

Performing proper hand hygiene and surgical hand antisepsis is essential to reducing the rates of health care–associated infections, including surgical site infections. The updated AORN "Guideline for hand hygiene" provides guidance on hand hygiene and surgical hand antisepsis, the wearing of fingernail polish and artificial nails, proper skin care to prevent dermatitis, the wearing of jewelry, hand hygiene product selection, and quality assurance and performance improvement considerations. This article focuses on key points of the guideline to help perioperative personnel make informed decisions about hand hygiene and surgical hand antisepsis. The key points address the necessity of keeping fingernails and skin healthy, not wearing jewelry on the hands or wrists in the perioperative area, properly performing hand hygiene and surgical hand antisepsis, and involving patients and visitors in hand hygiene initiatives. Perioperative RNs should review the complete guideline for additional information and for guidance when writing and updating policies and procedures. *AORN J 105 (February 2017) 203-212. © AORN, Inc, 2017. http://dx.doi.org/10.1016/j.aorn.2016.12.010*

Key words: *hand hygiene, surgical hand antisepsis, dermatitis, fingernail polish.*

A health care–associated infection after a surgical intervention can be devastating for a patient. The transmission of pathogens is a major concern for perioperative personnel that can be addressed through proper hand hygiene and surgical hand antisepsis. The removal of both transient and resident microorganisms from the hands of perioperative team members before they come in contact with patients is imperative.[1] Using proper technique for both hand hygiene and surgical hand antisepsis decreases the risk that a patient will acquire a surgical site infection.[1] Proper hand hygiene also provides for the safety of health care workers who come in contact with contaminated surfaces.[1]

The AORN "Guideline for hand hygiene"[1] was updated in September 2016. AORN guideline documents provide guidance based on an evaluation of the strength and quality of the available evidence for a specific subject. The guidelines apply to inpatient and ambulatory settings and are adaptable to all areas where operative and other invasive procedures may be performed.

Topics addressed in the hand hygiene guideline include proper maintenance of hands and fingernails; wearing of jewelry on the wrists or hands; proper performance of hand hygiene and surgical hand antisepsis; selection of hand hygiene products, including how to analyze their effectiveness, cost, and acceptance by health care personnel; and quality assurance and performance improvement considerations. This article elaborates on key takeaways from the guideline document; however, perioperative RNs should review the complete guideline for additional information and for guidance when writing and updating policies and procedures.

Key takeaways from the AORN "Guideline for hand hygiene" include the following recommendations:

- Perioperative team members should
  - maintain healthy fingernail condition,
  - maintain healthy skin condition by taking measures to prevent hand dermatitis,
  - perform hand hygiene, and

http://dx.doi.org/10.1016/j.aorn.2016.12.010

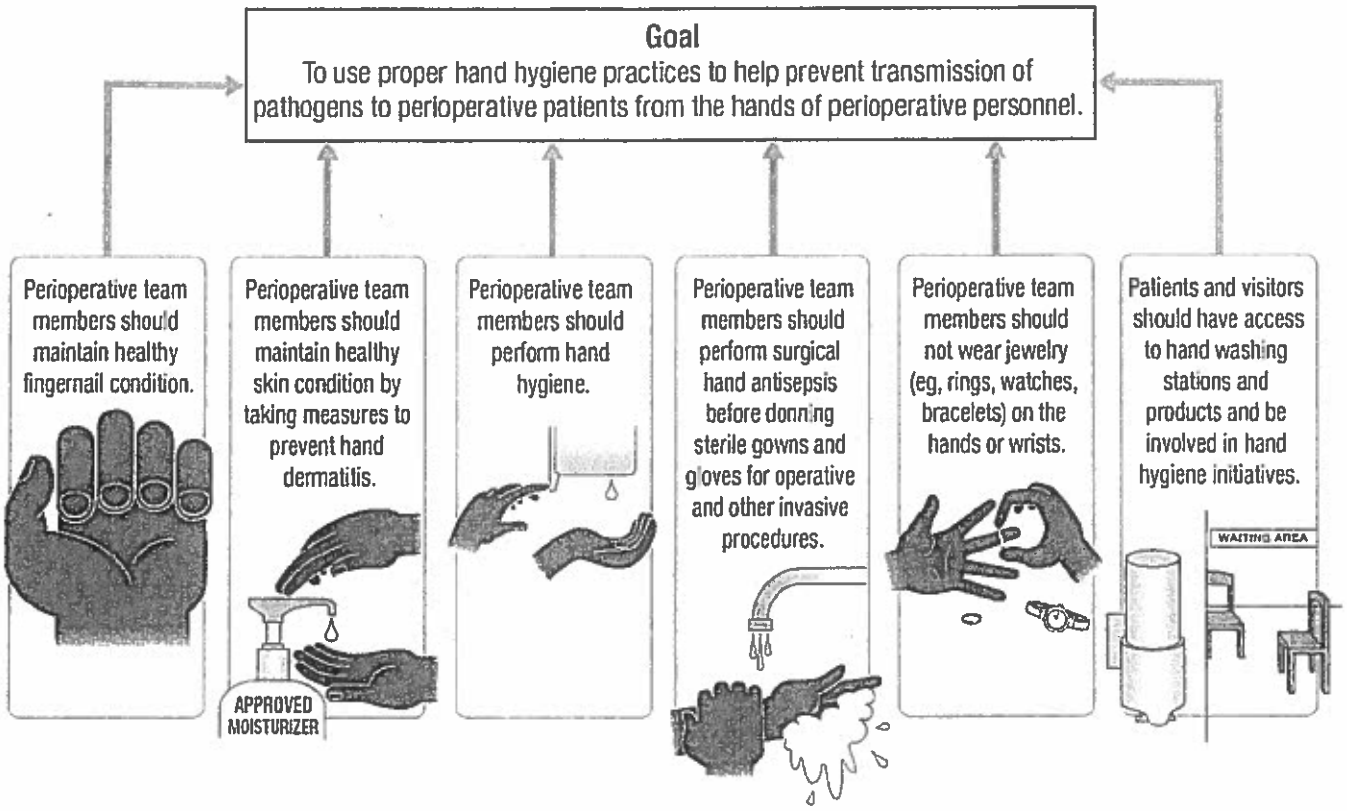

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Figure 1. Key takeaways from the AORN "Guideline for hand hygiene."

- perform surgical hand antisepsis before donning sterile gowns and gloves for operative and other invasive procedures.
- Perioperative team members should not wear jewelry (eg, rings, watches, bracelets) on the hands or wrists.
- Patients and visitors should have access to hand washing stations and products and be involved in hand hygiene initiatives (Figure 1).

The following scenario highlights the key takeaways and other aspects of the AORN guideline. Each key takeaway is then discussed in detail after the scenario.

SCENARIO

Nurse S, a perioperative RN, arrives at the community hospital where she works and goes to the locker room to change into her hospital scrubs. Her nails are short, with freshly applied polish, which her hospital policy allows. Before entering the OR, Nurse S removes the rings from her fingers and places them on a long necklace that she tucks into her scrub top.

Nurse S performs hand hygiene with an alcohol-based hand rub product. She recently experienced hand dermatitis from the cold weather and has worked with her employee health department to resolve the dermatitis so she can continue to work. Recommendations from the employee health nurse were to use the alcohol-based hand rub rather than soap and water unless her hands are visibly soiled and to regularly use a moisturizing skin care product approved by the health care facility. She was also encouraged to make sure her hands are fully dried before she dons surgical gloves.

Nurse S joins the surgical technologist in opening the sterile supplies for the first procedure of the day. After the OR is prepared, Nurse S goes to the ambulatory surgery area to meet her patient and perform her assessment. As she enters the room and introduces herself, Nurse S performs hand hygiene in view of the patient and family members by using the alcohol-based hand rub from a dispenser placed just inside the door of the room. The patient will undergo a left knee arthroscopy, so Nurse S verifies the procedure with her patient and then checks the left knee for the hospital-approved site mark, which is the word "yes." She asks whether the patient or the family members have any questions she can answer for them before she returns to the OR to complete the preparations for surgery. After answering their questions, Nurse S lets her patient know that it is okay to remind health care providers to perform hand hygiene before participating in her care. As she leaves the room, Nurse S again performs hand hygiene using the alcohol-based hand rub.

Hand hygiene products are readily available throughout the facility. Nurse S has recently noticed that new dispensers have been installed outside elevators and stairwells, outside and inside all patient rooms, throughout hallways, in nursing stations, and at all entrances to the hospital. Perioperative personnel have also recently begun a campaign to improve hand hygiene compliance. They remind coworkers and surgeons to perform hand hygiene whenever they see a lapse in compliance. As a visual cue, they have placed containers of hand hygiene product on the bedside stands of every patient. This quickly reminds both personnel and physicians to perform hand hygiene before any patient contact, and allows patients and family members to also perform hand hygiene before eating, after shaking hands, and whenever they feel it is necessary.

When Nurse S returns to the OR, the surgical technologist is just completing surgical hand antisepsis using the approved surgical hand antiseptic product. With the recent emphasis on hand hygiene at the facility, including the perioperative area, various staff members have been engaged to audit hand hygiene, as well as surgical hand antisepsis, and to provide real-time feedback to colleagues in the OR suite. Nurse S observes that the technologist has performed her hand antisepsis appropriately, following the product manufacturer's instructions for use. In the past, however, Nurse S has seen improper performance of surgical hand antisepsis when observing surgeons and scrub personnel at scrub sinks. Although it can be difficult to begin the conversation, Nurse S always asks these individuals to return to the scrub sink and properly perform hand antisepsis before they are gowned and gloved.

Data captured through random audits of hand hygiene in the perioperative department have demonstrated that compliance has steadily increased during the past few months since the hand hygiene campaign measures were implemented. The infection prevention practitioners have also recognized perioperative services for this steady improvement in hand hygiene compliance.

KEY TAKEAWAYS DISCUSSION

Adhering to proper hand hygiene is the first step in reducing health care–associated infections. The key takeaways from the AORN "Guideline for hand hygiene"[1] do not cover the entire guideline. Rather, they help the reader focus on important or new information that should be implemented into perioperative practice.

Fingernails

Maintaining short fingernails decreases the risk of puncturing gloves, harboring pathogens under the nails, impeding proper hand hygiene, and possibly injuring patients. Studies have demonstrated that both artificial nails and nail extenders contribute to contamination of the hands and have led to outbreaks of infection.[2-9] The hospital where Nurse S is employed allows personnel to wear nail polish, as long as it is freshly applied and not chipped. Difficulty in monitoring fingernail polish for chips and length of application may lead some organizations to prohibit perioperative personnel from wearing nail polish. Whether wearing of nail polish is allowed in the perioperative setting should be determined by a multidisciplinary committee that reviews the evidence and makes an informed decision. The determination should also address wearing of gel nail polishes that are dried under ultraviolet light, because it is currently not known whether wearing these types of polishes carries the same risk of harboring pathogens as wearing artificial nails does.[2,3,8,10,11]

Skin Condition

Maintaining healthy hands and skin can be difficult in the perioperative setting. Personnel frequently perform hand hygiene as well as surgical hand antisepsis. Dermatitis can be painful and prevent personnel from properly washing their hands or performing hand hygiene.[3,12] In addition, damaged skin may harbor more pathogens than healthy skin does.[3] Therefore, it is essential that personnel take measures to prevent dermatitis. As Nurse S did, employees who are experiencing skin breakdown should work with employee health or infection prevention personnel to determine the cause of the dermatitis and find appropriate treatments. The use of moisturizers should be limited to those approved by the health care organization. Some lotions can alter the integrity of gloves and change the effects of hand antiseptics.[2-4,12,13]

A key component of maintaining healthy hands is to ensure they are fully dried after washing and before donning gloves.[3] This is especially important when donning sterile gloves that will be worn for an extended amount of time. Another important factor in skin breakdown is the use of water that is too hot.[14] Employees should be aware of this and regulate water temperatures both at work and home to decrease the potential for skin breakdown. Temperatures of between 70° F and 80° F (21.1° C and 26.7° C) have been recommended by the Facility Guidelines Institute.[14] The use of alcohol-based hand rubs is recommended rather than soap and water unless hands are visibly soiled, because hand rub products are better tolerated and result in less dermatitis.[2]

Hand Hygiene

It is crucial that perioperative personnel do not assume that wearing gloves negates the necessity for hand hygiene. Hand

Resources for Implementation

- Guideline implementation topics: hand hygiene. AORN, Inc. *http://www.aorn.org/guidelines/guideline-implementation-topics/aseptic-technique/hand-hygiene.*
- AORN Syntegrity. *http://www.aorn.org/syntegrity.*
- ORNurseLink. *http://www.ornurselink.org/home.*
- *Perioperative Competency Verification Tools and Job Descriptions* [USB drive]. Denver, CO: AORN, Inc; 2016. *http://www.aorn.org/guidelines/clinical-resources/publications/document-collections/perioperative-competency-verification-tools-and-job-descriptions.*
- *Policy and Procedure Templates* [CD-ROM]. 4th ed. Denver, CO: AORN, Inc; 2015. *http://www.aorn.org/guidelines/clinical-resources/publications/document-collections/policy-and-procedure-templates.*

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Web site access verified December 1, 2016.

hygiene should be performed both before and after any patient contact; before handling of clean or sterile items; whenever a possible exposure to blood or body fluids has occurred; after handling of items that have been in contact with the patient, including stretchers, beds, and linens; when hands are soiled; before and after a meal; and after use of a restroom.[2-4,15-21] In some instances, performing hand hygiene once allows the person to complete several clean tasks, such as opening all sterile items before a procedure.[1]

Soap and water should be used whenever hands are visibly soiled, after a blood or body fluid exposure, after care is provided to patients who are infected with spore-forming organisms or norovirus, and after use of the restroom.[2-4] When hands show no visible soiling, alcohol-based hand rub products should be used, and hands should be rubbed together until they are dry.[3,4] Personnel should always follow the manufacturer's instructions for use for any product used for hand hygiene, including the recommendation for the amount of product needed to cover all hand surfaces.[3]

In the scenario, Nurse S performed hand hygiene in view of the patient and family members before she greeted them and before she left the room. It is important that patients and family members see hand hygiene being performed by those who will be caring for them. Because Nurse S had to uncover the patient to confirm that the surgical site was marked, her patient could be confident that Nurse S had not touched anything else before touching her.

What Else Is in the Guideline?

Read the AORN "Guideline for hand hygiene"[1] to learn what the evidence says about the following topics:

- At what length should perioperative personnel maintain their fingernails? (Recommendation I.a.)
- When should the activities of health care personnel with dermatitis or other skin conditions be restricted? (Recommendation I.e.)
- When should perioperative team members weigh the risks and benefits of delaying hand hygiene? (Recommendation III.b.)
- What are the requirements for placement of hand hygiene product dispensers? (Recommendations III.h.1. and III.h.2.)
- What is the standardized surgical hand antisepsis protocol for using a surgical hand rub? (Recommendation IV.a.1.)
- What is the standardized surgical hand antisepsis protocol for using a surgical hand scrub? (Recommendation IV.b.1.)
- What are the considerations for selecting hand hygiene products for use in the perioperative setting? (Recommendation V.)

Reference

1. Guideline for hand hygiene. In: *Guidelines for Perioperative Practice.* Denver, CO: AORN, Inc; 2017:29-50.

Surgical Hand Antisepsis

Preoperative surgical hand antisepsis is considered the primary defense for protecting patients from any pathogens that might exist on the hands of personnel in suites for operative and other invasive procedures. Sterile gloves serve as a secondary defense.[22] The documented risk for failure of surgical gloves[23] makes it crucial that personnel perform surgical hand antisepsis before donning gowns and gloves and initiating a surgical procedure. Just as important, using proper technique for surgical hand antisepsis is necessary, and the manufacturers' instructions for use should be followed for the particular products used in the workplace.

Surgical hand antisepsis may be performed using a surgical hand scrub or a surgical hand rub. If a surgical hand scrub is used, sinks should be located in the semirestricted area and near entrances to operating and procedure rooms. It is preferable that sinks have electronic sensor controls or be operated by the knee or foot.[4,4] In addition, the evidence indicates that surgical hand scrubs should not be performed using a brush,

because scrubbing with a brush may damage skin and increase bacterial shedding from the hands.[3,4,24-26]

Nurse S observed the surgical technologist completing surgical hand antisepsis and was able to determine that the product had been properly applied. The RN has a duty to speak up when any break in technique occurs, including someone not performing hand hygiene or improperly performing surgical hand antisepsis, to help keep the patient safe.

Jewelry

In the scenario, Nurse S removed her rings before entering the OR, ensuring that she could properly perform hand hygiene throughout her day. Proper hand hygiene can be impeded when rings, watches, and bracelets are worn in the perioperative setting. Microorganisms under jewelry can be difficult to remove and may result in higher bacterial counts on the hands because of improper use of hand hygiene products.[5,7] These microorganisms may then be transferred to patients during care and could cause a health care–associated infection. The World Health Organization recommends the removal of all rings and other hand and wrist jewelry in the perioperative environment.[3]

Involving Patients

The importance of accessible hand hygiene stations and hand rub dispensers cannot be overemphasized. Easy accessibility increases compliance with hand hygiene by personnel and physicians.[1,14] When patients observe that all personnel who come in contact with them stop to perform hand hygiene, it may reinforce the importance that they should also comply with this simple-to-perform activity that can reduce the risk for surgical site infections as well as other health care–associated infections. One way to increase engagement is to involve patients in hand hygiene product evaluations.[3] It is possible that patients will have sensitivities to various chemicals or fragrances, so involving patients in product testing may also improve patient satisfaction.

Engaging patients and visitors in protecting themselves against infection also empowers them to stop anyone who has not performed hand hygiene from touching them. In the scenario, patients and family members were encouraged to speak up if they did not see personnel and physicians perform hand hygiene, which demonstrates to them that the organization takes protecting everyone from infection seriously. In addition, it may increase their awareness of the importance of hand hygiene in general, not just in health care settings.

CONCLUSION

Patients undergoing a surgical or other invasive procedure put themselves in the hands of the perioperative team. They trust that everyone they interact with is taking the proper precautions to protect them from developing a health care–associated infection. Proper hand hygiene and surgical hand antisepsis are the most significant interventions perioperative personnel can take to prevent or reduce the transmission of pathogens, thus decreasing patients' risk for surgical site infections.[1] Perioperative personnel have an evidence-based resource in the AORN "Guideline for hand hygiene" that can be used to guide practice.

References

1. Guideline for hand hygiene. In: *Guidelines for Perioperative Practice*. Denver, CO: AORN, Inc; 2017:29-50.
2. Ellingson K, Haas JP, Aiello AE, et al. Strategies to prevent healthcare-associated infections through hand hygiene. *Infect Control Hosp Epidemiol*. 2014;35(8):937-960.
3. *WHO Guidelines on Hand Hygiene in Health Care*. Geneva, Switzerland: World Health Organization; 2009.
4. Boyce JM, Pittet D; Healthcare Infection Control Practices Advisory Committee, Society for Healthcare Epidemiology of America, Association for Professionals in Infection Control, Infectious Diseases Society of America Hand Hygiene Task Force. Guideline for hand hygiene in health-care settings: recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. *Infect Control Hosp Epidemiol*. 2002;23(12 suppl):S3-S40.
5. Fagernes M, Lingaas E. Factors interfering with the microflora on hands: a regression analysis of samples from 465 healthcare workers. *J Adv Nurs*. 2011;67(2):297-307.
6. Rupp ME, Fitzgerald T, Puumala S, et al. Prospective, controlled, cross-over trial of alcohol-based hand gel in critical care units. *Infect Control Hosp Epidemiol*. 2008;29(1):8-15.
7. Hautemaniere A, Cunat L, Diguio N, et al. Factors determining poor practice in alcoholic gel hand rub technique in hospital workers. *J Infect Public Health*. 2010;3(1):25-34.
8. AST standards of practice for surgical attire, surgical scrub, hand hygiene and hand washing. Association of Surgical Technologists. http://www.ast.org/uploadedFiles/Main_Site/Content/About_Us/Standard_Surgical_Attire_Surgical_Scrub.pdf. Published April 13, 2008. Accessed November 28, 2016.
9. Infection prevention and control guidelines for anesthesia care. American Association of Nurse Anesthetists. http://www.aana.com/resources2/professionalpractice/Pages/Infection-Prevention-and-Control-Guidelines-for-Anesthesia-Care.aspx. Published February 2015. Accessed November 28, 2016.
10. *Surgical Site Infection: Evidence Update June 2013* [Evidence Update 43]. Manchester, UK: National Institute for Health and Care Excellence; 2013.
11. Wood A. Ultraviolet (UV)-cured nail polish [Clinical Issues]. *AORN J*. 2015;101(6):701-704.

12. van der Meer EWC, Boot CRL, van der Gulden JWJ, et al. Hands4U: the effects of a multifaceted implementation strategy on hand eczema prevalence in a healthcare setting. Results of a randomized controlled trial. *Contact Dermatitis.* 2015;72(5):312-324.
13. Harnoss JC, Brune L, Ansorg J, Heidecke C-D, Assadian O, Kramer A. Practice of skin protection and skin care among German surgeons and influence on the efficacy of surgical hand disinfection and surgical glove perforation. *BMC Infect Dis.* June 10, 2014;14:315. doi:10.1186/1471-2334-14-315.
14. Facility Guidelines Institute. *Guidelines for Design and Construction of Hospitals and Outpatient Facilities.* Chicago, IL: American Society for Healthcare Engineering of the American Hospital Association; 2014.
15. Loftus RW, Muffly MK, Brown JR, et al. Hand contamination of anesthesia providers is an important risk factor for intraoperative bacterial transmission. *Anesth Analg.* 2011;112(1):98-105.
16. Cosgrove MS. Infection control in the operating room. *Crit Care Nurs Clin North Am.* 2015;27(1):79-87.
17. Munoz-Price LS, Birnbach DJ. Hand hygiene and anesthesiology. *Int Anesthesiol Clin.* 2013;51(1):79-92.
18. Rowlands J, Yeager MP, Beach M, Patel HM, Huysman BC, Loftus RW. Video observation to map hand contact and bacterial transmission in operating rooms. *Am J Infect Control.* 2014;42(7):698-701.
19. Allen G. Hand hygiene and the surgical team. *Perioper Nurs Clin.* 2010;5(4):411-418.
20. Krediet AC, Kalkman CJ, Bonten MJ, Gigengack ACM, Barach P. Hand-hygiene practices in the operating theatre: an observational study. *Br J Anaesth.* 2011;107(4):553-558.
21. Fernandez PG, Loftus RW, Dodds TM, et al. Hand hygiene knowledge and perceptions among anesthesia providers. *Anesth Analg.* 2015;120(4):837-843.
22. Adams AB. Surgical hand antisepsis: where we have been and where we are today. *Perioper Nurs Clin.* 2010;5(4):443-448.
23. Guideline for sterile technique. In: *Guidelines for Perioperative Practice.* Denver, CO: AORN, Inc; 2017:75-104.
24. Abdelatiff DA, El-Haiyk KS, Noura HG, El-Qudaa RF, El-Sabouni RS. Comparing of using sterile brush during surgical scrubbing versus brushless for surgical team in operating room. *Life Sci J.* 2014;11(1):387-393.
25. da Cunha ÉR, Matos FGOA, da Silva AM, de Araújo EAC, Ferreira KASL, Graziano KU. The efficacy of three hand asepsis techniques using chlorhexidine gluconate (CHG 2%) [in Portuguese]. *Rev Esc Enferm USP.* 2011;45(6):1440-1445.
26. Okgün Alcan A, Demir Korkmaz F. Comparison of the efficiency of nail pick and brush used for nail cleaning during surgical scrub on reducing bacterial counts. *Am J Infect Control.* 2012;40(9):826-829.

Judith L. Goldberg, DBA, MSN, RN, CSSM, CNOR, CHL, CRCST, is the director of Patient Care Services and Perioperative and Procedural Services at Lawrence + Memorial Hospital, New London, CT. *Dr Goldberg has no declared affiliation that could be perceived as posing a potential conflict of interest in the publication of this article.*

Continuing Education: Guideline Implementation: Hand Hygiene 1.1 CE

www.aornjournal.org/content/cme

PURPOSE/GOAL

To provide the learner with knowledge specific to implementing the AORN "Guideline for hand hygiene."

OBJECTIVES

1. Discuss hand hygiene considerations related to maintaining healthy fingernails in the perioperative setting.
2. Explain methods perioperative personnel can use to prevent dermatitis.
3. Describe proper hand hygiene practices.
4. Discuss considerations for surgical hand antisepsis.
5. Discuss the implications of wearing jewelry on the hands and wrists in the perioperative setting.
6. Describe ways to engage patients in hand hygiene initiatives.

The Examination and Learner Evaluation are printed here for your convenience. To receive continuing education credit, you must complete the online Examination and Learner Evaluation at *http://www.aornjournal.org/content/cme*.

QUESTIONS

1. Maintaining short fingernails decreases the risk of
   1. contracting dermatitis.
   2. harboring pathogens.
   3. impeding hand hygiene.
   4. injuring patients.
   5. puncturing gloves.

   a. 2 and 4 b. 1, 3, and 5
   c. 2, 3, 4, and 5 d. 1, 2, 3, 4, and 5

2. Wearing nail polish is always prohibited in the perioperative setting.

   a. true b. false

3. Some moisturizing hand lotion products can
   1. alter the integrity of gloves.
   2. be used as a substitute for surgical hand scrubs.
   3. be used instead of soap and water when hands are visibly soiled.
   4. change the effects of hand antiseptics.

   a. 1 and 4 b. 2 and 3
   c. 1, 2, and 3 d. 1, 2, 3, and 4

4. To help prevent dermatitis, perioperative personnel should
   a. leave hands slightly damp before gloving.
   b. use an alcohol-based hand rub instead of soap and water.
   c. use soap and water instead of an alcohol-based hand rub.
   d. wash with water hotter than 80° F (26.7° C).

5. Hand hygiene should be performed
   1. after a meal.
   2. after patient contact.
   3. before handling of clean or sterile items.
   4. before patient contact.
   5. when a possible blood or body fluid exposure has occurred.

   a. 2 and 4 b. 1, 2, and 3
   c. 2, 3, 4, and 5 d. 1, 2, 3, 4, and 5

6. Soap and water should be used instead of an alcohol-based hand rub when hands are visibly soiled.

   a. true b. false

7. Sterile gloves are the primary defense for protecting patients from pathogens on the hands of health care personnel.
   a. true b. false

8. Surgical hand antisepsis
   1. may be performed using a surgical hand rub.
   2. may be performed using a surgical hand scrub.
   3. should be performed using a brush.
   4. should not be performed using a brush.
   a. 1 and 3 b. 2 and 4
   c. 1, 2, and 3 d. 1, 2, and 4

9. Wearing of rings, watches, or bracelets in the perioperative setting may
   1. cause dermatitis.
   2. impede proper hand hygiene.
   3. result in a higher bacterial count on hands.
   4. result in microorganisms being transferred to patients.
   a. 1 and 3 b. 2 and 4
   c. 2, 3, and 4 d. 1, 2, 3, and 4

10. Easy-to-access hand hygiene stations and hand wash dispensers can
    1. help reduce the risk of health care–associated infections.
    2. engage patients and visitors in protecting themselves against infection.
    3. increase compliance with hand hygiene by personnel and physicians.
    4. reinforce the importance of hand hygiene to patients.
    a. 1 and 3 b. 2 and 4
    c. 1, 2, and 4 d. 1, 2, 3, and 4

American Health Care Center
Competency Verification Tool—Perioperative Services
Practice: Hand Hygiene

Name:_____ **Date:** _____

Competency Statement: The perioperative RN or non-RN team member has completed facility- or health care organization-required education and competency verification activities related to hand hygiene.[1]

1. Guideline for hand hygiene. *Guidelines for Perioperative Practice*. Denver, CO: AORN, Inc; 2016.

Patient Outcome: The patient is free from signs and symptoms of infection.[2]

2. Petersen C, ed. Infection. In: *Perioperative Nursing Data Set*. 3rd ed. Denver, CO: AORN, Inc; 2011:254-276.

Competency Statements/Performance Criteria	Verification Method [Select applicable code from legend at bottom of page]						Not Met (Explain why)
	DEM/ DO/DA	KAT	S/SBT/ CS	V	RWM/ P&P	O	
1. Follows established perioperative hand hygiene practices for maintaining healthy skin and fingernail condition.							
2. Keeps nails at a length where the nails do not extend beyond the tips of the fingers when the hands are held vertically and viewed from the palmar side.							
3. Removes chipped nail polish before entering the restricted area.							
4. Does not wear artificial fingernails or other fingernail enhancements in the perioperative environment.							
5. Uses facility or health care organization-approved hand hygiene products and hand lotions.							
6. Removes rings, watches, and other jewelry that cannot be contained within the scrub attire before entering the semirestricted and restricted areas.							
7. Identifies when hand hygiene should be performed, including							
a. before and after every patient contact,							
b. before performing a clean or sterile task,							
c. after risk for blood or body fluid exposure,							
d. after contact with patient surroundings,							
e. before and after eating,							

DEM/DO/DA = Demonstration/Direct Observation/Documentation Audit
S/SBT/CS = Skills Laboratory/Scenario-based Training/Controlled Simulation
RWM/P&P = Review of Written or Visual Materials/Policy/Procedure Review (Specify P&P #s _____)
KAT = Knowledge Assessment Test
V = Verbalization
O = Other: _____

American Health Care Center
Competency Verification Tool—Perioperative Services
Practice: Hand Hygiene – RN or Non-RN

Competency Statements/Performance Criteria	Verification Method [Select applicable code from legend at bottom of page]						Not Met (Explain why)
	DEM/ DO/DA	KAT	S/SBT/ CS	V	RWM/ P&P	O	
f. after using the restroom, and							
g. when hands are visibly soiled.							
8. Performs hand washing with soap and water by a. adjusting water to a comfortable temperature, avoiding hot water;							
b. wetting hands thoroughly with water;							
c. apply amount of soap needed to cover all surfaces of the hands;							
d. rubbing hands together vigorously covering all surfaces of the hands and fingers;							
e. washing for at least 15 seconds;							
f. rinsing well to remove all soap;							
g. drying hands thoroughly with a disposable towel, and							
h. using a disposable towel to turn the water off and open the door if hands-free controls are not available.							
9. Identifies when an alcohol-based antiseptic hand rub may be used (ie, when hands are not visibly soiled).							
10. Performs hand hygiene using an alcohol-based antiseptic hand rub product by a. applying the amount of alcohol-based hand rub recommended by the manufacturer to cover all surfaces of the hands and							
b. rubbing hands together, covering all surfaces of the hands and fingers until they are dry.							
11. Describes symptoms of irritant or allergic contact dermatitis (eg, redness, itching) and reasons to report these symptoms as soon as they are noted.							
12. Follows established protocols for reporting if cuts, abrasions, weeping dermatitis, or fresh tattoos are present on exposed skin, and does not work in the perioperative areas until the condition is healed and clearance for work has been received by [facility-specific personnel]							

DEM/DO/DA = Demonstration/Direct Observation/Documentation Audit
S/SBT/CS = Skills Laboratory/Scenario-based Training/Controlled Simulation
RWM/P&P = Review of Written or Visual Materials/Policy/Procedure Review (Specify P&P #s _____)

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American Health Care Center
Competency Verification Tool—Perioperative Services
Practice: Hand Hygiene – RN or Non-RN

Competency Statements/Performance Criteria	Verification Method [Select applicable code from legend at bottom of page]						Not Met (Explain why)
	DEM/ DO/DA	KAT	S/SBT/ CS	V	RWM/ P&P	O	
13. Verbalizes a review of facility or health care organization policies and procedures related to hand hygiene.							
14. Participates in quality improvement activities related to hand hygiene as assigned.							

Concurrent competency verification of the following is recommended	
• [Additional competencies related to hand hygiene as determined by the facility or health care organization]	•
•	•
•	•

DEM/DO/DA = Demonstration/Direct Observation/Documentation Audit
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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) LICENSE NUMBER	SURVEYOR ID	(X2) DATE SURVEY COMPLETED
7003183	40079, 15168	07/18/2018

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Western Diversey Surgical Center	2744 N. Western Ave, Chicago, Illinois, 6047

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
000	A licensure complaint investigation was conducted for complaint #182340 on 07/18/2018, at Western Diversey Surgical Center in Chicago, Illinois. The Facility was in compliance with Title 77: Public Health Chapter I: Department of Public Health Subchapter b: Hospital and Ambulatory Care Facilities Part 205 Ambulatory Surgical Treatment Center Licensing Requirements Section 205.710 Pregnancy Termination Specialty Centers, for this survey.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
7003183	19840/36774	8/30/17-8/31/17

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Western Diversey Surgical	2744 N Western Ave, Chicago, IL 60647

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A000	A licensure survey was conducted on 8/31/17. The Facility was not in compliance with TITLE 77: PUBLIC HEALTH CHAPTER I: DEPARTMENT OF PUBLIC HEALTH SUBCHAPTER b: HOSPITAL AND AMBULATORY CARE FACILITIES PART 205 AMBULATORY SURGICAL TREATMENT CENTER LICENSING REQUIREMENTS, as evidenced by:			

KS 10/11/17

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE

TITLE Administrator

DATE 10/6/17

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7003183	19840/36774	8/30/17-8/31/17

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Western Diversey Surgical	2744 N Western Ave, Chicago, IL 60647

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A028	205.410 d) d) The facility shall have written procedures to assure the safety in storage and use of all narcotics and medications in accordance with State and federal law. This Regulation is not met as evidence by: A. Based on observation, document review, and interview, it was determined that for 1 of 2 (Operating Rooms/OR #2) anesthesia carts, the Facility failed to ensure that the medications were kept secured as required by policy. This potentially affected an average census of 90 patients per month. Findings include: 1. On 8/30/17, at approximately 9:45 AM, an observational tour of the Facility's OR #2 was conducted. The anesthesia cart, containing medications such as intravenous hydralazine (antihypertensive), succinylcholine (used to relax muscle during surgery), and intravenous diphenhydramine (used for allergic reaction), was found unlocked. OR #2 was not being used for any procedure on 8/30/17. 2. On 8/30/17 at approximately 11:00 Am, the Facility's policy titled "Medication Policy" (reviewed 6/17) was reviewed. The policy required, "... H. Security: 1. Medications... should be kept locked..." 3. On 8/30/17 at approximately 9:45 AM, an interview was conducted with E #1 (Administrator). E #1 stated that OR #2 was not scheduled for procedures and the medication cart should be locked.		A028- The cart was found unlocked at time of Inspection and was corrected immediately by the Anesthesiologist. Cart was then locked. Staff was reminded to keep the cart locked at all times when not in use for the safety of patients and employees. Administrator monitoring daily.	8/30/17

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE

TITLE Administrator

DATE 10/06/17

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) LICENSE NUMBER	SURVEYOR ID	(X2) DATE SURVEY COMPLETED
7003183	19840/36774	8/30/17-8/31/17

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Western Diversey Surgical	2744 N Western Ave, Chicago, IL 60647

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A001	205.410 d) continued... B. Based on observation, document review and interview, it was determined that the Facility failed to ensure sterile supplies were stored separately from non-sterile items as required by policy. This potentially affected an average census of 90 patients per month. Findings include: 1. On 8/30/17 at approximately 9:30 AM, an observational tour of the Facility's recovery room area was conducted. A storage cabinet was observed containing several unopened intravenous fluids along with 1 box of crackers and 6 boxes of Ocean Spray canned apple juice. 2. On 8/30/17 at approximately 10:30 AM, the Facility's policy titled "Infection Control Plan" (revised 7/17/) was reviewed. The policy required, "... A. General Precautions... 7. Sterile supplies are kept separate from non-sterile supplies..." 3. On 8/30/17 at approximately 9:35 AM, the above finding was discussed with the Registered Nurse (E #2). E #2 stated that the box of crackers and apple juice should have been kept separately from the intravenous fluid.	A001	Food was being stored in the wrong cabinet and Staff was instructed to move it immediately To the proper designated location which it Was done. Staff was reinstructed on proper Storage location. Administrator monitoring daily	8/30/17

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

DATE: 10/6/17

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) LICENSE NUMBER	SURVEYOR ID	(X2) DATE SURVEY COMPLETED
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A061	205.540 f) f) Patients shall be discharged only on the written signed order of a physician. The name, or relationship to the patient, of the person accompanying the patient upon discharge from the facility shall be noted in the patient's medical record. This Regulation is not met as evidence by: Based on document review and interview, it was determined that for 1 of 20 (Pt. #1) clinical records reviewed, the Facility failed to ensure that the physician's discharge order was signed as required by policy. Findings include: 1. On 8/30/17 at approximately 10:00 AM, the clinical record of Pt. #1 was reviewed. Pt. #1 was a 36 year old male with a diagnosis of lumbar disc herniation, and underwent a right sacroiliac (joint connecting pelvis to lowest part of the spine) steroid injection. Pt. #1's discharge order lacked the signature of the discharging physician. 2. On 8/30/17 at approximately 3:00 PM the Facility's policy titled, "... Discharge Criteria" (reviewed 6/17) was reviewed. The policy required, "... The patient is discharged upon orders from the physician..." 3. On 8/30/17 at approximately 3:10 PM, the Facility's, "Medical Staff Bylaws" (reviewed (6/17) was reviewed and required, "... All orders for treatment... will be in writing...A... order will be considered in writing if... signed by the attending Medical Staff person." 3. On 8/30/17 at approximately 3:30 PM, the findings were discussed with the Administrator (E #1). E #1 stated that the discharge order should be signed by the physician.	A061	1 out of 20 charts was missing a signature from The physician on the discharge page. The Dr. Was notified and he came to sign the chart. He Was reminded that all charts must be fully signed Prior to the patient being discharged after the procedure. Nurse manager and administrator monitoring daily.	08/30/17

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

DATE: 10/6/17

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
7003183	19840/36774	8/30/17-8/31/17

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A063	205.550.a) a) Each ASTC shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers and visitors. This Regulation is not met as evidence by: A063 Based on observation, document review, and interview, it was determined that for 2 of 3 (E #2/registered nurse and E #3/medical assistant) personnel observed in the surgical restricted area, the Facility failed to ensure adherence to the surgical attire as required. Findings include: 1. On 8/30/17 at approximately 9:45 AM, an observational tour of the Facility's surgical restricted area was conducted. During the tour, the following were observed: - E#2 was wearing earrings and her hair was exposed approximately 3-4 inches at the back. - E #3 was not wearing a head cap and shoe covers. 2. On 8/30/17 at approximately 11:00 AM, the Facility's policy titled "Dress Code for the Surgical Suite" (reviewed 6/17) was reviewed and required, "... A. All personnel entering the restricted area of the surgical suite must be in surgical attire... 2. Cap or hood... 4. Shoe covers. B. All possible head... hair will be covered while in the ... restricted area of the surgical suite... G. All jewelry should be removed..." 3. On 8/30/17 at approximately 9:50 AM, findings were discussed with E #1. E #1 stated that E #2's hair should not be exposed and should not be wearing earrings. E #1 added that E #3 should have been wearing a cap and shoe covers while in the surgical restricted area.		2 employees were improperly dressed during the Site visit and were instructed on the spot of Their deficiencies and was instructed on immediate Correction. Employees were asked to read the dress Code policy and were given warnings for not having proper dress. Other employee was shown how to wear the cap with all hair in the cap and no jewelry. Nurse manager and administrater monitoring daily.	08/30/17

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE

TITLE: Administrater

DATE: 10/6/17

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7003183	19840/36774	8/31/17-8/31/17

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XS 10/6/17

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator DATE 10/6/17

Illinois Department of Public Health

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AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE

TITLE Administrator

DATE 10/06/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE

TITLE Administrator

DATE 10/6/17

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Western Diversey Surgical	2744 N Western Ave, Chicago, IL 60647

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A061	205.540 f) f) Patients shall be discharged only on the written signed order of a physician. The name, or relationship to the patient, of the person accompanying the patient upon discharge from the facility shall be noted in the patient's medical record. This Regulation is not met as evidence by: Based on document review and interview, it was determined that for 1 of 20 (Pt. #1) clinical records reviewed, the Facility failed to ensure that the physician's discharge order was signed as required by policy. Findings include: 1. On 8/30/17 at approximately 10:00 AM, the clinical record of Pt. #1 was reviewed. Pt. #1 was a 36 year old male with a diagnosis of lumbar disc herniation, and underwent a right sacroiliac (joint connecting pelvis to lowest part of the spine) steroid injection. Pt. #1's discharge order lacked the signature of the discharging physician. 2. On 8/30/17 at approximately 3:00 PM the Facility's policy titled, "... Discharge Criteria" (reviewed 6/17) was reviewed. The policy required, "... The patient is discharged upon orders from the physician..." 3. On 8/30/17 at approximately 3:10 PM, the Facility's, "Medical Staff Bylaws" (reviewed (6/17) was reviewed and required, "... All orders for treatment... will be in writing...A... order will be considered in writing if... signed by the attending Medical Staff person." 3. On 8/30/17 at approximately 3:30 PM, the findings were discussed with the Administrator (E #1). E #1 stated that the discharge order should be signed by the physician.	A061	1 out of 20 charts was missing a signature from The physician on the discharge page. The Dr. Was notified and he came to sign the chart. He Was reminded that all charts must be fully signed Prior to the patient being discharged after the procedure. Nurse manager and administrator monitoring daily.	08/30/17

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

DATE: 10/6/17

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7003183	19840/36774	8/30/17-8/31/17

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Western Diversey Surgical	2744 N Western Ave, Chicago, IL 60647

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A063	205.550 a) a) Each ASTC shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers and visitors. This Regulation is not met as evidence by: A063 Based on observation, document review, and interview, it was determined that for 2 of 3 (E #2/registered nurse and E #3/medical assistant) personnel observed in the surgical restricted area, the Facility failed to ensure adherence to the surgical attire as required. Findings include: 1. On 8/30/17 at approximately 9:45 AM, an observational tour of the Facility's surgical restricted area was conducted. During the tour, the following were observed: - E#2 was wearing earrings and her hair was exposed approximately 3-4 inches at the back. - E #3 was not wearing a head cap and shoe covers. 2. On 8/30/17 at approximately 11:00 AM, the Facility's policy titled "Dress Code for the Surgical Suite" (reviewed 6/17) was reviewed and required, "… A. All personnel entering the restricted area of the surgical suite must be in surgical attire… 2. Cap or hood… 4. Shoe covers. B. All possible head… hair will be covered while in the … restricted area of the surgical suite… G. All jewelry should be removed…" 3. On 8/30/17 at approximately 9:50 AM, findings were discussed with E #1. E #1 stated that E #2's hair should not be exposed and should not be wearing earrings. E #1 added that E #3 should have been wearing a cap and shoe covers while in the surgical restricted area.		2 employees were improperly dressed during the Site visit and were instructed on the spot of Their deficiencies and was instructed on immediate Correction. Employees were asked to read the dress Code policy and were given warnings for not having proper dress. Other employee was shown how to wear the cap with all hair in the cap and no jewelry. Nurse manager and administrator monitoring daily.	08/30/17

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

DATE: 10/6/17

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

January 15, 2016

Renlin Xia, Administrator
Western Diversey Surgical Center
2744 North Western Avenue
Chicago, IL 60647-

Re: Western Diversey Surgical Center
Chicago
Licensure survey

Dear Renlin Xia:

On 01/14/16, a life safety code licensure monitoring survey was conducted at the above Ambulatory Surgical Treatment Center to verify completion of your Plan of Correction received on 09/12/14. All previously cited deficiencies have been corrected, therefore, the facility is no longer under monitoring.

If you have any questions, please do not hesitate to call us at 217/785-4247. The Department's TTY # is 800/547-0466, for use by the hearing impaired.

Sincerely,

[redacted]

Henry Kowalenko, Division Chief
Division of Life Safety and Construction

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000037	A. BUILDING: 01 - MAIN BUILDING B. WING _____	R 01/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN DIVERSEY SURGICAL CENTER	2744 NORTH WESTERN AVENUE CHICAGO, IL 60647

(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
{L 000}	Initial Comments On March 24, 2015 a follow up to the Life Safety portion of an Ambulatory Surgical Treatment Center Annual Licensure Survey was conducted at the above facility by Surveyor 17659. The survey was based on the revised plan of correction dated October 24, 2014. On July 16, 2014 a follow up to the Life Safety portion of an Ambulatory Surgical Treatment Center Annual Licensure Survey was conducted at the above facility by Surveyors 12798 and 17659. The survey was based on the plan of correction received on 3/10/14. On August 27, 2013 the Life Safety portion of an Ambulatory Surgical Treatment Center Annual Licensure Survey was conducted at the above facility by Surveyor 13755. He was accompanied during the survey walk-through by the provider's Nurse Managers and maintenance personnel. The facility is a single story building determined to be of minimum Type II (000) construction type and fully sprinklered. The facility was surveyed as an existing Ambulatory Health Care Occupancy under the 2000 Edition of the NFPA 101 Life Safety Code, including Chapter 21 and the 77 IL Administrative Code 205, Ambulatory Surgical Treatment Center Licensing Requirements. Unless otherwise noted, those code sections listed herein that do not include a reference to a specific NFPA code and year of issue (such as NFPA 70 1999) are taken from the 2000 Edition of the NFPA 101 Life Safety Code. Unless otherwise noted, all deficiencies cited	{L 000}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000037	A. BUILDING: 01 - MAIN BUILDING B. WING _____	R 01/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN DIVERSEY SURGICAL CENTER	2744 NORTH WESTERN AVENUE CHICAGO, IL 60647

(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
{L 000}	Continued From page 1 herein were found through random observation during the survey walk-through, staff interview, or document review. The Licensing requirements are NOT MET as evidenced by the deficiencies cited under the following L-Tags. On January 14, 2016 a follow up to the Life Safety portion of an Ambulatory Surgical Treatment Center Annual Licensure Survey was conducted at the above facility. All remaining deficiencies were observed to be corrected and no new deficiencies cited.	{L 000}		

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

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January 15, 2016

Renlin Xia, Administrator
Western Diversey Surgical Center
2744 North Western Avenue
Chicago, IL 60647-

Re: Western Diversey Surgical Center
Chicago
Electrical system upgrade (POC)
IDPH No: 10175

Dear Renlin Xia:

Based on the evaluation of the physical plant and life safety standards, the above has been approved for use. The Department's file for this project will be closed.

As required for the entire facility, this unit must be operated and maintained in accordance with the requirements of the Hospital Licensing Act (210 ILCS 8/1 et. seq.) and the Department's rules entitled Hospital Licensing Requirements (77 Ill. Adm. Code 250). For eligibility for Medicare reimbursement, the unit must be operated and maintained in accordance with the federal Conditions of Participation for hospitals (42 CFR 482.1 et. seq.).

If you have any questions about this approval, please do not hesitate to call us at 217/785-4247. The Department's TTY number is 800/547-0466, for use by the hearing impaired.

Sincerely,

[redacted]

Henry Kowalenko, Division Chief
Division of Life Safety and Construction

Cc: Anastasios Tsakiridis
A. Tsakiridis Architect & Associates
1008 Weathersfield Way
Schaumburg, IL 60193-

Americans United for Life

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ILLINOIS DEPARTMENT OF PUBLIC HEALTH

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Street and Apt. No., or PO Box No.
City, State, ZIP+4®
PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions

7016 0340 0001 1775 6970

November 14, 2016

American Women's Medical Group
2744 North Western Avenue
Chicago, IL 60647

Dear Administrator:

The Department received a concern in regards to your agencies advertisement as to the location in which the surgical procedure of Dilation and Evacuation is being performed. The web page for American Women's Medical Center provides information of surgical abortions including suction curettage or dilation and evacuation as being provided at one of the locations listed on the website. In reviewing the license renewal applications for licensed ambulatory surgical treatment centers- Western Diversey Surgical Center at 2744 North Western Avenue, Chicago, IL 60647 and Fullerton Kimball Medical Center at 3409 W Fullerton Ave. Chicago, IL 60647, neither renewal application has dilation and evacuation listed as an approved surgical procedure by the agency's Consulting Committee. As per section 205.130 a)

a) The list of surgical procedures performed by a center shall be included in the application as provided in Section 205.120 and in the renewal application as provided in Section 205.125. All surgical procedures to be performed in a facility must be approved by the facility's Consulting Committee prior to their performance, and annually reviewed and reapproved. Documentation of the approval must be submitted with the initial and renewal applications.

Please respond in writing to this office no later than 15 days after receipt of this letter. Please identify which agency is providing this surgical service and send a copy of the consulting committee's approval for this service at the licensed ambulatory surgical treatment center. If you have any questions regarding this request, please address your concerns to the Illinois Dept. of Public Health, Division of Health Care Facilities and Programs, 525 West Jefferson Street, 4th Floor, Springfield, Illinois 62761-0001, or feel free to call myself at 217/ 782-0381. The Department's TTY number is 800/ 547-0466, for use by the hearing impaired.

Sincerely,

[redacted]

Karen Senger, RN, BSN
Division Chief
Division of Health Care Facilities and Programs
Illinois Department of Public Health

Americans United for Life

7016 0340 0001 1775 6970

WESTERN DIVERSEY SURGICAL CENTER

2744 N. Western Avenue, Chicago, IL 60647 | 773-772-7726

November 25, 2016

Karen Senger, RN, BSN
Division Chief
Illinois Department of Public Health
525-535 West Jefferson Street
Springfield, Illinois 62761-0001

Dear Ms. Senger:

This letter in response to your inquiry dated November 14, 2016. We want to thank you for bringing to our attention the error in omission of the dilation and evacuation from our renewal applications. This and all other procedures were approved by our consulting committee but left off the list in a clerical error. We have since notified the consulting Committee of the error and they have amended the meeting minutes to reflect their approval and agreement to perform dilation and evacuation procedures at the Western Diversey Surgical Center. We will also add D&E to the license renewal application for 2017.

Please see the attached amended Consulting Committee meeting minutes.

Sincerely,

[redacted]

Dr. Renlin Xia
President & Chief Medical Officer

Americans United for Life

CONSULTING COMMITTEE

The consulting committee met on Wednesday November 23, 2016

Members Present: Josephine Kamper, M.D.
Renlin Xia, M.D.
Marie Frukacz
Perla Aniciete, R.

The consulting committee was called to order by Renlin Xia, M.D. Medical Director at 10:00 a.m.

It was brought to our attention by IDPH that D&E was omitted in our application for renewal license.

The consulting committee amended and approved D&E as one of the procedures being performed at Western Diversey Surgical Center 2744 N. Western Avenue Chicago, Illinois. D&E will be added to procedures that are approved by the committee on the renewal license application in 2017.

MEETING WAS ADJOURNED AT 10:30 a.m. by Dr. Renlin Xia, Director

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CONSULTING COMMITTEE

The consulting committee met on Monday January 11, 2016

Members Present: Josephine Kamper, M.D.
Renlin Xia, M.D.
Marie Frukacz
Perla Aniciete, R.N.

The consulting committee was called to order by Renlin Xia, M.D. Medical Director at 1:00 p.m.

The committee reviewed pathology reports on procedures performed at Western Diversey Surgical Center. The following patients were notified for abnormal pathology. Dr. Renlin Xia found no need to make any changes.

Oct 30th #2

Nov 0

Dec 0

Number of procedures requiring subsequent hospitalization: 0

Complications requiring additional treatment: 0

Number of uterine perforations: 0

Number of lacerated cervix: 0

Number of ectopic pregnancies: 0

Number of post-surgical infections reported:

Weekly reports are still being sent to IDPH regarding type of anesthesia that is used for all surgeries.

The Following Procedures have been approved:

Endometrial Biopsy
Dilatation and Curettage
D & C with Vacuum Aspiration
D&E
Open Laparoscopy Tubal Ligation
Cervical Conization

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Laser of genital warts
Colposcopy with Biopsy
Polypectomy
Treatment of Condylomata Acuminata
Biopsy of Vaginal Vulvar Lesions
Bartholin's Gland Cyst Marsupialization
Cystoscopy
Diagnostic Laparoscopy
Operative Laparoscopy
Hernia Repair
Vein Ligation and Stripping
Hemorrhoidectomy
Incision and Drainage of Abscess
Excision Repair of Skin Lesion
Breast Biopsy
Excision of Unknown Soft Tissue Mass
Removal of Screws
Knee Arthroscopy
Release of Carpal Tunnel Syndrome
Release of Trigger Finger
Ankle Arthroscopy
Arthroplasty / Phalangectomy
Bunionectomy
Plantar Fasciotomy
Tenotomy
Laser of Plantar Warts
Regional Anesthesia
Epidural Injection
Facet joint Injections
Sacroiliac Joint Injections
Lumbar and Cervical Discogram
Vertebroplasty
Disc Decompression
Kyphoplasty
Colonoscopy
Esophagogastroduodenoscopy

MEETING WAS ADJOURNED AT 3:30 p.m. by Dr. Renlin Xia, Director

Americans United for Life

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Americans United for Life

Ξ☐ ASTC HHA ☐ HMO HOSPICE X HOSPITAL

NAME AND ADDRESS: Western Diversey Surgical Center
OF FACILITY: 2744 North Western Ave. Chicago, Illinois, 60647

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
	On survey date 12/7/17 an onsite licensure survey was conducted in response to the survey dated 9/24/15 at Western Diversey Surgery Center in Chicago, Illinois. All deficiencies were corrected. The Facility is in compliance with Illinois Administrative Code 77 Ill: Public Health Chapter I: Department of Public Health Subchapter b: Hospital and Ambulatory Care Facilities Part 205 Ambulatory Surgical Treatment Center licensing requirements for this survey.		

DATE OF SURVEY 12/7/15 BY 15168
(Surveyor)

(Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

AMBULATORY SURGICAL CENTER

NAME AND ADDRESS OF FACILITY: Western Diverse y Surgical Center, 2744 N. Western Ave., Chicago, IL 60647

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
	A licensure survey (#7003183) and a complaint investigation (#152083) were conducted on 9/24/15. The Ambulatory Surgical Center was not in compliance with licensure requirements (Section 205.410 and 205.530), as evidenced by:		

DATE OF SURVEY 9/24/15 BY 19843 (Surveyor) _____ (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

AMBULATORY SURGICAL CENTER

NAME AND ADDRESS OF FACILITY: Western Diverse y Surgical Center, 2744 N. Western Ave., Chicago, IL 60647

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.410 (b) Equipment	**There shall be written procedures governing the care, use, sterilization, storage, and disposal of all materials to ensure that an adequate supply of equipment is available for each procedure.** A. Based on document review, observational tour, and interview, it was determined for 1 of 1 sterilizer load, the facility failed to ensure a sterilizer load was packed properly, potentially affecting over 100 patients having surgery each month. Findings include: 1. On 9/24/15 at 12:00 PM, the Magna-Clave Operator's Manual was reviewed. The Manual required, "III. Tray Preparation and Loading... C. Wrapped Trays and Instruments... c. Place individually wrapped instruments on perforated trays. Provide adequate space between instruments for steam circulation. Caution: Do not overload trays or inadequate sterilization may result." No weight limit was found. 2. During an observational tour in the operating area (OR) on 9/24/15 at 10:45AM. wrapped instruments were in the sterilizer ready for processing. The instruments packs were stacked on each other. The center of the half moon container held 10 packs stacked top to bottom, without an absorbent cloth between packs. 3. On 9/24/15 at 10:50 AM an interview was conducted with a Registered Nurse, (E#2). E#2 stated he did not know how many packs could be sterilized in one load or what the load weight limit was. E #2 estimated the weight of the loaded tray to be 30 to 40 pounds.	Section 205.410 A. 1, 2, 3 Policy and Procedure revisions were made and approved by the Consulting Committee Meeting on Nov. 06, 2015 (see attached revised Policy and Procedure on "Sterilization". Policy changes has been in-serviced to the staff on Nov. 07, 2015 (see attached in-service sign in-sheet). Changes in Policy and Procedure has also been incorporated to our Performance Improvement Activities which will be monitored and reported every month, re-evaluated in 3 months for effectiveness. Above plan has been completed in currently being implemented (Nov. 09, 2015) Mr. Adriy Khlopas RN will be responsible for all the above activities.	Nov. 09, 2015

DATE OF SURVEY _____ BY _____ _____
(Surveyor) (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

Western-Diversey Surgical Center
2744 N. Western Ave., Chicago, IL 60647

Consulting Committee Minutes

Date: Nov. 06, 2015

Time: 10:00 am

Location: Western-Diversey Surgical Center (conference room))

No of Pages: *(2)*

I Approval of the previous minutes of meeting
The minutes of the previous meeting has been approved. No changes or addendum were made

II Credentialing
There were no new MD's pending for approval of credentials.

III Approval/review of Policies and Procedures
A revised policy on Sterilization and Disinfection Guidelines is presented by A. Khlopas, RN – the policy revisions and addendum has been discussed and approved by the committee. Staff training/in-service will be held on Nov. 07, 2015. (see attached training module – Magnaclave User Manual and Revised Policy on Sterilization and Disinfection Guidelines)
A revised policy on Labeling of Drugs and Solutions is presented by A. Khlopas, RN – the policy revision has been discussed and approved for implementation immediately.
Other activities: Policy Reviewed: Malignant Hyperthermia – Emergency Measures; Expiration Dates (medications)
The Safety Policy was also revised and presented, with emphasis that from now on a circulating RN will be made available and assigned to all surgical and diagnostic procedures in the operating room. This changes in Safety Policy was discussed by the committee and approved – staff are to receive memo regarding the changes in Policy and Procedure.

IV Tissue Review Report
All tissue report were presented and has found no discrepancies between pre-op and post-operative findings.

V QA/PI Report
All performance improvement activities has been presented with nothing unusual to report. A new monitoring tool has been added to the performance improvement activities and is discussed and approved for pilot testing, this new performance improvement activities will be done in 3 successive months, will be reported monthly and evaluated at the end of the 3rd month for effectiveness. (see attached new Performance Improvement Activities monitoring tool).

VI Infection Prevention and Control
There has been no report of any infection in the previous month, all follow-ups to monitor for infection has been conducted on 100% of patients.

VII Environment of Care

It was mentioned that a reminder should be done for the staff on segregation of waste; i.e. all contaminated waste with blood and body fluids should always be placed in red bio-hazard container and non-contaminated items (boxes, outside wrappers may go to regular black garbage.

VI Census Report
All census report from OR, lab and admitting department has been presented with no conflicting numbers noted.

VII Employee Related Agenda
No new hires as of this time

VIII Other Agendas and Announcements
A follow-up meeting may be held sooner – announcement will be made on the date.

Adjournment

Attendees:

Renlin Xia, MD (Medical Director)

Karen Walczak, APN (Member)

Andriy Khlopas, RN (Member)

Josephine Kamper, MD (Member)

Sofia Demas (Office Manager)

Marie Frukacz (Office Manager)

Americans United for Life

WESTERN DIVERSEY SURGICAL CENTER
ORGANIZATION PLAN
2744 N. WESTERN AVE
CHICAGO, IL 60647

C.E.O.
Renlin Xia, M.D.

Consulting Committee
Renlin Xia, M.D.
Josephine Kamper, M.D.
Karen Walczak, APN
Andriy Khlopas, R.N.

Medical Director
Renlin Xia, M.D.

Office Manager
Marie Frukacz
Sophia Demas

R.N. Supervisor
Karen Walczak, APN

Medical Lab
Kevin Cheng,Ph.D.
Kim Lee White
Natasha Kukuruza

Circulating/Surgical R.N.
Andriy Khlopas, R.N.
Arnold Sabater, R.N.

Medical Assistant
Mariela Escarpito
Alejandra Perez
Andrej Martyniz
Magaly Napoles

Reception
Berta DeLaPena
Emily Rivera
Billing
Sally Deng

Americans United for Life

I POLICY

It is the policy of Western-Diversey Surgical Center to follow guidelines in achieving sterilization of instruments, supplies, and equipment.

II PROCEDURES

A. All decontamination of instrument trays and reusable items are processed in the soiled utility area; sterilization in the clean utility area.

B. Protective attire to be worn while washing instruments includes:
   1. Eyewear (e.g., goggles, splash glasses, facial shields)
   2. Utility gloves
   3. Moisture repellent or splash-proof skin protection (e.g., gowns, aprons)

C. Methods used for disinfection will be based on whether the item is critical, semi-critical, or non-critical, according to the risk of infection to the patient.
   1. *Critical:* Items that enter sterile tissue or the vascular system are considered sterile. These are cleaned using steam/dry heat/gas sterilization or a chemical disinfectant with an EPA classification of "Disinfectant / Sterilant" (kills spores).
      a. Surgical instruments
      b. Catheters
      c. Implants
      d. Needles
   2. *Semi-critical:* Items that come in contact with non-intact skin or mucous membranes, which should be free of micro-organisms, except bacterial spores. The following semi-critical items are cleaned with an EPA "high level disinfectant" with tuberculocidal activity label claim.
      a. Respiratory therapy equipment
      b. Anesthesia equipment
      c. Bronchoscopes, gastrointestinal endoscopes
      d. Thermometers
   3. *Noncritical:* Items that come in contact with intact skin will be cleaned with an EPA "hospital disinfectant" or low-level disinfectant.
      a. Blood pressure cuffs
      b. Crutches
      c. Linens
      d. Tables and furniture

III STERILIZATION (A process that kills all microbial life including bacterial spores)

A. There are four methods of sterilization:
   1. Steam under pressure (steam autoclave)
   2. Dry heat
   3. Chemical vapor under pressure (chemical autoclave)
   4. An EPA-registered "disinfectant/sterilant" that kills spores

B. Items to be sterilized should be cleaned to eliminate all soil before sterilization.
   1. Clean by rinsing under water and scrubbing thoroughly with detergent and water.
   2. An ultrasonic cleaner can also be used.
   3. Rinse and dry the cleaned items, completely.

C. Wrap items in the appropriate packaging material.

D. The manufacturer's written instructions for operating the sterilizer should be followed.
   1. Every sterilized item should have identification.
      a. Date of sterilization
      b. Sterilizer used, if more than one
   2. The time, date, and initials of person performing the task should be documented.
   3. Load weight should be no more than 40 lbs, including the tray that hold the item to be sterilized.
   4. Towels should be placed in between layers of items when stacking more than one item of item to be sterilized.

E. Flash sterilization should be used only in an emergency.
   1. This would include items dropped on the floor.
   2. Instances where there is no other sterilization alternative.
   3. Exposure times/temperature relationships should follow all manufacturers' written instructions.
   4. Implantable items should not be flash sterilized.
   5. A log will be kept of any items sterilized.

F. Items should be transported in a manner to maintain cleanliness and sterility, and to prevent physical damage.

G. Items should be stored in cabinets or on shelves that allow for adequate cleaning, air circulation, distance from vents, sprinklers, and lights.

H. Preventive maintenance of the sterilizers will be performed monthly, following the sterilizer manufacturer's service manual as a reference.

1. The chamber discharge system should be cleaned monthly according to manufacturer's instructions.
2. A maintenance record should be kept for each sterilizer and should include:
   a. Date of service
   b. Model number of sterilizer
   c. Serial number of sterilizer
   d. Description of service performed
   e. Description and quantity of parts replaced
   f. Results of biological testing
   g. Name of person performing service
   h. Signature and title of person acknowledging completed work

I. High-Level Disinfectant/Sterilant
1. Chemical germicides selected for disinfection should be registered with the EPA.
   a. The manufacturer's written instructions should be followed for use.
   b. Items to be disinfected should be thoroughly cleaned, rinsed and as dry as possible, to avoid interference with the disinfecting process or dilution of the disinfectant.
   c. Items with lumens and channels, crevices and jaws should be disassembled before cleaning when the design permits and according to manufacturer's instructions.
      (1) Item(s) should be in contact with an enzymatic cleaner detergent for the recommended exposure time.
   d. Prior to use, items should be aseptically
      (1) removed from the disinfectant,
      (2) rinsed thoroughly with sterile water, and
      (3) dried in a manner that minimizes the risk of contamination.
2. An expiration date, determined according to manufacturer's written recommendations, should be marked on the container of the disinfectant solution currently in use.
3. High-level disinfectant solutions should be kept covered and used in a well-ventilated area.
4. High-level disinfectant contact with skin, mucous membrane and eyes should be avoided.

Reference: "Recommended Practices for Disinfection," and "Steam and Ethylene Oxide (EO) Sterilization" Association of Operating Room Nurses, Standards and Recommended Practices.

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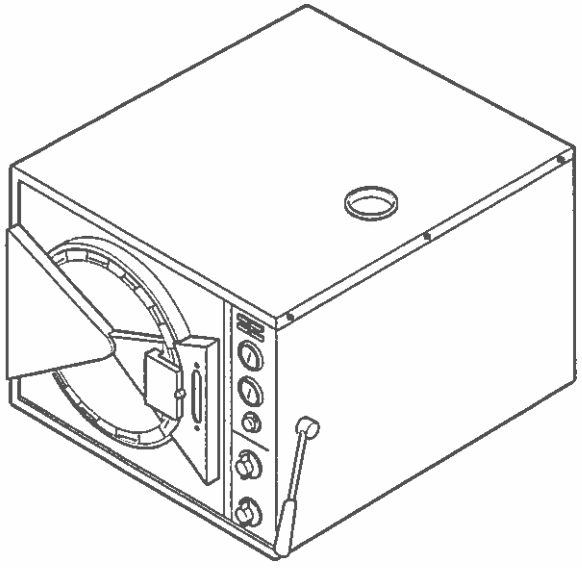
Magna-Clave

Use & Care Manual



Pelton & Crane

Americans United for Life

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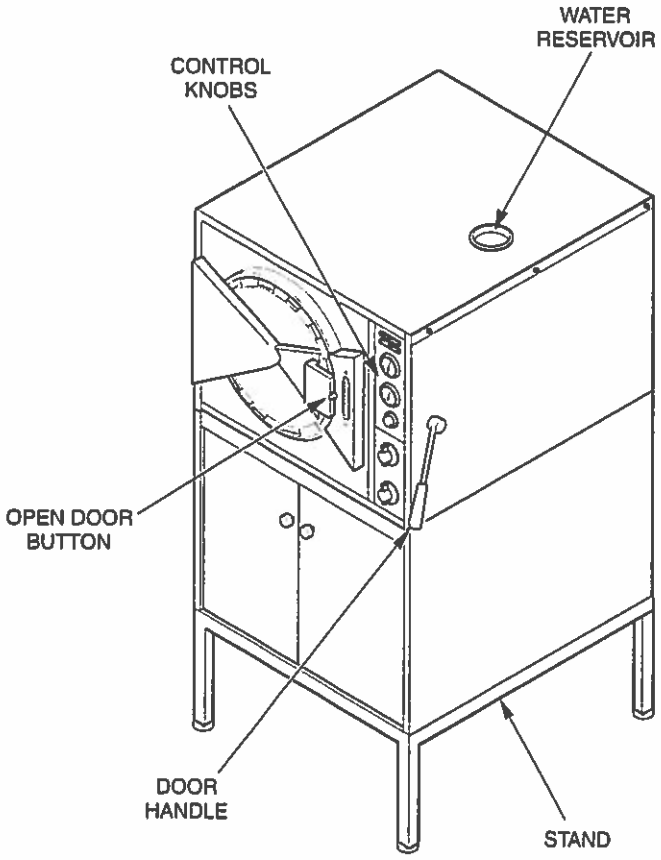


SECTION 1
FAMILIARIZATION

I. SAFETY FEATURES

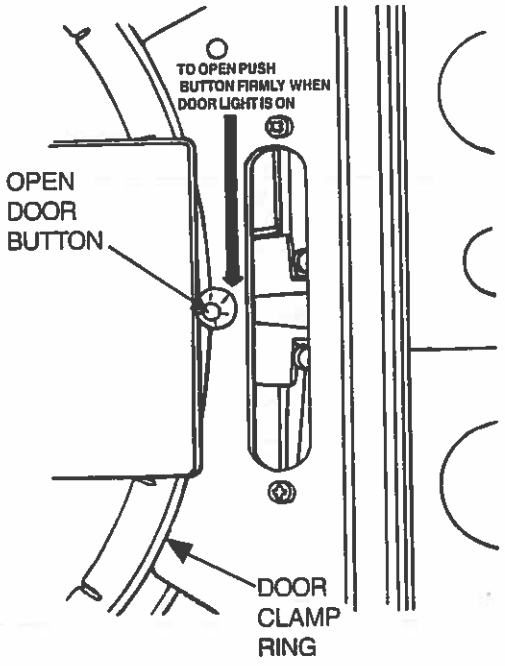
The Magna-Clave design offers several safety features for your protection.

A. Door Clamp Ring

A patented door clamp ring provides maximum safety by locking the entire rim of door. When activated by the door handle, the door clamp ring expands in diameter, allowing the door to open.

B. Open Door Button

The open door button energizes the door interlock solenoid. It must be depressed before moving the door handle up into the open position. The button is operative only when the **Open Door** light is illuminated.



C. Door Handle

When door handle is in down position, the door is locked and the rim is completely sealed. When door handle is in up position, the door clamp ring is expanded. To open door, move door handle to upward position by the following method:

- Ensure that **Power On** light is illuminated
- **Open Door** light must be illuminated
- Depress **Open Door** button

WARNING: Do not attempt to move door handle upward until:

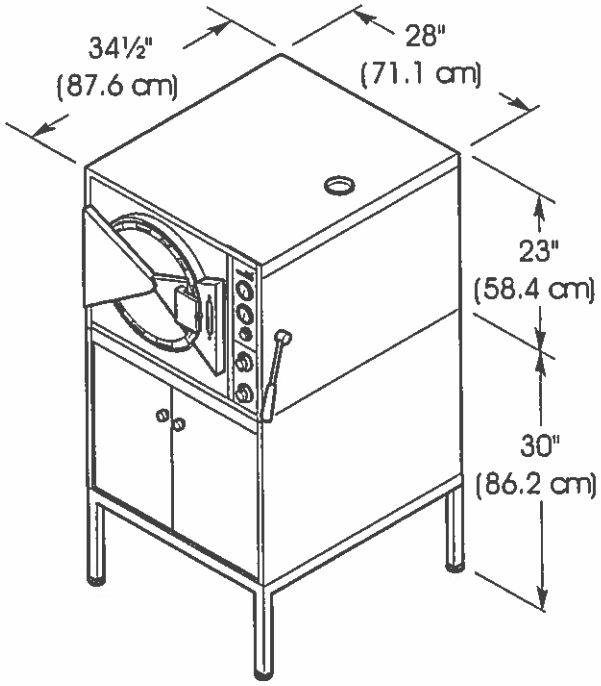
- **Open Door** light is illuminated
- Pressure gauge indicates '0'
- Function is in **Vent** or **Fill** position

D. Relay Control

The relay controls supply power to the main heaters only when proper start up procedures have been followed. It senses when the "Door Open" light is on and power is made available to the main heaters for normal operation.

- **Overheat protector:** If unit trips the overheat protector, the main heater is removed by relay controls and cannot be restored without going through the start-up procedure. This insures when the sterilization cycle is interrupted by an out of water condition or similar failure, the Magnaclave will remain off until the operator restarts the cycle.
- **Main Heater:** The timer activates the relay controls at the end of the cycle. Power is removed from the main heaters and the buzzer notifies the operator that the sterilization cycle is completed. The buzzer will continue to sound until the operator turns unit to vent. With the heater power removed the Magnaclave will start cooling down. For proper drying of the contents, the unit should be vented within 15 minutes of the completion of the cycle.
- **Fail Safe Operation:** In the event of a power failure, the power to the main heaters is removed by the relay control if there is an interruption to the incoming power. The heater will remain off until operator restarts the unit.

SECTION 1
FAMILIARIZATION

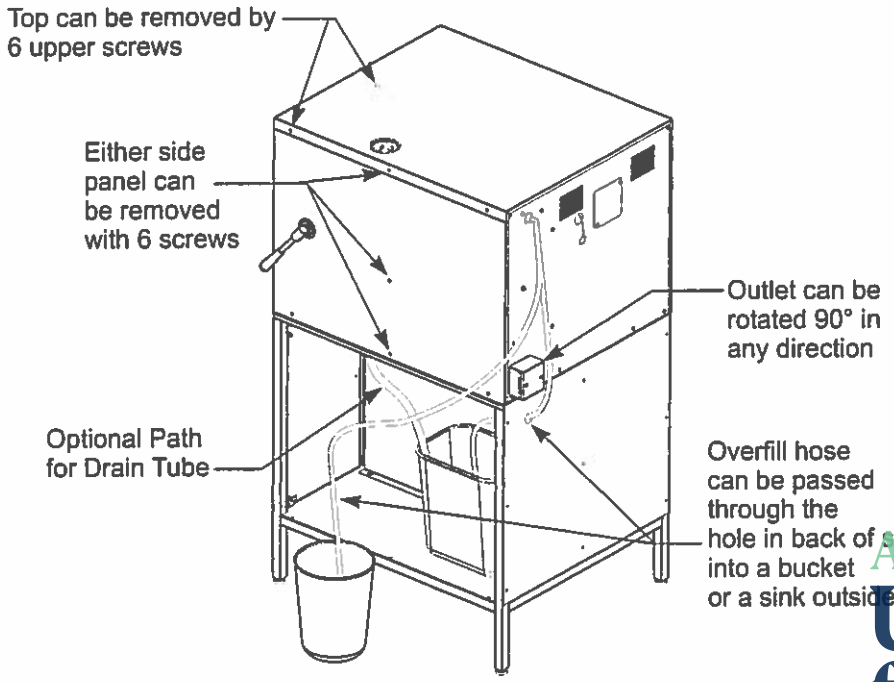


II. PHYSICAL CHARACTERISTICS

Exterior:
The overall dimensions are 28" (71.1 cm) wide X 34 1/2" (87.6 cm) deep X 53" (134.6 cm) high (with stand), 23' (58.4 cm) high (without stand).

Interior:
The overall chamber shall measure 30" (76.2 cm) deep X 16" (40.6 cm) diameter.

Installation Requirements:
A space 46" (116.8 cm) wide X 541/2" (138.4 cm) deep X 65" (165.1 cm) high (with stand), 35" (88.9 cm) high (without stand) should be provided to properly operate and maintain the sterilizer.



III. ELECTRICAL REQUIREMENTS

The Magnaclave is available in 208 VAC at 24 amps or 220/240 Vac, 50 or 60 hz. at 21 amps. This unit must be installed in accordance to your local electrical codes. An outlet box is provided on the back of the unit for the electrical connections and requires a dedicated 30 amp circuit. This unit may be permanently connected to an electrical panel with 30 amp breakers (recommended 10 AWG wire) or by connecting a 30 amp power cord to the outlet box. If the Magnaclave is wired using a 30 amp power cord, the receptacle for the power cord should be accessible. The green wire in the outlet box is for the protective earth ground, care should be taken when wiring the Magnaclave to verify that green ground wire is connected to the electrical system's ground.

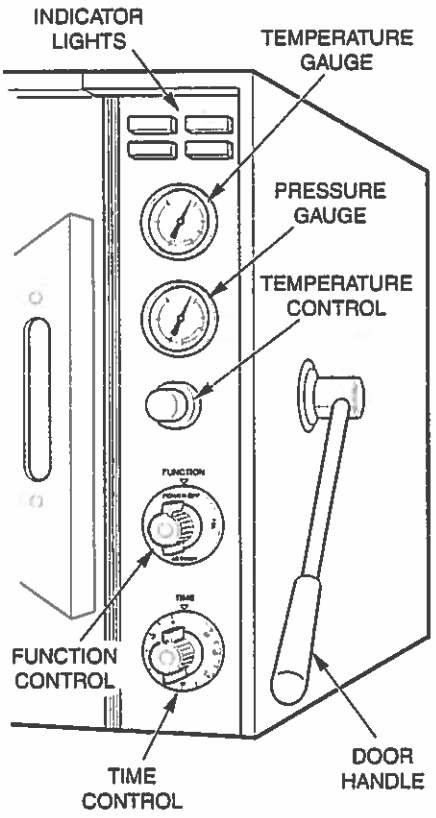
IV. CONTROLS AND INDICATORS

A. Indicator Lights

1. **Power On** - The **Power On** light indicates that electrical power is being supplied to the autoclave. It is illuminated when the **Function** control is in the **Fill, Sterilize** or **Vent** position. When **the Power On** light is illuminated, the wall heaters of the autoclave are energized to maintain a warm, standby condition.
2. **Heat On** - The **Heat On** light indicates that electrical power is being supplied to the main heating elements which generate steam inside the boiler. When the **Function** control is in the **Sterilize** position and the door handle in the down position (door locked), the **Heat** On light will be illuminated and the main heating elements are energized. The light remains illuminated until the steam temperature inside the chamber reaches the setting on the **Temperature** control. The main heating elements will cycle off-and-on to maintain the desired temperature.
3. **Sterile** - The **Sterile** light is illuminated when: the **Function** control is in the **Sterile** position, the desired temperature is reached and the **Time** control indicates "0.' At the beginning of the cycle, the **Time** control should be set at the desired time for sterilization. When the **Time** control turns to "0," the **Sterile** light illuminates and the buzzer or chime sounds to indicate the end of the sterilization cycle.

   *Determined by manufacturing date of unit.
4. **Open Door** - The **Open Door** light is illuminated when the Function control is in the **Vent** or **Fill** position and pressure in the chamber is low enough to allow the door to be safely opened.

CONTROL KNOBS



CAUTION: The door cannot be opened and no attempt should be made to operate the door handle until the **Open Door** button is depressed.

B. Gauges

1. **Temperature Gauge** - The **Temperature** gauge measures the steam temperature in the discharge line from the chamber. It is marked with a green area from 250'F to 270'F to indicate normal sterilizing temperatures.
2. **Pressure Gauge** - The **Pressure** gauge measures pressure within the chamber. It is marked with a green area between 15 and 31 PSI (pounds per square inch).

1. **Temperature Control** - Temperature and pressure inside the chamber are controlled by the Temperature control. It may be set from approximately 240cF to 270"F. Markings on the control indicate approximate settings. For a more precise setting, refer to Section 3.

2. **Function Control** - All operations of the Magna-Clave are controlled by the Function control as follows:

   a. **Power Off** - All power is turned off; door cannot be opened.

   b. **Fill**- Water from reservoir is allowed to enter chamber; wall heating elements are energized.

   c. **Sterilize** - Power is supplied to all heating elements as required; door cannot be opened.

   d. *Vent* - Unused water and steam in chamber are returned to reservoir after sterilizing cycle is complete. The door can be opened when the pressure decreases to a safe level and the Open Door light is illuminated. The wall heaters remain energized. This reduces pressure build up time for successive sterilizing cycles and promotes drying of the sterilized material.

3. **Time Control** - The **Time** control is manually set at the beginning of each sterilizing cycle. Timing begins when the preset temperature is reached and time control counts down to "0.'

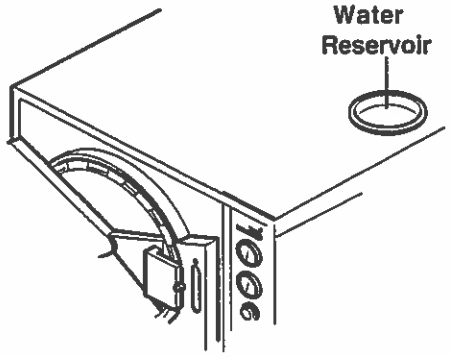
   NOTE: Do not set the time control for an interval of less than five minutes.

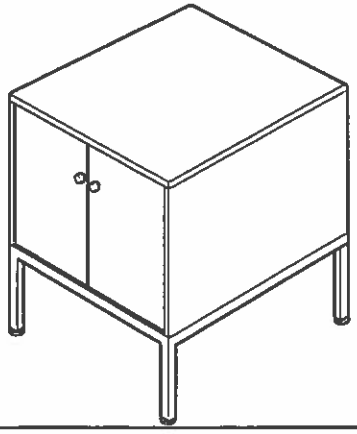
D. Audible Signal

1. Buzzer - When the **Time** control returns to "0", a buzzer will sound to indicate the end of the cycle. The buzzer sounds continuously until the **Function** control is turned to **Vent**. The Time control must be set at the beginning of each sterilizing cycle. If it is not set, the buzzer will indicate end of sterilizing cycle when the preset temperature is reached, and the sterilizing cycle will not be complete. Once buzzer sounds the main heater will turn off.

E. Water Reservoir

1. The water reservoir provides an ample water supply for cooling discharged steam and water. The reservoir should be filled with distilled or demineralized water to prevent corrosion. It should be filled until water appears in bottom of reservoir cup. An overflow tube supplied with the unit, is attached to the backside of the unit. The drain hose attaches to the brass fitting beneath the autoclave to facilitate proper drainage and cleaning. For installation information, refer to 094075, Installation of the Magna-Clave.





F. Stand

1. The Magna-Clave stand provides a convenient storage compartment to house trays or supplies.

SECTION 2
PREPARATIONS FOR STERILIZATION

I HANDLING AND CLEANING OF INSTRUMENTS

NOTE: Instruments must be thoroughly cleaned prior to placement in the sterilizer.

A. Handling

1. Wear heavy rubber gloves while handling instruments. Clean gloved hands with a germicidal cleaner (iodophor surgical scrub). Wash gloved hands well when instruments handling is complete.
2. Transport soiled instruments on a tray to the cleanup area. Protect your hands from contact with soiled instruments to prevent any serious infection.
3. Sort out any nonsurgical devices or other instruments that cannot withstand immersion without rusting. Refer to Table 2—1.

Table 2-1 ITEMS RECOMMENDED FOR STEAM STERILIZATION
• Straight stainless steel instruments
• Surgical stainless steel hinged instruments.
• Air powered instruments made for autoclaving e.g. hand pieces).
• Heat resistant plastic items
• Rubber gloves
• Rubber tubing
• Glass slabs, beakers and stones.
• Gauze

NOTE: The Magnaclave is not designed for sterilizing fluids in containers.

NOTE: Check manufacturer's recommendations for individual items before autoclaving.

B. Cleaning

Items must be completely cleaned before sterilizing. Processing instruments with debris or blood contamination may result in staining and/or damage to instruments or sterilizer.

1. Rinse instruments with hard stream of water immediately after use to remove debris. Handle soiled instruments following procedure outlined in Section 2-1-A.
2. Wash instruments in an ultrasonic cleaner for five to 10 minutes immersed in a fresh solution of detergent and distilled or demineralized water or a germicide solution. Follow manufacturer's recommended procedures. Clean all instruments in an open position.

   NOTE: For best results, use a detergent specifically designed for use in an ultrasonic cleaner with a neutral ph (7).

   (Health Sonics, Pleasanton, CA; L&R, Kearny, NJ, or comparable brand). A Germicide, 2% glutaraldehyde or equivalent may also be used. Be sure to follow manufacturer's instructions for mixing and use. Otherwise, unsatisfactory results and/or damage may occur. Discard and replace ultrasonic cleaning solution daily.
3. After cleaning, rinse instruments very thoroughly for 30 seconds in tap water. Then perform a final rinse with distilled or demineralized water after the 30 second rinse to remove impurities found in most tap water. Inspect instruments to ensure removal of all debris. Repeat cycle as necessary.

   NOTE: To prevent staining, instruments should be rinsed with demineralized (distilled) water and dried. After rinsing in tap water in areas with hard water (water with a high mineral/salt content), dry the instruments. (Drying should not be a substitute for rinsing.) When autoclaving instruments which are not stainless steel, use a corrosion inhibitor pre-dip for two or three minutes. (This may be 2% solution of sodium nitrite in distilled water.) Allow the pre-dip to dry on the instruments without wiping.
4. Follow the recommendations by the instrument manufacturer on the use of lubricating products after instruments have been ultrasonically cleaned.

B. Cleaning

5. With the increasing concern for asepsis, offices are using more disinfectants and instrument soaks. If any of the disinfectants are introduced into the autoclave during the cycle (either directly or by incomplete rinsing after soaks), corrosion of the stainless steel chamber, instruments and trays or baskets may occur. There are several chemicals commonly used as disinfectants which may break down under temperature and pressure to cause corrosion to the stainless steel trays and instruments, even in a properly passivated 304 stainless steel chamber. These chemicals include:

- ➲ Any disinfectant containing Zephiran Chloride (Benzalkonium Chloride), a quaternary ammonium compound. (A number of practices still use quaternary ammonium com pounds, although this is no longer recommended by professional organizations.)
- ➲ Any Amine based disinfectant containing quaternary amine hydrochlorides.
- ➲ Any disinfectants containing sulfite products.
- ➲ Any disinfectants containing phenolic products. Some disinfectants commonly used in practices containing phenols are:
- ➲ Any disinfectants containing active hydrogen halide group.
- ➲ Sporicidin@, Lysol@, and Omni II@.

II. SPECIAL PREPARATION GUIDE FOR CARBON STEEL INSTRUMENTS

A. Handling

1. Handle and thoroughly clean instruments as outlined above. (Refer to Section 2-1.)

B. Cleaning

1. Prepare a 2% solution of sodium nitrite (one tablespoon per quart of water). Immerse instruments in the solution and allow them to remain for three minutes.

C. Sterilization Preparation

1. Remove instruments and prepare for sterilization. (Refer to Section 2-III.) Do not rinse or wipe instruments prior to sterilization.

NOTE: Do not place carbon steel instruments directly on the MagnaClave's stainless steel tray. Before placing instruments on the tray, line the tray with a towel or paper wrap.

D. Instrument Wrapping

1. Instruments which will be wrapped for sterilization should be packaged in a material which promotes drying.

   NOTE: Instruments in packages may not dry well and may require use of an atmosphere reducer (Vapor Phase, Lorvic Corporation, St. Louis, MO,) for best drying results.

III. TRAY PREPARATION AND LOADING

A. General Guidelines for Tray Preparations

- An internal process indicator strip should be included with each sterilizer load to verify gross heat penetration.
- A biological spore test indicator should be used weekly in a representative sterilizer load for sterilization assurance.
- Date packages and re-sterilize after one month, or according to packaging manufacturers' specifications.
- Sterilization indicators/monitors should be placed in the front bottom area of the sterilizer.
- DO NOT mix or cause contact of dissimilar metals (i.e. metals such as carbon steel and stainless steel) during sterilization or storage.
- Make sure that all instruments are sterilized in an open position. (Refer to AORN guidelines.)
- Place all sharps (scissors, knives, skin hooks) so they do not touch during autoclaving. Cotton or gauze may be used to isolate and protect the sharp edges and the smaller instruments.
- Do not place metal instruments, other than stainless steel, directly on stainless steel autoclave trays. The trays should be lined with thin cloth or paper liners.
- Any item which might hold water should be placed so the water will drain out.
- Use small packs to separate larger ones. See instructions for preparing wrapped trays.
- Never stack trays on top of one another. At least one inch should separate trays.
- Wrapped trays and packs must not touch the sides of the sterilizer.
- Do not overload trays. Overloading may cause sterilization failure.

SECTION 2
PREPARATIONS FOR STERILIZATION

B. Unwrapped Trays

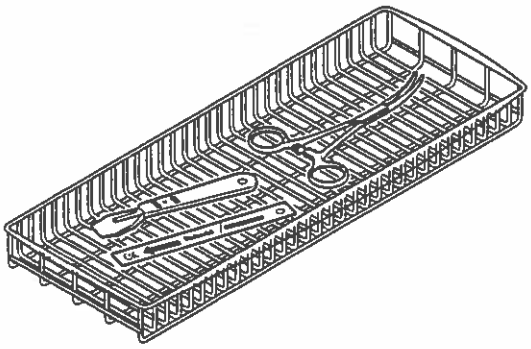
These trays are prepared for sterilization of nonsurgical instruments and canisters to prevent transmitting infectious disease. Always include a process or spore test indicator with every sterilizer load.

1. Loose Instruments

a. Distribute a single layer of instruments in the bottom of a perforated tray. Instruments made of metal other than stainless steel should not contact the stainless steel autoclave tray. A very thin liner of paper or cloth should be used for separation. Provide adequate space between instruments for steam circulation. Do not overload. Be sure to include a process or spore test indicator.

b. Place tray on rack in sterilizer.
NOTE: If multiple layers of instruments are to be separated by fabric, see instructions for preparing wrapped trays.

c. Refer to Section 3 for operating instructions.



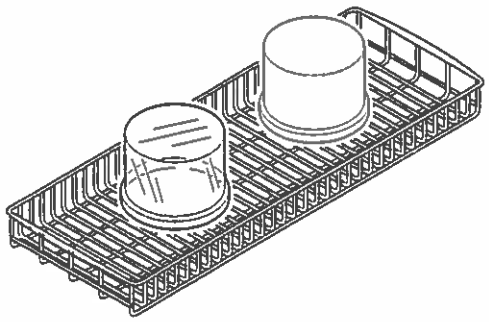
2. Open Metal or Glass Canisters

a. Place open metal and glass canisters on a perforated tray. Tilt canisters down for adequate steam penetration. Be sure to include a process or spore test indicator.

b. Place tray on rack in sterilizer. Do not overload or inadequate sterilization and drying may result.

c. Make sure containers are placed so they will drain and dry adequately.

d. See Section 3 for operating instructions.



3. Rubber Tubing

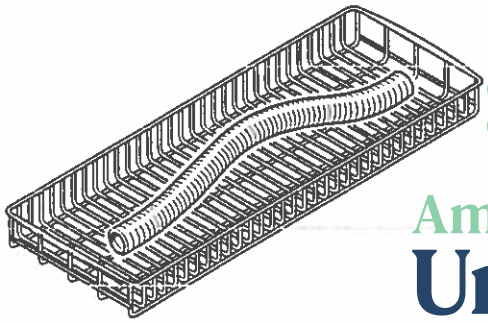
a. Clean tubing thoroughly.

b. Rinse with pyrogen free water leave wet. Leave both ends open. Coil and wrap without kinks or sharp bends.

c. Place tubing on an autoclave tray. Be sure to include a process or spore test indicator.

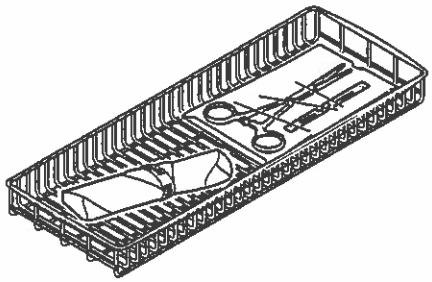
d. Place tray on rack in sterilizer. Do not overload or inadequate sterilization and drying will result.
CAUTION: Tubing which will come in contact with a surgical wound should be prepared as outlined above, and wrapped to maintain sterility.

e. Refer to Section 3 for operating instructions.



C. Wrapped Trays and Instruments

There are several ways to prepare wrapped trays. Refer to Table 2-2 for acceptable wrapping materials.



a. Individually wrap instruments, which have been cleaned according to Section 2-1, in autoclave bags or paper (3M, St. Paul, MN; Propper, Long Island City, NY). Do not tightly roll instruments in paper.

b. Seal with autoclave tape or heat sealer (3M, St. Paul, MN; Propper, Long Island City, NY).

CAUTION: Do not use staples, pins or other devices which will puncture the packaging material. Otherwise, sterility may be compromised.

c. Place individually wrapped instruments on perforated trays. Provide adequate space between instruments for steam circulation.

CAUTION: Do not overload trays or inadequate sterilization may result.

d. Include a process or spore test indicator. Place the indicator inside an individually wrapped instrument which will be placed in the front of the bottom tray.

e. Place trays on the rack in the sterilizer. Provide adequate space between trays to allow steam circulation.

f. Refer to Section 3 for operating instructions.

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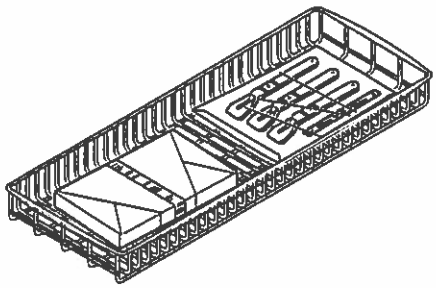
2. Wrapped Instruments



a. Collect a group of similar instruments which have been cleaned according to Section 2-1.

or

Collect instruments used for a particular procedure (i.e. amalgam, exam, etc.) which have been cleaned according to Section 2-1. Do not mix dissimilar metals.

b. Place instruments in autoclave bag (3M, St. Paul, MN; Propper, Long Island City, NY).

or

Loosely wrap instruments in two to four layers of muslin towels or autoclave paper (3M, St. Paul, MN; Propper, Long Island City, NY).

CAUTION: Do not wrap instruments too tightly. Inadequate sterilization may result from improper wrapping or placing too many instruments per package. (If a large number of instruments per package are desired, refer to Section 2-II-D for PACKS).

c. Place a process or spore test indicator inside a representative bag.

d. Seal with autoclave tape (3M, St. Paul, MN; Propper, Long Island City, NY) or heat sealer.

CAUTION: Do not use staples, pins or other devices which will puncture the packaging material. Otherwise, sterility may be compromised.

e. Place packages on perforated trays. Ensure adequate space between packages to allow steam circulation.

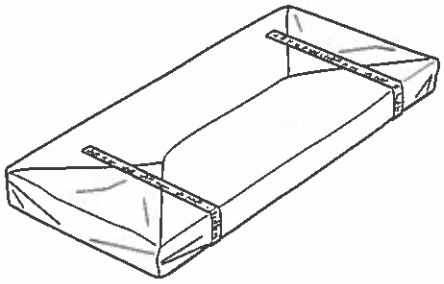
NOTE: Place the package containing the sterilization monitor in the front of the bottom tray.

f. Load tray in the rack in the sterilizer. Ensure adequate space between packages to allow steam circulation.

CAUTION: Do not overload or inadequate sterilization may result.

g. Refer to Section 3 for operating instructions.

3. **Wrapped Trays**
   a. Place instruments, cleaned according to Section 2-I, in a perforated tray. Allow adequate space between instruments for steam circulation.
   b. Place a process or spore test indicator in at least one tray to be cycled.
   c. Wrap the tray in two to four layers of towels or other wrapping material. (Refer to Table 2-2.) Close using autoclave tape.
   d. Place wrapped trays on the rack in the sterilizer. Ensure that the wrapping does not touch the sides of the chamber. Allow adequate space between trays for steam circulation.



NOTE: Place the tray containing the sterilization monitor in the bottom of the sterilizer.

CAUTION: Do not overload or inadequate sterilization may result.

   e. Refer to Section 3 for operating instructions.

D. Packs

Packs are for sterilizing surgical instruments, gloves and textiles.

1. **Instruments and textiles**
   a. Clean instruments according to Section 2-I. Textiles should be laundered prior to sterilization.

      NOTE: Do not use high chlorine or phosphate content detergents chlorine bleach in laundering items prior to sterilization. Staining of the autoclave and instruments or more severe damage may result. The use of chlorides may also result in cracks in the chamber.
   b. Loosely package instruments with not more than 10 per pack. Instruments of the same type which are nested should be separated by a layer of absorbent towels and placed so that water will run out. Loosely roll or fold textiles.

      CAUTION: Density should not exceed 1/2 the capacity of the pack and the packs should not exceed 1/2 the capacity of the tray. Otherwise inadequate sterilization could result.

      Or

      Wrap properly cleaned articles in two to four layers of muslin towels or other packaging material. (Refer to Table 2-2.)
   c. Place a process or spore test indicator inside a representative pack.
   d. Seal with autoclave tape or heat sealer (3M, St. Paul, MN; Propper, Long Island City, NY).

      CAUTION: Do not use staples, pins or other devices that could puncture packaging material. Otherwise sterility could be compromised.
   e. Place packs on perforated trays. Leave adequate space between packs to allow steam to circulate. Load packs upright, side-by-side on the tray. Do not stack.

      CAUTION: Adequate drying will not occur unless space is left between packs. Metal and glass containers should not be used to separate packs as these will inhibit drying. Packs should not exceed 1/2 the capacity of the tray. Otherwise, sterilization could be compromised.
   f. Load trays onto the racks in the sterilizer. Ensure that packs do not touch the sides of the chamber. Allow adequate space between trays for steam circulation. If packs are large, some trays may be omitted to allow more clearance.

      CAUTION: Do not overload or inadequate sterilization may result.
   g. Place pack containing sterilization monitor in the bottom front of the sterilizer.
   h. Refer to Section 3 for operating instructions.

2. Surgical gloves

NOTE: Disposable gloves should not be sterilized.

a. Clean and dry gloves.
b. Place a square of muslin or other absorbent towel into the glove up to the finger.
c. Place a strip of muslin or other absorbent towel around the cuff and fold it back.
d. Place a process or spore test indicator one glove. Wrap gloves in muslin or other packaging material. (Refer to Table 2-2.)
e. Place wrapped packs of gloves on end in a perforated tray. Leave space between packs to allow steam to circulate.
f. Load trays onto rack in the sterilizer. Leave adequate space between trays for steam circulation. Ensure that packs do not touch sides of chamber.

   CAUTION: Do not overload. Do not seal container. Inadequate sterilization may result.
g. Place pack containing sterilization monitor in the front bottom of the sterilizer.
h. Refer to Section 3 for operating instructions.

Table 2-2 WRAPPING MATERIALS FOR STEAM STERILIZATION

SUITABLE	UNSUITABLE
Muslin 2 (layers) Nylon bagging material Kraft paper Commercial autoclave paper (must be as permeable as muslin) Plastic and paper bags (must be permeable)	Canvas Aluminum foil Steam impermeable plastics Sealed tubes, jars and cannisters Drums not recommended

Table 2-3 RECOMMENDED PERIODS OF EXPOSURE

Material to be Sterilized VS. Time in Minutes	KPa	103	138	172
	PSI	15	20	25
	F°	250	260	267
	C°	121	127	131
Fabrics - Loosely woven - Wrapped in muslin		30	20	-
Fabrics - Tightly woven		40	30	-
Instruments - In tray - Muslin cover		15	10	3
Instruments - Individually wrapped in muslin		30	15	10
Syringes and Needles		15	10	7
Drums - Loosely woven contents		30	20	-
Drums - Tightly woven contents		40	30	-
Utensils - Loosely woven contents		30	20	10
Rubber - In muslin packs Gloves		15	-	-
Rubber Covers - In muslin packs		15	-	-
Brushes and Miscellaneous Articles				
Wrapped -		15	-	

SECTION 3
OPERATIONS

WARNING: Failure to operate or maintain the Magnaclave in accordance to these instructions may impair the protection provided by the Magnaclave.

WARNING: Do not attempt to bypass any of the safety interlock systems described below. Failure to do so could result in personal injury.

I. GENERAL

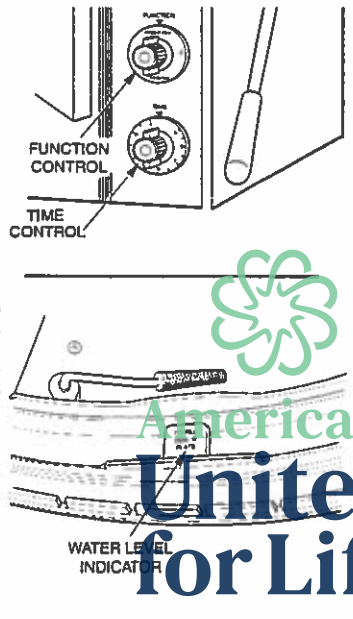
A. When the **Function** control is in the **Power** Off position, all electrical power is off and the door cannot be operated. An additional safety interlock is included to prevent the door from being opened when there is an unsafe level of pressure in the chamber. Another interlock prevents the main heaters from becoming energized to generate steam unless the door is fully locked. The **Open Door** light will illuminate when it is safe to open the autoclave door. When the **Function** control is in the **Fill** position, water flows from the reservoir into the chamber. When the water level indicator in the chamber is covered, the **Function** control should be turned to **Sterilize** to stop the flow of water. To generate steam, the door must be closed and locked. The **Time** control should be set at the beginning of the sterilizing cycle. Timing will begin when the preset temperature has been reached, and will continue until the **Time** control returns to **"0."**

B. When the sterilizing procedure is complete, the **Sterile** light will illuminate and the chime will sound. When the buzzer sounds, turn the **Function** control to **Vent** to cut off the **Sterile** light and the buzzer. Steam and unused water will then be returned to the reservoir from the chamber and pressure inside the chamber will be reduced to near zero. When the chamber pressure reaches a safe level, the **Open Door light** will become illuminated.
WARNING: Never attempt to open door unless open door light is illuminated and pressure gauge indicates "0."
To aid in absorbing moisture, the door can now be slightly opened. The chamber heaters will remain energized. Leave materials inside the chamber until dry. Drying time is determined by the size of the material and manner in which it was packed. Drying times have not been established due to varying conditions. When the **Function** control is left in the **Vent** position, the Magna-Clave will remain in a warm, standby condition.

II. OPERATING PROCEDURES FOR NORMAL STERILIZATION

WARNING: Burns and bodily injury can result from improper use of this autoclave. If any malfunction is suspected, set the function knob to vent. Remove power from the unit and contact a qualified service technician.

WARNING: Do not attempt to open door unless function knob is in "FILL" or "Vent" and the "Open Door" light is on. If the cycle was aborted, allow unit to set 10 minutes after the "Open Door" light comes on before opening the door.



A. Unlock door

Turn **Function** control to **Vent** or **Fill.** Depress and hold **Open Door button** on front of Magna-Clave and lift door locking handle on right side of unit.

B. Fill

Turn **Function** control to **Fill.** When water in chamber covers water level indicator, rotate **Function** control to **Sterilize.** *Note: Ensure water level indicator is completely submerged in water.*

C. Load

Load chamber. Refer to Section 2-III.

SECTION 3
OPERATIONS

D. Lock Door

Close door and push down the door locking handle on the right side of the Magna-Clave.

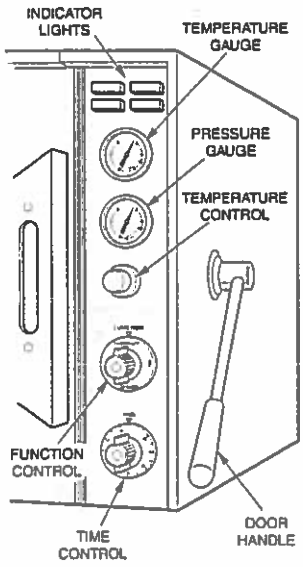
E. Set Time Control

Rotate **Time** control clockwise to desired sterilizing time. The **Time** control will start when the preset temperature is reached.

NOTE: If Time control is not set at the beginning of the sterilizing cycle, the buzzer will sound and the ***Sterile*** *light will illuminate as soon as the preset temperature is reached.*

F. Set Temperature

Turn **Temperature** control to the desired temperature. When a more precise setting is desired, turn **Temperature** control fully clockwise. When temperature gauge reaches desired temperature, rotate **Temperature** control slowly counterclockwise until the **Heat-On** light goes off. Once the control is set, it is not necessary to move it unless a change in sterilizing temperature is desired.



CAUTION: Unit should be periodically monitored during sterilization to ensure temperature gauge is climbing until the preset temperature is obtained. Once the temperature gauge reaches approximately 220° F, the pressure gauge should start climbing. If pressure fails to increase within 30 minutes, turn function control to vent and recheck water level. Ensure water is to the water indicator. The pressure rising may vary due to line voltage or unit load.

Monitor unit according to the time indicated below:
(Rising pressure may vary due to line voltage or unit load.)

15 Minutes: Unit should be monitored to determine the unit is heating by observing temperature gauge.

30 Minutes: Both temperature and pressure gauges should be obtaining temperature and pressure. Unit should read preset temperature and corresponding pressure.

NOTE: If unit is not building pressure but temperature is climbing, turn unit off. Turn Function control to vent and check water level.

G. Vent

After the buzzer sounds and **Sterile light** illuminates, turn the **Function** control to **Vent.**

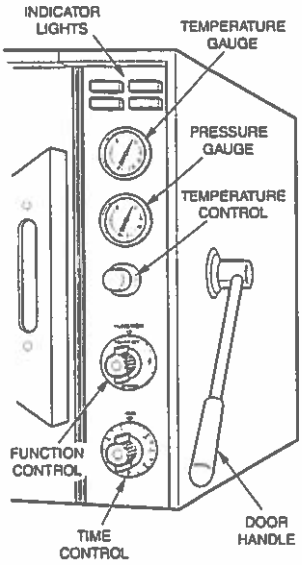
H. Unlock Door

After ensuring that the **Open Door** light is illuminated and that the pressure gauge indicates "0," lift door locking handle while depressing **Open Door** button on front of Magna-Clave.

I. Drying: After unlocking door, allow door to stand partially open with **Function** control still in the **Vent** position.

SECTION 3
OPERATIONS

IV. OPERATING GUIDELINES



A. The Magna-Clave may be preheated by turning the **Function** control to **Vent** 30 minutes before the autoclave is needed. This will allow for a faster desired sterilizing temperature.

B. Water should only be added to the reservoir when the Function control is in the **Vent** or **Power Off** position. Demineralized or distilled water must always be used to prevent corrosion. The minimum water level should always reach the level indicating mark on the back of reservoir.

C. Do not attempt to turn the Function control from **Sterilize** to **Fill** or from **Vent** to **Sterilize**. There are mechanical stops which prevent the **Function** control from being turned in this manner.

D. Improper sterilization may result if chamber is overloaded or too crowded.

E. The **Time** control must be set at the beginning of each cycle to the desired sterilizing time. If the **Time** control is not properly set, the buzzer or chime will sound and the **Sterile** light will illuminate. This indicates the end of the sterilizing cycle, and will not allow completion of the cycle.

*NOTE: Do not set the **Time** control for an interval of less than five minutes.*

SECTION 3
CARE AND MAINTENANCE

1. PREVENTIVE MAINTENANCE SCHEDULE

CHECK	FREQUENCY	PROCEDURE	ACTION
Clean and inspect chamber	Weekly	12 oz.. Omni-Cleaner to I gallon distilled water on 20 minute cycle.	See Sections 4-II and 4-IV. Call authorized service representative cracks or fissures are found. Do not operate unit.
Safety valve ring **WARNING: When ring is pulled on safety valve with unit under pressure steam is discharged from the chamber at a high temperature. Keep clear of steam discharge path to avoid burns. Use of a hot pad or instrument to pull ring is suggested.**	Every 3 months	Manually pull ring on back of the unit while chamber is under pressure.	If valve does not open, turn off POWER and call for service representative.
Door gasket	Weekly	Inspect and clean using Omni-Cleaner or mild detergent and distilled water. Check for leaks (have leaking gasket replaced).	Call authorized service representative for replacement gaskets.
Chamber fill filter	Weekly	Inspect and clean.	See Section 4-II.
Door interlock	Weekly	Inspect. See Section 4-II.	Call authorized service representative for improper closure or signs of wear.
Boiler ring	Weekly	Inspect and clean using nonchlorinated pad which contains no metal.	

SECTION 3
CARE AND MAINTENANCE

II. CLEANING

It is highly recommended that the autoclave be cleaned a minimum of once a week with Omni-Cleaner (Part No. WZI-091295) and distilled or demineralized water. The Omni-Cleaner is a mildly alkaline concentrate used to clean and descale autoclaves. Minerals, especially chlorides, are corrosive to stainless steel. Therefore, tap water with a high mineral content should not be used. When sterilizing saline solutions, it is **imperative** that the autoclave be cleaned **after** each **use.** With proper cleaning, the autoclave will provide higher performance and longer life.

A. Cleaning Procedures

1. Mix 12 ounces of Omni-Cleaner in one gallon of distilled, demineralized water.
2. Drain water from reservoir. Refill reservoir with a solution of Omni-Cleaner and water. (The reservoir will not be full. However, the level will be adequate.)
3. Run one- 20 minute sterilizing cycle to remove all grease and grime from the system. If the autoclave is extremely dirty, it may require a second cleaning. Do not sterilize instruments while cleaning the autoclave.
4. Drain cleaning solution from reservoir and chamber. Rinse thoroughly with clean, mineral-free water, and run a rinse cycle for fifteen minutes.
5. Drain rinse solution and wipe inside of boiler thoroughly. If scale or lime deposits remain on inside of chamber, ensure that autoclave is cool. Then clean with water, plastic or nylon scouring pads and a nonchlorinated detergent.

   NOTE: Detergents containing chlorine are corrosive to stainless steel and should not be used. Do not use ordinary steel wool or steel brushes on stainless steel. Pads containing metal may damage chamber.
6. Refill reservoir with clean, mineral-free water. The Magna-Clave is now ready for use.

B. Draining Reservoir

1. The reservoir drain hose is located inside the right-hand door of stand, near the top. For Magna-Claves which do not have a stand, the hose will be located under the front edge and to the left of the unit. The drain hose may be drained by removing it from its clip and unscrewing the tip end. The hose should be drained into a 10 quart capacity container. When the reservoir is completely drained, replace tip and clip drain hose in place.

C. Cleaning Fill Filter

1. Pull out fill tube and filter assembly from inside of chamber and clean filter with a stiff brush and nonchlorinated detergent.
2. Replace fill tube and filter assembly. Make sure filter is flat against bottom of chamber. If the filter does not lie flat against bottom of chamber, an excessive amount of water will remain in the chamber after the sterilizing cycles. Failure to clean this filter regularly will result in excessive time to fill and vent chamber.

D. Cleaning

1. Clean all exterior surfaces with mild detergent and water using a sponge or cloth.
2. Exterior surfaces may be disinfected using an iodophor (Biocide, Biotrol, Inc., N. Salt Lake City, Utah, or equivalent), glutaraldehyde (Cidex, Surgicos, Dallas, Texas, or equivalent) or sodium hypochlorite (household bleach diluted 1:10-1:100. Be sure to follow manufacturer's instructions for mixing and use. Otherwise, unsatisfactory results and/or damage may occur. Do not use household bleach on interior stainless steel surface.

SECTION 3
CARE AND MAINTENANCE

III. STERILIZATION ASSURANCE

A. Clinical Record Keeping

Validate daily and weekly records to assure and substantiate sterilization procedures.

B. Techniques for sterilization assurance:

1. Use dated color change indicator closure tapes (3M, St. Paul, @; Propper, Long Island City, NY) on all packs, or use bags with process indicators.
2. Use internal process indicator strips inside all sterilizer loads to verify gross heat penetration.
3. Use a biological spore test indicator (Attest® Biological Monitoring System, 3M, St. Paul, MN; Propper, Long Island City, NY,) inside a representative sterilizer load weekly.3. Use a biological spore test indicator (Attest® Biological Monitoring System, 3M, St. Paul, MN; Propper, Long Island City, NY,) inside a representative sterilizer load weekly.
4. Follow manufacturer's instructions for using all test materials and maintaining good clinical records. Contact dealer to obtain biological test indicators that meet AAMI standards.
5. Follow Preventive Maintenance schedule (Section 4-I,) to ensure proper operation of the autoclave.

IV. OPTIONAL ACCESSORIES

A. Trays

A basket tray and shallow flat tray are standard equipment. A bedpan tray is available as an option.

B. Temperature Recorder

A recording thermometer which provides a permanent record of the steam temperature may be factory or field installed. The steam temperature is recorded on a circular chart for a 24 hour period.

V. INSPECTIONS

A. General

1. The Magna-Clave is a pressure vessel that falls under various state and/or local laws which differ in inspection requirements. Some laws require complete periodic inspection of a pressure vessel. The inspection period varies according to individual laws. This inspection is usually performed by a qualified inspector commissioned by the National Board of Boilers and Pressure Vessels. Insurance companies may also require a similar type of inspection. The governmental agency in your area and/or your insurance company will determine the inspection requirements for your Magna-Clave.
2. For additional information concerning the Magna-Clave, contact Pelton & Crane, P.O. Box 241147, Charlotte NC, 28224 or your full service dealer. When ordering service or parts, always include the serial number of your unit.

B. Inspecting the Chamber

1. **Inside Chamber Inspection**

   Make a thorough inspection inside the chamber every six months. If cracks or fissures are found, call a qualified service technician. **Do not operate a unit with cracks in the chamber.**

   WARNING: Do not perform the following test with any pressure in the chamber.

C. Door Interlock Check

1. With the unit cold, open door and push down on door locking handle.
2. Rotate **Function** control counterclockwise to **Sterilize.**
3. Depress and hold **Open Door** button and pull up on door locking handle as if to open door. **Do not force door handle.** Use no more force than it takes to open the door normally.
4. If door locking handle can be pulled all the way up and the clamp ring expanded, turn the **Function** control to **Power Off** and call a qualified service technician immediately. **Never operate a Magna-Clave in this condition.**
5. If door locking ring cannot be opened, rotate the **Function** control to **Vent,** depress **Open Door** button, lift door locking handle up, and open door locking ring. The Magna-Clave is now ready for use again.

VI. PRODUCT DISPOSAL

Contact your local authorized dealer for proper disposal of the device to ensure compliance with your local environmental regulations.

GLOSSARY

Asepsis:	Freedom from infective microorganisms.
Autoclave:	A container for sterilizing by steam under pressure.
Bioburden:	The level of organisms on a particular item at a specific time.
Biological Monitor or Spore Test:	A preparation of resistant microorganisms which is used to verify sterilization. Usually requires incubation which may be performed by an independent laboratory.
Cold Sterilant:	An agent which sterilizes at room temperature. Usually a chemical such as glutaraldehyde.
Corrosion Inhibitor:	A chemical substance which, when used in small amounts, effectively reduces the corrosion rate of metals such as carbon steel.
Disinfection:	Destruction of bacteria.
Pathogen:	Any microorganism or virus that can cause disease.
Process Monitor:	Am indicator which is sensitive to at least one sterilization parameter. Useful to indicate sterilization bypass but does NOT indicate sterilization. Examples: autoclave tape, heat-sensitive bag markings, heat sensitive marked strips, fusible glass melting pellets.
Sanitize:	To make an item surgically clean but not necessarily Sterile. Usually accomplished using a low-level disinfectant.
Septic:	Unsterile. Infection caused by introduction of pathogenic microorganisms.
Spores:	The reproductive cell of some microorganisms which is highly resistant.
Sterilization:	Total destruction of all microbial life including bacteria, viruses and spores.
Ultrasound:	A type of cleaner which uses ultrasonic waves at high frequency to agitate contaminants and dirt from items.
Vegetative Bacteria:	A freely multiplying form of bacteria.

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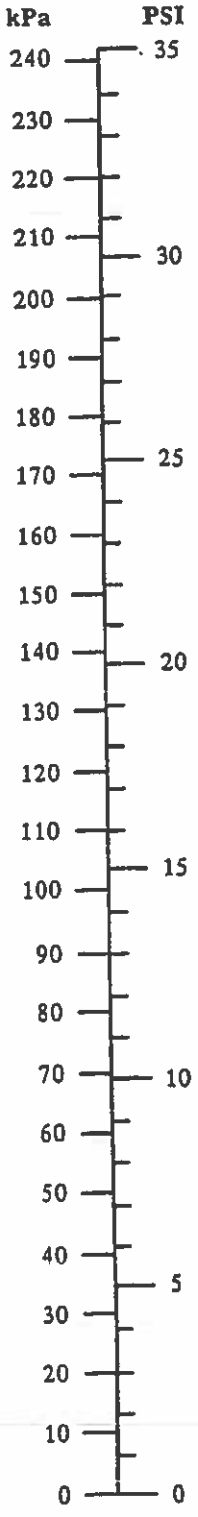
AUTOCLAVE CONVERSION SCALE

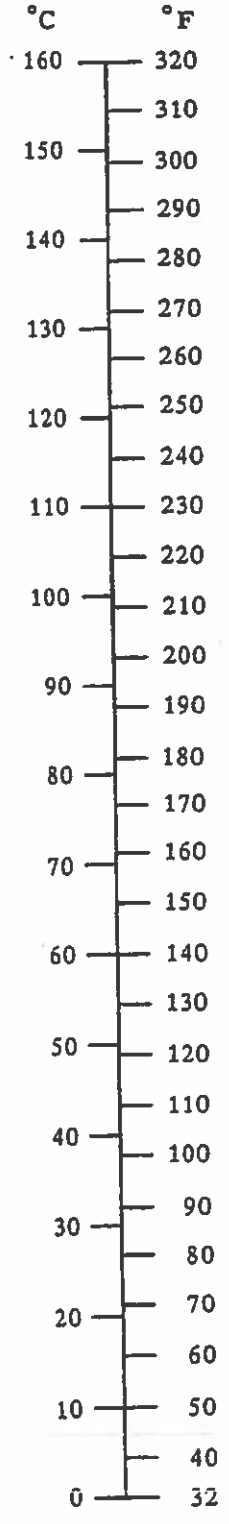
PRESSURE



1 PSI = 6.89 kPa

1 kPa = 0.145 PSI

TEMPERATURE



°C = 5/9 (°F−32°)

°F = (9/5 X °C) + 32°

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NOTES

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We reserve the right to make any alterations which may be due to any technical improvements.

Pelton & Crane
PO Box 7800
Charlotte, NC 28241-7800
USA

Order No. 0940160
Rev. 14, 08/06

Printed in USA

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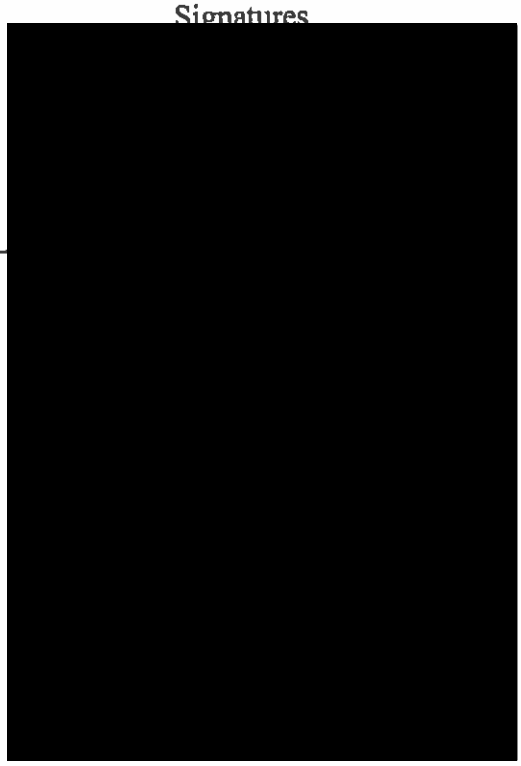
Western-Diversey Surgical Center
2744 N. Western Ave., Chicago, IL 60647

In-Service Sign in Sheet

Date: November 07, 2015

In-Service Title: Sterilization and Disinfection Guidelines; Recommended Practices on Use of MagnaClave.

Preceptor: A. Sabater, RN, BSN

Attendees Name Printed Name	Signatures
1. Marie Frukacz	
2. Andriy Khlopas, RN	
3. Sofia Demas	
4. Mariela Escorpito	
5. Alejandra Perez	
6. Andrei Martiniv	
7. Magaly Napoles	
8. Kim Lee White	
9. Emily Rivera	
10.	
11.	
12.	
13.	
14.	

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ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

AMBULATORY SURGICAL CENTER

NAME AND ADDRESS OF FACILITY: Western Diverse y Surgical Center, 2744 N. Western Ave., Chicago, IL 60647

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.410 (b) Equipment (Continued)	B. Based on document review and interview, it was determined for 13 of 13 weeks in July, August, and September 2015 (7/1/15 through 9/24/15), the Facility failed to ensure weekly biological indicator tests were completed and properly documented, potentially affecting over 100 patients having surgery each month. Findings include: 1. On 9/24/15 at 12:00 PM, the Magna-Clave Operator's Manual was reviewed. The Manual required, "III. Tray Preparation and Loading. A. General guidelines for tray preparation… A biological spore test indicator should be used weekly in a representative sterilizer load for sterilization assurance." 2. On 9/24/15 at 12:10 PM, a policy titled, "Sterilizer Monitoring", effective 3/16/09, was reviewed. The policy required, "II Procedures. A. Spore testing will be conducted on a weekly basis… The indicator in the results test should be negative; the control test should be positive…" 3. On 9/24/15 at 11:40 AM, the biological indicator log was reviewed for 2015. There was no documentation biological spore tests were performed during the past 5 weeks (Aug. 26, Sept. 2, 9, 16, & 23) 4. The log dated 7/1/15 through 8/19/15, included the wrong results (negative) for the control sample. 5. The log dated 7/1/15 through 8/19/15, did not include any results for the tested spore sample. 6. On 9/24/15 at 1:10 PM an interview was conducted with a Registered Nurse (E#2). E#2 stated the control results should be positive, there were no test results recorded in Sept… …he had not been completed since 8/19/15.	Section 205.410 B. 1,2, 3, 4, 5, 6 Policy and Procedure were reviewed with the staff on Sterilizer Monitoring, (see attached in-service/review of policy on Sterilizer Monitoring), Spore testing procedure was clarified with the staff and form was revised to clearly indicate procedure in performance of spore testing(see attached revised form). The said changes will be reported monthly to the consulting commitee, a quraterly review of the monitoring process will also be done every quarter a reported to the consulting commitee. M. Fricakz will be responsible in overseeing monitoring and performance process is implemeted. Done Nov. 09, 2015	Nov. 09, 2015

DATE OF SURVEY 9/24/15 BY 19843 (Surveyor) _____ (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

I POLICY

It is the policy of Western-Diversey Surgical Center to monitor the efficacy of the sterilizing process to insure the sterility of instruments, and to maintain a documented monitoring control system to meet national guidelines.

II PROCEDURES

A. Spore testing will be conducted weekly and on every load for implantable.

1. Biological indicators are placed in a test pack representative of the load.
2. When removed, the vial (result test) is placed in a biological spore testing machine with a biological indicator vial (control test) that has not been placed in the sterilizer.
3. After the appropriate time has elapsed (24 to 48 hours), read the result. The indicator in the result test should be negative (-); the control test should be positive (+).
4. Record the result of the test on the spore test log, and sign as confirmation of physical parameters being attained.

B. If the result of the spore test from the vial is positive, the sterilizer is not used, and the result is reported to the Surgical Coordinator.

1. The Surgical Coordinator will perform a second test. If the second test is positive, the sterilizer is repaired and not used until all tests are negative.
2. All instruments are packages processed with a positive test result are pulled from the shelves and re-sterilized.
3. The spore test log with a positive test will be compared to the surgical log. Patients indentified will be called and asked to come into the office to check for infection.

WESTERN-DIVERSEY SURGICAL CENTER
2744 N. Western Ave., Chicago, IL 60647

Documentation of Spore Testing

Instructions:

Testing to be done a minimum of once a week.
Document for each test result (+) or (-)
For each processed test result that is (+) state action taken at the back of this form.
Refer to "3M Attest" instruction manual for proper use.
Use garvity cycle only (270 degrees centigrade)

Load #	Date	Sterilization Time (3min.)	Control Test Result (N=pos)	Processed Test Result (N= neg)	Result Date	Initial

rev. 11/06/2015
aps
revised 11/19/12 aps

WESTERN-DIVERSEY SURGICAL CENTER

2744 N. Western Ave., Chicago, IL 60647

PERFORMANCE IMPROVEMENT ACTIVITIES

Title: Sterilization and Disinfection Monitoring Tool

Guide:

1. This tool will be used by another person other than the staff using loading for sterilization.
2. Activities will be done on every load for 3 consecutive months, collated and reported monthly to the Surgical Consulting Committee Meeting and evaluated Quarterly.
3. On each load of the sterilizer, log date, load number, quantity of load (per packet or tray), weight per load including tray, autoclave setting parameters.
4. During sterilization cycle, log will be maintained if autoclave setting parameters has been meet, answer Yes or No.
5. Log on each load if spacers between items are utilized (rack separator or towels) if more than one item is loaded.

DATE	LOAD#	QTY	WEIGHT	PARAMETERS Temp/Pressure	PARAMETRS MET? Y/N	SPACERS ETILIZED? Y/N

Date implemented: 11/09/2015

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Western-Diversey Surgical Center
2744 N. Western Ave., Chicago, IL 60647

In-Service Sign in Sheet

Date: November 07, 2015

In-Service Title: Review of Policy and Procedures : Sterilizer Monitoring (SPORE TESTING) and How to use New Form on Spore Testing.

Preceptor: A. Sabater, RN, BSN

Attendees Name Printed Name	Signatures
1. Marie Frukacz	[redacted]
2. Andriy Khlopas, RN	
3. Sofia Demas	
4. Mariela Escorpito	
5. Alejandra Perez	
6. Andrei Martiniv	
7. Magaly Napoles	
8. Kim Lee White	
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ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

AMBULATORY SURGICAL CENTER

NAME AND ADDRESS OF FACILITY: Western Diverse y Surgical Center, 2744 N. Western Ave., Chicago, IL 60647

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.410 (d) Equipment	**There shall be written procedures to assure the safety in storage and use of all narcotics and medications in accordance with state and federal law.** A. Based on document review, observational tour, and interview, it was determined, for 6 of 6 vials of Dantrium, the Ambulatory Surgical Center (ASC) failed to ensure the safety of patients in the event of malignant hyperthermia, potentially affecting more than 100 surgical patients per month. Findings include: 1. On 9/24/15 at 1:00 PM, the Malignant Hyperthermia poster was reviewed and included, "Emergency Treatment for Malignant Hyperthermia... 2. Administer dantrolene sodium 2 to 3 mg/kg initial bullish rapidly with increments of 10 mg/kg total. Continue to administer dantrolene until signs of malignant hypothermia...are controlled. Occasionally a total dose of greater than 10 mg/kg may be needed. Each vial of dantrolene contains 20 mg of dantrolene..." 2. A 150 pound person weighing approximately 68 kg, an initial dose of 2 to 3 mg/kg of dantrolene requires 136 to 204 mg of dantrolene (7 to 10 vials). 3. On 9/24/15 at 10:45 AM, an observational tour was conducted in the surgical area. Six vials of dantrolene were in the emergency cart. 4. On 8/24/15 at 11:10 AM, an interview was conducted with a registered nurse (E #2). E #2 stated 18 vials of dantrolene should be available in the event of malignant hypothermia. No other vials of dantrolene were found.	Section 205.410 Equipment A. 1,2, 3, 4. Medication list in the Facility was revised and quantity of Datrolene Sodium was changed from 6 to 18 vials. More Dantrolene Sodium was currently in order and should arrive next week. Medication list will continouosly be monitored on a monthly basis and reported to the consulting committee for any deficiencies (see attached medication list revision). Memo was also passed to the staff on Nov. 06, 2015 about the changes in the medication list. The above procedures and montoring will be done and overseen by M. Fucakz. Done Nov. 09, 2015.	Nov. 09, 2015

DATE OF SURVEY 9/24/15 BY _____ (Surveyor) _____ (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

PURPOSE:

To provide guidelines for treatment of malignant Hyperthermia to ensure patient safety.

RESPONSIBILITY:

The Anesthetist is responsible for ensuring Dantrolene is on site, and not out of date.
When Dantrolene is 30 days prior to expiration, the Head Nurse will order additional supplies.
Dantrolene will not be dispose of until new supplies are available.

PROCEDURE:

A. Immediately discontinue all inhalation anesthetics. Hyperventilate with 100% oxygen at high gas flows (10L min. or greater.) Stop anesthesia and surgery.
B. In the absence of blood gas analysis bicarbonate 1-2 mEq/kg should be administered.
C. Dantrolene sodium should be obtained, mixed with sterile distilled water and 2.5 mg/kg administered intravenously. At present dantrolene is packaged as a lyophilized preparation that contains 20mg of Dantrolene and 3 grams mannitol per vial.
D. Simultaneously, cooling should be started by all routes: surface, nasogastric lavage, intravenous cold solution, wound, and rectally.
E. Change anesthetic tubing and if possible, soda lime.
F. Arrhythmias will usually respond to treatment of acidosis and hyperkalemia. If they persist or are life threatening, standard anti-arrhythmic agents may be used, with the exception of calcium channel blockers.
G. Administer further doses of dantrolene as necessary titrated to the heart rate, muscle rigidity, and temperature. Response to dantrolene should begin to occur in minutes; if not, more drug should be administered. Although the average successful dose of dantrolene is about 2 mg/kg, much higher doses may be needed (lOmg/kg and more). Fortunately, dantrolene does not produce significant myocardial depression at these doses.
H. Change anesthetic tubing.
I. Determine and monitor closely urine output, serum potassium, calcium, arterial blood gases, end tidal CO2 and clotting studies. Hyperkalemia is common in the acute phase of MH and should be treated with intravenous glucose and insulin.
J. Arrange patient transfer to hospital so that patient can be observed in an ICU setting for at least 24 hours since recrudescence of MH may occur, particularly following a case that was difficult to treat.
K. Follow CK, calcium, potassium and clotting studies until such time as they return to normal (e.g. q 6 hours). Observe for DIC.
L. ECG should also be obtained and followed post-operatively.
M. Monitor body temperature closely since over vigorous treatment of MH may lead to hypothermia. Temperature instability may persist for several days after acute episode. Body temperature of 41 to 42 degrees are compatible with survival and normal brain function if treated promptly.

N. Ensure urine output of greater than 1 ml/kg/hour. Consider CVP monitoring because of fluid shifts that may occur.

O. When the patient's condition has stabilized convert from intravenous to oral dantrolene. Although data are not available regarding optimal doses and duration of treatment with dantrolene after an episode, the patient should probably receive a total of 4 mg/kg/day in divided doses for 48 hours postoperatively.

Counsel the patient and family regarding MH and further precautions. Refer patient to:

Malignant Hyperthemia Association of the United States (MHAUS)
P.O. Box 191
Westport, CT 06881-0191

Caution: This protocol may not apply to every patient and must of necessity be altered according to specific patient needs.

DIAGNOSIS ACUTE PHASE TREATMENT

Signs of MH:
Increased ETCO2

- trunk or total body rigidity
- Masseter spasm or trismus
- Tachycardia/tachypnea
- Acidosis
- Increased temperature (may be late sign)

GET HELP. GET DANTROLENE - Notify Surgeon.

- Discontinue volatile agents and succinylcholine.
- Hyperventilate with 100% oxygen at flows of 10 L/min. or more.
- Halt the procedure as soon as possible; if emergent, use non-triggers.

(The circle system and CO2 absorbent need not be changed.)

Dantrolene 2.5mg/kg rapidly IV through large-bore IV, if possible

- Repeat until there is control of the signs of MH.
- Sometimes more than 10 mg/kg (up to 30 mg/kg) is necessary.
- Dissolve the 20 mg in each vial with at least 60 ml **sterile preservative-free water** for injection. Prewarming
  (not to exceed 38°C) the sterile water will speed solublization of dantrolene.
- The crystals also contain NaOH for a pH of 9; each 20 mg bottle has 3 gm mannitol for isotonicity.

Bicarbonate for metabolic acidosis.

- 1-2 mEq/kg if blood gas values are not yet available.
- Cool the patient with core temperature >39°C. Lavage open body cavities, "Stomach, bladder, or rectum.
- Apply ice to surface.
- Infuse cold saline intravenously.

Stop cooling if temperature <38°C and falling to prevent drift <36°C.

Dysrhythmias usually respond to treatment of acidosis and hyperkalemia.

- Use standard drug therapy **except calcium channel blockers, which may cause hyperkalemia or cardiac arrest in the presence of dantrolene.**

Hyperkalemia - Treat with hyperventilation, bicarbonate, glucose/insulin, calcium.

- Bicarbonate 1-2 mEq/kg IV.
- For **pediatric,** 0.1 units insulin/kg and 1 ml/kg 50% glucose **or** for **adult,** 10 units regular insulin IV and 50 ml 50% glucose.
- Calcium chloride 10 mg/kg or calcium gluconate 10-50 mg/kg for life threatening hyperkalemia.
- Check glucose levels hourly.

Follow ETCO2, electrolytes, blood gases, CK, core temperature, urine output and color, coagulation studies. If CK and/or K+ rise more than transiently or urine output falls to less than 0.5 ml/kg/hr, induce diuresis to >1 ml/kg/hr urine to avoid myoglobinuria-induced renal failure.

- Venous blood gas (e.g., femoral vein) values may document hypermetabolism better than arterial values.
- Central venous or PA monitoring as needed and record minute ventilation.
- Place Foley catheter and monitor urine output.

To convert kg to lbs for amt of dantrolene, give patients 1 mg/lb (2.5 mg/kg approximates 1 mg/lb).

Americans United for Life

Guide on How to Use This Form

1 Once every month, inventory list of all medications will be monitored as to PAR level (qty maintained in facility), expiration date/s (medications within 30 days of expiration should be re-ordered) mark alongside the month where the expiring medication is scheduled to be replaced.
2 If medication/s is added or deleted from list, the master list should be updated and the updated list will be utilized for the next monitoring month.
3 If medication/s of the same name expires on a different date, write down the earliest medication expire date.
4 PAR Level should be maintained at all times (that is the minimum amount of medication kept in stock)
5 On the column of month, write down date medications are checked.
6 On the bottom part of the form on each months column, write down initial of person conducting the check.
7 Look-alike, sound-alike medications should be marked directly on each bottle of the referrenced look-alike and sound-alike medications. i.e. red dot sticker

WESTERN-DIVERSEY SURGICAL CENTER

2744 N. Western Ave., Chicago, IL 60647

Medication List

Americans United for Life

Crash Cart

Year:

Medication Name	Dosage	Expiration Date	PAR Level	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Atropine Sulfate	0.4mg/ml	6-16	6												
Atropine Sulfate PF	0.1mg/ml	9-17	6												
Amiodarone HCl	50mg/ml	5-17	4												
Epinephrine	1:10,000	9-16	4												
Dopamine	40mg/ml	4-16	6												
Ephedrine	50mg/amp	2-16	4												
Adenosine	3mg/ml	4-16	6												
Lidocaine HCl 2% PF	100mg/5ml	10-16	2												
Esmolol	10mg/vial	6-16	4												
Verapamil	5mg/vial	9-16	4												
Sodium Bicarbonate	50 mEq/50ml	11-16	6												
Calcium Chloride	1mg/ml	9-17	4												
Amonia Inhalant	0.3ml each	6-19	10												
Dephenhydramine	50mg/ml	1-17	6												
Solu-Cortef	100mg/2ml	12-16	3												
Nitrostat	100 tab	11-16	2												
50% Dextrose Inj.	50ml/vial	6-17	10												
Aspirin (chewable) tab	36 tab														
Dantrolene Sodium	20mg/vial	12-16	18												
Dexamethasone Na	4mg/ml	10-16	6												
Naloxone HCl	0.4mg/ml	9-16	6												
Albuterol	90mcg/ct	3-16	4												
Phenyplephrine	10mg/ml	6-16	4												
initial of staff monitoring															

WESTERN-DIVERSEY SURGICAL CENTER

2744 N. Western Ave., Chicago, IL 60647

Medication List

Americans United for Life

Control Station

Year:

Medication Name	Dosage	Expiration Date	PAR Level	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Lidocaine HCl 1%	1mg/ml	2-17	25												
Lidocaine HCl 1% with Epi	1mg/ml	12-16	10												
Sevouflorane	250ml	11-17	4												
Ondansetron	2mg/ml	2-17	3												
Marcaine 0.25% 30ml	2.5mg/ml	4-17	25												
Marcaine 0.5% 30ml	5mg/ml	11-17	25												
Marcaine 0.5% w/ Epi30ml	5mg/ml	1-17	10												
Hyalgan	20mg/2ml	3-17	5												
Ethyl Chloride	spray	1-17	2												
Depo-Medrol	40mg/ml	10-16	10												
Medroxyprogesterone	150mg/ml	9-16	10												
Isovue M-300	61% - 50ml	1-17	3												
Ibuprofen Tab	400mg/tab	12-16	500												
initial of staff monitoring															

WESTERN-DIVERSEY SURGICAL CENTER

2744 N. Western Ave., Chicago, IL 60647

Medication List

Americans United for Life

PACU

Year:

Medication Name	Dosage	Expiration Date	PAR Level	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Ibuprofen tab	400mg/tab	12-16	500												
Misoprostol Tab	100mg/tab	12-16	100												
Misoprostol Tab	200mg/tab	12-16	100												
Clindamycin IV	300mg/2ml	3-17	4												
Tylenol Tab	500mg/tab	12-16	500												
Cefazolin	1g	12-16	4												
Ketorolac	30mg/ml	4-17	25												
Albuterol Sulfate	90mcg	3-16	2												
Ondansetron	2mg/ml	2-17	3												
Diphenhydramine	50mg/ml	1-17	7												
Diphenhydramine Tab	25mg/tab														
Pitocin	10units	7-16	20												
Propofol	10mg/ml	3-16	25												
Midazolam	1mg/ml	7-16	10												
Fentanyl Citrate	50mcg/ml	4-16	50												
Anectine	20mg/ml	9-16	3												
Rocuronium Bromide	10mg/ml	4-16	3												
Methylgonovine Maleate	42mg/ml	9-16	3												
Flu Vaccine		6-16													
Hyper RHO s/d Mini dose	250 unit	10-17	10												
Hyper RHO s/d Full dose	500 unit	7-16	3												
initial of staff monitoring															

WESTERN-DIVERSEY SURGICAL CENTER

2744 N. Western Ave., Chicago, IL 60647

Medication List

Americans United for Life

Crash Cart

Year:

Medication Name	Dosage	Expiration Date	PAR Level	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Atropine Sulfate	0.4mg/ml	6-16	6												
Atropine Sulfate PF	0.1mg/ml	9-17	6												
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Naloxone HCl	0.4mg/ml	9-16	6												
Albuterol	90mcg/ct	3-16	4												
Phenyplephrine	10mg/ml	6-16	4												
initial of staff monitoring															

WESTERN-DIVERSEY SURGICAL CENTER

2744 N. Western Ave., Chicago, IL 60647

Medication List

Americans United for Life

Control Station

Year:

Medication Name	Dosage	Expiration Date	PAR Level	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Lidocaine HCl 1%	1mg/ml	2-17	25												
Lidocaine HCl 1% with Epi	1mg/ml	12-16	10												
Sevouflorane	250ml	11-17	4												
Ondansetron	2mg/ml	2-17	5												
Marcaine 0.25% 30ml	2.5mg/ml	4-17	25												
Marcaine 0.5% 30ml	5mg/ml	11-17	25												
Marcaine 0.5% w/ Epi30ml	5mg/ml	1-17	10												
Hyalgan	20mg/2ml	3-17	5												
Ethyl Chloride	spray	1-17	2												
Depo-Medrol	40mg/ml	10-16	10												
Medroxyprogesterone	150mg/ml	9-16	10												
Isovue M-300	61% - 50ml	1-17	3												
Ibuprofen Tab	400mg/tab	12-16	500												
initial of staff monitoring															

WESTERN-DIVERSEY SURGICAL CENTER

2744 N. Western Ave., Chicago, IL 60647

Medication List

Americans United for Life

PACU

Year:

Medication Name	Dosage	Expiration Date	PAR Level	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Ibuprofen tab	400mg/tab	12-16	500												
Misoprostol Tab	100mg/tab	12-16	100												
Misoprostol Tab	200mg/tab	12-16	100												
Clindamycin IV	300mg/2ml	3-17	4												
Tylenol Tab	500mg/tab	12-16	500												
Cefazolin	1g	12-16	4												
Ketorolac	30mg/ml	4-17	25												
Albuterol Sulfate	90mcg	3-16	2												
Ondansetron	2mg/ml	2-17	3												
Diphenhydramine	50mg/ml	1-17	7												
Diphenhydramine Tab	25mg/tab														
Pitocin	10units	7-16	20												
Propofol	10mg/ml	3-16	25												
Midazolam	1mg/ml	7-16	10												
Fentanyl Citrate	50mcg/ml	4-16	50												
Anectine	20mg/ml	9-16	3												
Rocuronium Bromide	10mg/ml	4-16	3												
Methylgonovine Maleate	42mg/ml	9-16	3												
Flu Vaccine		6-16													
Hyper RHO s/d Mini dose	250 unit	10-17	10												
Hyper RHO s/d Full dose	500 unit	7-16	3												
initial of staff monitoring															

Memorandum

To: All WDSC (Full or Part Time)

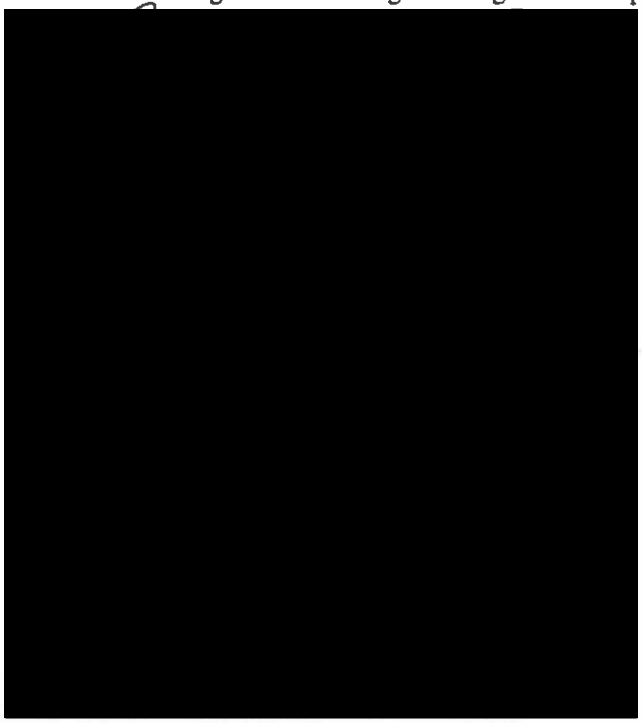
From: A. Sabater, RN, BSN

Date: 11/9/2015

Re: Updated Medication List; Policy and Procedure Revision

Please be informed that our medication master list has been updated, most importantly – we are adding to our stock more Dantrolene Sodium to total a minimum of 18 vials in case of incidence of Malignant Hyperthermia. Moreover, all are reminded and are asked assistance in checking all medications prior to dispense, opening or reconstituting – make sure medications are not expired – if nearing expiration date, notify the nurse supervisor. If opened medications are utilized, check label – they should be labeled with date opened, life expectancy from opening should be in 28 days and initial of person who initiated opening the medication.

Moreover, the Safety Guidelines policy has been revised and approved by the consulting committee for immediate implementation, changes include but not limited to "All surgical and diagnostic cases will have a designated circulating RN assigned in the operating room.



Americans United for Life

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

AMBULATORY SURGICAL CENTER

NAME AND ADDRESS OF FACILITY: Western Diverse y Surgical Center, 2744 N. Western Ave., Chicago, IL 60647

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.410 (d) Equipment (continued)	B. Based on documentation, observational tour, and interview it was determined, the Facility failed to ensure expired medications were not available for use as per policy, potentially affecting more than 100 patients receiving surgery each month. Findings include: 1. The policy entitled "Expiration Dates" (Revised 6/29/15) was reviewed on 9/24/15 at approximately 1:00 PM. The policy included, "I. Policy - It is the policy of Western Diversey Surgical Center to check the expiration dates of all medications and supplies, monthly to prevent the dispensing of expired drugs and supplies. II. Procedures - H. Once every month, the Medical Assistant/Surgical Tech will be responsible for checking all supplies and medications for expiration dates. 1. When an expired item is found it is removed from stock and segregated from other supplies/medications... I. The person administering any medication is responsible for checking the expiration date on the medications(s)..."	Section 205.410 (d) Equipment B. 1. 2. 3. All expired medication were discarded. The policy titled " Expiration Date" under Medication Management was reviewed with the staff and in-service on labeling and discarding of outdated medications was done on Nov. 06, 2015 (see attached policy review and in-service sign in sheet). Monitoring of of medications will be incorporated in our performance improvement activities and results will be reported to the consulting committee monthly. The monitoring will be done and reported by Andriy Khlopas, RN. The procedures changes are done and implemented Nov. 09, 2015.	Nov. 09, 2015

DATE OF SURVEY 9/24/15 BY 30461
(Surveyor)

(Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

I POLICY

It is the policy of Western-Diversey Surgical Center to check the expiration dates of all medications and supplies, monthly, to prevent the dispensing of expired drugs and supplies.

II. PROCEDURES

A. Once every month, the Nursing Personnel will be responsible for checking all supplies and medications for expiration dates.
   1. When an expired item is found, it is removed from stock and segregated from other supplies/medications.
   2. The Surgical Coordinator is responsible for initiating return for credit or replacement, or disposing of items.

B. The person administering any medication is responsible for checking the expiration date on the medication(s).

C. An Incident Report should be filed for review by the Performance Improvement Committee, whenever an expired medication is found on the shelf.

Americans United for Life

Western-Diversey Surgical Center
2744 N. Western Ave., Chicago, IL 60647

In-Service Sign in Sheet

Date: November 06, 2015

In-Service Title: Looking Back: Policy Review Expiration Date, Malignant Hyperthermia and Labeling of Drug and Solutions.

Preceptor: A. Sabater, RN, BSN

Attendees Name Printed Name	Signatures
1. Marie Frukacz	[redacted]
2. Andriy Khlopas, RN	
3. Sofia Demas	
4. Mariela Escorpito	
5. Alejandra Perez	
6. Andrei Martiniv	
7. Magaly Napoles	
8. Kim Lee White	
9. Emily Rivera	
10.	
11.	
12.	
13.	
14.	

Americans United for Life

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

AMBULATORY SURGICAL CENTER

NAME AND ADDRESS OF FACILITY: Western Diverse y Surgical Center, 2744 N. Western Ave., Chicago, IL 60647

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.410 (d) Equipment (continued)	2. During an observational tour in the operating area (OR) on 9/24/15 at 10:45 AM, the following expired medications were found: In the anesthesia cart in OR room 2: - 1 pre-filled syringe of Atropine Sulfate 1mg (milligram) (0.1 mg/ml). expired on 1/9/15 - 1 pre-filled syringe of Atropine 1mg (0.1mg/ml), expired on 1/4/15. In the crash cart in the semi-restricted corridor: - 2 vials of Diphenyhydramine 50mg/ml had an expiration date of 7/2015. - 1 vial of Diphenyhydramine 50mg/ml had an expiration date of 8/2015. - 1 pre filled syringe of Atropine 1mg had an expiration date of 4/2015. 3. On 9/24/15 at approximately 11:30AM a Registered Nurse, RN, (E#2) was interviewed. E#2 stated expired medications are not administered.		

DATE OF SURVEY 9/24/15 BY 30461

(Surveyor) (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

AMBULATORY SURGICAL CENTER

NAME AND ADDRESS OF FACILITY: Western Diverse y Surgical Center, 2744 N. Western Ave., Chicago, IL 60647

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.410 (d) Equipment (continued)	C. Based on documentation review, observational tour, and interview, it was determined, the Facility failed to ensure medications were properly labeled after opening, or disposed as required per policy. Findings include: 1. On 9/24/15 at 2:00 PM, the policy entitled "Medication Policy" (Revised 1/23/12) was reviewed and indicated "D. Preparation 3. Medications drawn up must be administered immediately, or labeled. 4. Expiration time for a drug drawn into a syringe. B. All drugs drawn into a syringe should be discarded within 24 hours or when completely used, whichever comes first. 4. Multidose Vials ...b. Once opened, they are only good for 28 days." 2. On 9/24/15 at 2:05 PM, the policy entitled "Labeling Drugs and Solutions" (Revised 1/23/12) was reviewed and indicated "A. All medications are labeled with following: ... 2. Expiration date when not used within 24 hours (i.e., multidose vials)... 5. Multi-dose vials medications should be dated when opened , the expiration date - 28 days later, and the initials of the individual who opened them. B. Any time one or more medications are prepared, but not administered immediately, the medication container must be labeled."		

DATE OF SURVEY 9/24/15 BY 30461 _____ _____
(Surveyor) (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

AMBULATORY SURGICAL CENTER

NAME AND ADDRESS OF FACILITY: Western Diverse y Surgical Center, 2744 N. Western Ave., Chicago, IL 60647

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.410 (d) Equipment (continued)	2. During an observational tour in the operating area (OR) on 9/24/15 at 10:45AM, the following open and unlabeled vials were found in OR room 2: - 2 vials of 10ml of Ketamine HCl (anesthetic) 500mg/10ml (multidose) - 2 vials of 50ml of Lidocaine 2% (anesthetic) 20mg/ml (multidose) - 1 vial of 20 ml of Xylocaine (anesthetic) 1% 10mg/ml (multidose) - 2 vials of 30ml of Marcaine (anesthetic) 0.5% (single dose) 3. A surgical procedure was taking place in OR room 1. There were 3 unlabeled syringes containing clear fluid on a surgical table. 4. On 9/24/15 at 11:15AM, an interview was conducted with the pain management physician (MD #3) who performed the procedure in room 1. MD #3 stated each syringe was a different size, so he knew the medication he had drawn up.	Section 205.410 C Labeling of Medications All opened and unlabeled medications were discarded. Policy and Procedure changes/revisions were made on Nov. 06, 2015. The said revision was presented and approved by the consulting committee on Nov. 07, 2015. Memo was passed to the staff on Nov. 09, 2015. (see attached Policy and Procedure revision; Consulting Committee minutes of meeting dated Nov. 07, 2015; Memo dated Nov. 09, 2015). Policy implementation responsibility will be under Andriy Khlopas, RN.	Nov. 09, 2015

DATE OF SURVEY 9/24/15 BY 30461 (Surveyor) _____ (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

I POLICY

It is the policy of Fullerton-Kimball Medical & Surgical Center to label any product or chemical transferred from its original container to another container.

II PROCEDURES

A. All medications are labeled with the following:
   1. Drug name, strength and amount;
   2. Expiration date when not used within 24 hours (i.e., multi-dose vials).
   3. Expiration time when expiration occurs in less than 24 hours (i.e, syringes, medicine cups, basins).
   4. The date prepared and the diluent for all compounded IV admixtures.

B. Any time one or more medications are prepared, but not administered immediately, the medication container must be labeled.
   1. The container enclosing the individual doses must be labeled
   2. Multiple doses prepared for later use must be segregated and secured from all other medications in the practice.

C. During a surgical procedure:
   1. Date and initial solution(s) upon opening.
   2. Saline/water bottles are discarded following the procedure.
   3. Antibiotic rider/irrigation - observe expiration date on label.
   4. Prior to pouring any solution/medication onto sterile field, review label and expiration date and show surgeon.
   5. Medications drawn on syringes or on other container on the sterile field should be labeled with medication name, strength and amount.

Memorandum

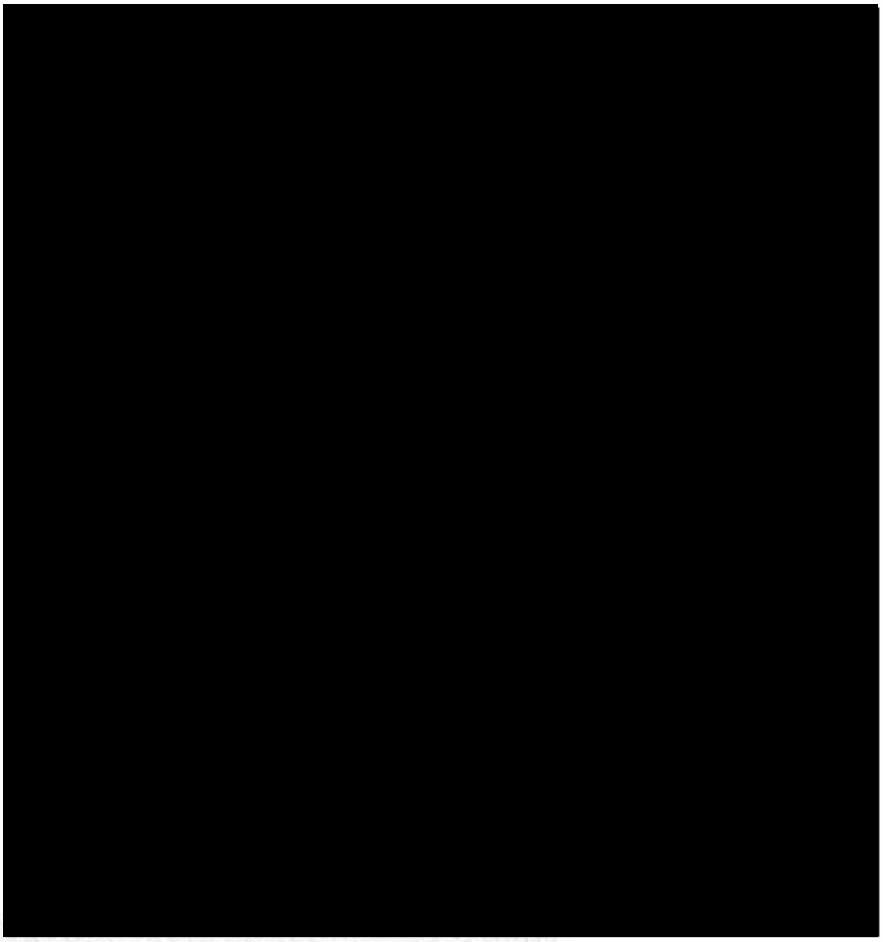
To: All WDSC (Full or Part Time), Anesthesia Staff and Surgeons

From: A. Sabater, RN, BSN

Date: 11/6/2015

Re: Labeling of Medications

Please be informed that all medications opened should be labeled of the following, Solution or Drug Name, Strength and Amount. Our Policy on Labeling of Drugs and Solutions has been revised/amended: Part C #5 states that: Medications drawn on syringes or transferred to another container on the sterile field should be labeled with Medication/Solution name, Strength and Amount.



Americans United for Life

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

AMBULATORY SURGICAL CENTER

NAME AND ADDRESS OF FACILITY: Western Diverse y Surgical Center, 2744 N. Western Ave., Chicago, IL 60647

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.530 (c)(3)(e) Operative Care	**A registered nurse, qualified by training and experience in operating room nursing, shall we present in the operating room and function as the circulating nurse during all invasive or operative procedures requiring aseptic technique. As used in this subsection "circulating nurse" means a registered nurse who is responsible for coordinating all nursing care, patient safety needs, and the needs of the surgical team in the operating room during an invasive or operative procedure requiring aseptic technique.** Based on observational tour and interview, it was determined for 1 of 1 registered nurse (E #2), the Ambulatory Surgical Center (ASC) failed to ensure a circulating nurse was present in the operating room during an operative procedure. Findings include: 1. The circulating nurse job description was requested on 9/24/15 at approximately 2:00 PM. A registered nurse (E #2) stated there he could not find a circulating nurse job description. 2. On 9/24/15 at 10:45 AM, an observation tour was conducted in the surgical area. In operating room (OR) room 1, a pain relief procedure, involving intravenous sedation and invasive needle injections to the back, was underway. There were 4 individuals present (2 doctors (MDs #1 & 2), 1 surgical technician (E #3), and a physician assistant (E #4). There was no circulating nurse in the room. A registered nurse (E #2) was in the recovery room where 3 patients were being monitored by E #2 and 2 medical assistants.		

DATE OF SURVEY 9/24/15 BY [illegible]
(Surveyor) (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

Americans United for Life

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

AMBULATORY SURGICAL CENTER

NAME AND ADDRESS OF FACILITY: Western Diverse y Surgical Center, 2744 N. Western Ave., Chicago, IL 60647

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.530 (c)(3)(e) Operative Care (continued)	3. On 8/24/15 at 11:10 AM, an interview was conducted with a registered nurse (E #2). E #2 stated he was moving back and forth between the operating room and the recovery room and was the only registered nurse on duty.	Section 205.530 Operative Care Policy revision was made on "Ambulatory Surgery Guidelines" policy revision was presented to the consulting committee and was approved and immediately implemented. (see attached minutes of conslting committee meeting dated Nov. 07, 2015 and Policy Revision on Ambulatory Surgery Guidelines. Memo was passed to the staff on Nov. 09, 2015 and changes in policy will be incorportated in our monthly performance improvement activities (see memo and sample or monitoring form for Performance Improvement activities) task will be the resdponsibility of Andriy Khlopas RN.	Nov. 09, 2015

DATE OF SURVEY 9/24/15 BY _____ _____
(Surveyor) (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

WESTERN-DIVERSEY SURGICAL CENTER

Policy Manual

Section: Surgery Effective Date: _____

Subject: Ambulatory Surgery Guidelines Revision Date: 11-06-2015

Policy No: Page: 1 of 1

I POLICY

It is the policy of American Women's Medical Center to follow established guidelines in the treatment of patients receiving outpatient surgical services.

II PROCEDURES

A. Outpatient surgical services shall be staffed and equipped to provide specialized care in the supervision of patients receiving surgery.

B. A Registered Nurse qualified and trained in the field of Operating Room and knowledge of aseptic technique shall be present on all cases performed in the operating room. He/she shall overlook and supervise an assistant to watch over the activities in the post-anesthesia care area.

C. Only patients classified as Class I, Class II, or Class III anesthesia risk are eligible for outpatient surgery at this facility.
   1. ASA classifications are as follows:
      Class I - Normal healthy patient
      Class II - Patient with mild systemic disease
      Class III - Patient with severe systemic disease that limits activity, but is not incapacitating
      Class IV - Patient with incapacitating systemic disease that is a threat to life
      Class V - A moribund patient
   2. Patients classified as a Class III risk may receive anesthesia at the discretion of the Anesthesia Provider.

D. Patients not acceptable for admission to the facility are as follows:
   1. Patients having infections, which require isolation and additional professional help in surgical or recovery room service.
   2. Surgery will be canceled if a patient shows evidence of respiratory disease or infection, on recommendation of the anesthesiologists.
   3. Expectation that airway may be compromised.
   4. Expectation of considerable blood loss.
   5. Expectation of considerable pain.
   6. Expectation of prolonged anesthesia.

D. It is the responsibility of the admitting physician to correctly evaluate the patient and the procedure for outpatient surgery, pre-operatively.

E. If the patient receives anesthesia, other than local, the patient must be informed, prior to admission to the facility of the following:
   a. Patient should not attempt to drive a motor vehicle immediately upon discharge from this facility
   b. Patient must make arrangements to have someone drive them home

REPLY TO REQUEST FOR ADDITIONAL INFORMATION OR OTHER ACTION

TO: Henry Kowalenko/Karen Senger

FROM: Thomas A. Busse, Staff Architect

Date: October 24, 2014

IN RESPONSE TO THE REQUEST ON THE REVERSE SIDE, THE FOLLOWING INFORMATION IS SUBMITTED:

Western Diversey Surgical Center
Chicago, IL
License # 7003183
Licensure Survey
Survey Date: 7/16/14

A revised Plan of Correction has been received and reviewed and found to be acceptable. The remaining deficiencies relate to the fire alarm system revisions (functional system does exist) and the installation of a new stationary emergency generator & electrical system (temporary mobile generator exists, but deficient as a permanent installation).

Interim Life Safety Measures include suspension of use of general anesthesia until the work is complete.

Work is to start by 11/20/14 and IDPH is to be notified upon commencement of work. Work is to be complete by 3/15/15. Therefore, a final follow-up survey is recommended to be scheduled following the 3/15/15 date. Inspection should include Electrical surveyor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000037	A. BUILDING: 01 - MAIN BUILDING B. WING _____	R 07/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN DIVERSEY SURGICAL CENTER	2744 NORTH WESTERN AVENUE CHICAGO, IL 60647

(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
(L 000)	Initial Comments On July 16, 2014 a follow up to the Life Safety portion of an Ambulatory Surgical Treatment Center Anual Licensure Survey was conducted at the above facility by Surveyors 12798 and 17659. The survey was based on the plan of correction received on 3/10/14. On August 27, 2013 the Life Safety portion of an Ambulatory Surgical Treatment Center Annual Licensure Survey was conducted at the above facility by Surveyor 13755. He was accompanied during the survey walk-through by the provider's Nurse Managers and maintenance personnel. The facility is a single story building determined to be of minimum Type II (000) construction type and fully sprinklered. The facility was surveyed as an existing Ambulatory Health Care Occupancy under the 2000 Edition of the NFPA 101 Life Safety Code, including Chapter 21 and the 77 IL Administrative Code 205, Ambulatory Surgical Treatment Center Licensing Requirements. Unless otherwise noted, those code sections listed herein that do not include a reference to a specific NFPA code and year of issue (such as NFPA 70 1999) are taken from the 2000 Edition of the NFPA 101 Life Safety Code. Unless otherwise noted, all deficiencies cited herein were found through random observation during the survey walk-through, staff interview, or document review. The Licensing requirements are NOT MET as evidenced by the deficiencies cited under the following L-Tags.	(L 000)		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000037	A. BUILDING: 01 - MAIN BUILDING B. WING _____	R 07/16/2014

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{L 051}	20.3.4/21.3.2 FIRE ALARM SYSTEM A manual fire alarm system, not a pre-signal type, is provided to automatically warn the building occupants. The fire alarm system is arranged to automatically transmit an alarm to summon the fire department. 20.3.4 and 21.3.4 This Regulation is not met as evidenced by: The components of the fire alarm system are not installed in a manner to make it clear how the system operates to comply with NFPA 101-2000, 21.3.4. A. The fire alarm system consists of an original system which has been altered to incorporate monitoring of the system in conjunction with a security system. Signage on the fire alarm panel indicated instructions for acknowledging and/or silencing the alarms by removal of fuses, resetting activation devices and reinstalling fuses. Upon observation, the fuses were removed which appeared to indicate the alarms were inoperable. However,upon testing, the system functioned as required with acknowledgement and resetting accomplished through the security code panel located near the center exit door. Proper updating of system components is required to make clear how the system is installed and/or operated. Obselete equipment and instructions should be removed to avoid confusion.	{L 051} A.	The new fire alarm contract for the installation of the new fire alarm system plus all the components as required to comply with NFPA 101-2000, 20.3.4 & 21.3.4. has been awarded to "Stanley Fire Alarm" Company as a design build contract. However the design was already completed, submitted and approved by your office. We are proceeding with the work with the installation of the conduit per City of Chicago code requirement, "that all electronic low voltage systems shall be encased in metal conduit". This work will be starting the 11/25/14 and finished by 12/15/14. The complete new fire alarm system will be complete by 01/15/15.	01/15/15
{L 106}	Type I ESS 3.4.2.2, 3.4.2.1.4 The ASC with life support equipment has a Type I Essential Electrical System powered by a generator with a transfer switch and separate power supply. The EES is in accordance with NFPA 99. 3.4.2.2, 3.4.2.1.4	{L 106}		

Illinois Department of Public Health

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{L 106}	Continued From page 2	{L 106}		
	This Regulation is not met as evidenced by: The ASTC Essential Electrical System is not installed as a NFPA 99 Type I, NFPA 110 Level 1 system in comformance with Licensing Requirements, NFPA 70, NFPA 99 and NFPA 110. Findings include:	A.	The new permanent emergency electric generator and the electrical upgrades as they were submitted and approved by your office. this work is presently been bid by qualified licensed electrical contractors. the proposals will be in by 11/15/14 the work will start on 11/20/14 and complete by 03/15/15.	03/15/15
	A. The ASTC is permitted under its License to administer anesthesia and required by IL Administrative Code 205.1780 to have an emergency generator. Section 205.115 requires compliance with NFPA 99-1999 Health Care Facilities, NFPA 110-1999 Standard for Emergency and Standby Power Systems and NFPA 70-1999 National Electric Code. NFPA 99-1999, 3-4.2.2.1 and NFPA 70-1999, 517-45(c) Essential Electrical Systems for Ambulatory Health Care Centers requires compliance with 517-30 thru 517-35 for those areas classified as Critical Care. Critical Care is defined as those areas in which patients are intended to be subject to invasive procedures and where connected to line-operated, patient-care-related electrical appliances.			
	1. The trailer-mounted 'temporary' generator is not installed in a permanent manner to comply with NFPA 110-1999, 2-2.4.1. Electrical connections and wiring are not installed in boxes or otherwise run in conduits and mounted in accordance with NFPA 70. Wiring was observed to be run thru ductwork assemblies at the old generator radiator air vent and unprotected by conduit from damage both inside the building and from the building to the generator equipment.	1.	The trailer-mounted 'temporary generator' is going to be repositioned (to make way for the new permanent emergency generator "which complies with NFPA 110-1999, 2-2.4.1 & NFPA 70." Of course as this reposition will take place the temporary generator's electric cables will be placed on temporary cable trays. Even though the cables are weather proof and water proof.	11-15-14

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{L 106}	Continued From page 3 2. The generator is not provided with a remote manual stop to comply with NFPA 110-1999, 3-5.5.6. 3. The generator is located in an exterior enclosure which is not equipped to be maintained at a minimum temperature not less than 32 degrees F or otherwise provided with a starting battery heater to maintain battery temperature at a minimum 50 degrees F and automatically shuts off when battery temperature reaches 90 degrees F (and when prime mover is running) to comply with NFPA 110-1999, 3-3.1. 4. The generator is not provided with a remote alarm annunciator panel to comply with NFPA 99-1999, 3-4.1.1.15 and NFPA 110-1999, 3 -5.5.2 to provide visual and audible alarms for the following conditions: a. When operating to supply power b. Overcrank (fail to start) c. Low water temperature d. High water temperature e. Low oil pressure f. Low fuel level g. Overspeed h. When battery charger malfunctions B. The emergency power system is not installed in accordance with NFPA 70-1999, 517-19. 1. Each Critical patient bed location (ORs and Stage 1 Recovery) is not provided with receptacles from at least two branch circuits; at least one from normal power supply and at least one from the emergency power supply to comply with NFPA 70-1999, 517-19(a). 2. Corrected 7/16/14	{L 106}	This is about the temporary generator 2. The generator has a manual stop on the trailer that the generator is mounted on However we are not sure this complies with the remote manual stop per NFPA 110-1999, 3-5.5.6.	03-15-15
		3.	The temporary generator is equipped with a starting battery & starting battery heater it does comply with NFPA 110-1999, 3-3.1. This generator started every time last winter with temperature down to (-20 F)	03-15-15
		4.	We finally got some second opinions from generator manufacturers that there no way to provide the temporary generator with remote alarm annunciator to comply with NFPA 99-1999, 3-4.1.1.15 and 110-1999, 3-5.5.2 *The Completion dates for the above items L 106A, A1, A2, A3 & A4 are referring to the final completion of the new generator system which is complying with all those requirements.*	03-15-15
		B. 1.	The Stage 1 Recovery and ORs beds will be provided with dedicated receptacles from the emergency panel and the general power panel. This work is on going and will be finished. *The Completion dates for the above item have been changed, however the idea was to make the home runs of this branches to the existing emergency panel and the phase them in with the new critical panel as the new system complete and which is complying with all requirements NFPA 70-1999, 517-19(a).*	03-15-15
		2.	Corrected	

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{L 106}	Continued From page 4 3. Corrected 7/16/14 C. The 'temporary generator' has been in use for nearly one year. Its installation and provisions for a permanent replacement of the failed generator were not submitted to the Dept. of Public Health for review as required by 205.1330 and specifically 205.1330(g)4 relative to electrical modifications.	{L 106} 3. C.	Corrected We acknowledged the misunderstanding for the reporting procedures of the 'temporary generator' and provided detail plans for all electrical modification plant. Hence were approved by your department. However we will comply with the requirements 205.1330 and 205.1330(g)4.	10-01-14
{L 130}	as indicated OTHER REFERENCED REQUIREMENTS Other Referenced Requirements: NFPA 70 - 2002 NFPA 13 -1999 NFPA 25 - 1998 Illinois State Plumbing Code Illinois Accessibility Code As Indicate below: This Regulation is not met as evidenced by: Based on random observation during the survey walk-through, document review, and staff interview, the facility is not in compliance with a series of Life Safety and other code requirements that are not documented under other L-Tags. Findings include:	{L 130}		
	A. Due to the number, variety, and severity of the life safety deficiencies observed during the survey walk-through, the provider shall institute appropriate interim life safety measures until all cited deficiencies are corrected. The provider shall include, as an attachment to its Plan of Correction (PoC) and referenced therein, a detailed narrative and proposed schedule for all such measures. The narrative shall describe all	A.	See attachment 'A' Narrative will be (implemented immediately)	09-25-14

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{L 130}	Continued From page 5 measures to be implemented, as well as the frequency with which they are to be conducted, and shall indicate the manner in which the measures are to be documented. The narrative shall also include comments related to changes in the interim life safety measures to remain in place as work toward the completion of its PoC progresses.	{L 130}		
{L 144}	Generator Testing 3.4.4.1, NFPA 110, 8.4.2 Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1, NFPA 110, 8.4.2 This Regulation is not met as evidenced by: The emergency generator system is not inspected and tested in accordance with NFPA 99-1999, 4.3.3.1 and NFPA 110-1999, 6.4.2. Findings include: A. The facility is provided with a trailer-mounted 'temporary' generator system indicated to be in use since 9/11/12. The system is indicated to be exercised weekly by a third party and annually load bank tested by a different third party. The following findings resulted from review of records available and interview: 1. Corrected 7/16/14 2. No initial testing of the 'temporary' generator was reviewed. No subsequent load bank testing of the 'temporary' generator system was reviewed. The last load bank testing available for the generator at the facility was for	{L 144} A. 1.	The temporary generator has been tested weekly, monthly and annually. Evidence of the paper work was previously submitted to your office commended and corrected. However the annual and special Bank loads is done be special professional. We did also do a load bank test which was also submitted to your office. We are certainly think there is some misunderstanding between our staff and your inspectors. Although, the testing of the 'temporary' generator has been proper as required per NFPA 99-1999, 6-4.3.3.1. and NFPA 110-1999, 6-4.2. Further clarification for this requirement will be helpful. Corrected	09-10-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{L 144}	Continued From page 6 the existing permanently installed generator in which use was discontinued. 3. Corrected 7/16/14 4. Corrected 7/16/14 5. Corrected 7/16/14	{L 144}	A special Bank loads test was done last year and was submitted to your office. We did not get any comments other than, it was not performed at the time of the installation of the "temporary' generator. 3. Corrected 4. Corrected 5 Corrected	
{L 145}	Type 1 EES 3.4.2.2.2 The Type I EES is divided into the critical branch, life safety branch and the emergency system in accordance with NFPA 99. 3.4.2.2.2 This Regulation is not met as evidenced by: The ASTC Essential Electrical System is not installed as a Type I system in comformance with Licensing Requirements, NFPA 110, NFPA 99 and NFPA 70. Findings include: A. The ASTC is permitted under its License to administer anesthesia and required by IL Administrative Code 205.1780 to have an emergency generator. Section 205.115 requires compliance with NFPA 99-1999 Health Care Facilities and NFPA 70-1999 National Electric Code. NFPA 99-1999, 3-4.2.2.1 and NFPA 70-1999, 517-45(c) Essential Electrical Systems for Ambulatory Health Care Centers requires compliance with 517-30 thru 517-35. NFPA 99-1999, 3-4.2.2.1 and NFPA 70-1999, 517-30(b)2 require the generating system to be comprised of a Life Safety branch and a Critical branch. The installed system did not appear to be arranged to provide power from two separate branches because only a single "emergency" panel was observed with mixed loads required to be on	{L 145} A.	We have agreed with your office to upgrade the Electrical Systems as required per NFPA 110, NFPA 99 and NFPA 70 especially and due to the failure of the original emergency generator. We are waiting for electrical bids due on 11-15-14 (Fourth dead line however we soliciting bids from new contractors). As soon as we receive the Bids we will submit the forms for the work schedule, cost of the work and the successful licensed electrical Contractor. The new Electrical System has been designed submitted to your office and approved by your office. We therefore proceeding with the execution of the work. We will complete the work by 02-15-15.	11-15-14 02-15-15

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(L 145)	Continued From page 7 either the Life Safety branch or the Critical branch in accordance with NFPA 99-1999, 3-4.2.2.2. A one-line diagram of the permanent electrical distribution system or the 'temporary' electrical distribution system was not reviewed.	(L 145)		

Attachment 'A'

10/23/2014

The interim Life Safety Measures will be implemented until all corrections are complete.

1. **The medical center has stopped performing medical procedures with the use of general anesthesia and will resume normal operations after all corrections are complete.**
2. **The Majority of the work is going to be confined in the existing electrical and mechanical room and outside the building**
    a) **The new Emergency Generator system witch is on the outside of the building.**
    b) **The required new transfer switch.**
    c) **The new emergency panels.**
    d) **The new fire alarm main panel.**

Even though most of all the work is going to take place during times that the clinic is not open to public (every week between Saturday afternoon and Wednesday morning. We will maintain all life safety system as they are and make the final connections and change over once the systems are complete and tested for final approval.

3. **The Center will be open to our medical clients every week from Wednesday to Saturday only for medical check ups and minor procedures with out the use of general anesthesia.**
4. **Any work that's going to require demo or will be disturbing existing conditions will be sealed with temporary closures air tied with portable air system and HEPA filters.**

Americans United for Life

WHOLE WOMAN'S HEALTH OF PEORIA, LLC

Changing the World, One Woman at a Time

October 21, 2015

Karen Senger, RN, BSN
Supervisor of Central Office Operations
Division of Health Care Facilities and Programs
Illinois Department of Public Health
525 West Jefferson Street, 4th Floor
Springfield, IL 62761

Dear Ms. Senger,
Please be advised of the following personnel changes at Whole Woman's Health of Peoria:

Bonnie Bottenberg, RN – Head Nurse
Sharon Lau – Clinic Administrator

These changes take effect immediately. Dr. Allen Palmer, MD continues in his role as Medical Director. If you have any questions you may reach me at the information listed below.

Sincerely,

[redacted]

Sharon Lau, Interim Administrator
Whole Woman's Health of Peoria
slau@wholewomanshealth.com
512-994-9130

RECEIVED OPHCA/HCFP
2015 OCT 26 A 11:

Americans United for Life

7405 N University St. Peoria, IL 61614 ph: (309) 691-9073 fax: (309) 691-4528
www.wholewomanshealth.com

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

July 1, 2016

Ms. Holly Worsfold, Administrator
Whole Woman's Health of Peoria, LLC
7405 North University
Peoria, IL 61614-

Re: Whole Woman's Health of Peoria, LLC
Peoria
Licensure survey

Dear Ms. Worsfold:

On 06/29/16, a life safety code inspection was conducted for the purpose of determining compliance with the requirements of the "Ambulatory Surgical Treatment Center Licensing Requirements" (77 Ill. Adm. Code 205) and the 2000 Edition of NFPA 101, Life Safety Code. Based on the survey conducted, we find that the previously cited deficiencies have been corrected and the facility is no longer under monitoring for physical environment.

If you have any questions about this approval, please do not hesitate to call us at 217-785-4264 The Department's TTY number is 800/547-0466, for use by the hearing impaired.

Sincerely

[redacted]

Henry Kowalenko, Division Chief
Division of Life Safety and Construction

Cc: Karen Senger, Supervisor
Central Office Operations Section, IDPH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL7001670	A. BUILDING 01 - MAIN BUILDING B. WING	R 06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHOLE WOMAN'S HEALTH OF PEORIA, LLC	7405 N UNIVERSITY SUITE D PEORIA, IL 61614

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{L 000}	Initial Comments	{L 000}		

On 02/17/2016 the life safety code portion of a Pregnancy Termination Center Licensure Survey was conducted. The surveyor was accompanied during the survey walk through by the following provider representative:

Clinic Manager (C.M.)

The facility is the single tenant in a nonsprinklered 1 story building that was observed to be of Type II unprotected construction. The facility is approximately 5,500 sq ft in area.

The facility was surveyed as an Existing Ambulatory Health Care Occupancy under the 2000 Edition of the NFPA 101 Life Safety Code, including Chapter 21, and under Part 205, Ambulatory Surgical Treatment Center Licensing Requirements, as amended by Subpart G, Section 205.710.

Unless otherwise noted, those code sections listed herein that do not include a reference to a specific NFPA code and year of issue (such as NFPA 70 1999) are taken from the 2000 Edition of the NFPA 101 Life Safety Code.

Unless otherwise noted, all deficiencies cited herein were found through direct observation, staff interview, or document review.

The life safety code requirements of licensure are NOT MET as evidenced by the deficiencies cited under the following L-tags:

On 06/29/2016 the life safety code portion of a Pregnancy Termination Center Licensure

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{L 000}	Continued From page 1 Monitoring Survey was conducted. The surveyor was accompanied during the survey walk through by the following provider representative: Clinic Manager (C.M.) Unless otherwise noted, all deficiencies were found through direct observation, staff interview, or document review to have been corrected. The life safety code requirements of licensure are MET.	{L 000}		

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L 000	Initial Comments On 02/17/2016 the life safety code portion of a Pregnancy Termination Center Licensure Survey was conducted. The surveyor was accompanied during the survey walk through by the following provider representative: Clinic Manager (C.M.) The facility is the single tenant in a nonsprinklered 1 story building that was observed to be of Type II unprotected construction. The facility is approximately 5,500 sq ft in area. The facility was surveyed as an Existing Ambulatory Health Care Occupancy under the 2000 Edition of the NFPA 101 Life Safety Code, including Chapter 21, and under Part 205, Ambulatory Surgical Treatment Center Licensing Requirements, as amended by Subpart G, Section 205.710. Unless otherwise noted, those code sections listed herein that do not include a reference to a specific NFPA code and year of issue (such as NFPA 70 1999) are taken from the 2000 Edition of the NFPA 101 Life Safety Code. Unless otherwise noted, all deficiencies cited herein were found through direct observation, staff interview, or document review. The life safety code requirements of licensure are NOT MET as evidenced by the deficiencies cited under the following L-tags:	L 000		
L 021	Doors/Firewalls 20.2.2.3, 21.2.2.3 Any door with a required fire protection rating, such as stairways, exit passageways, horizontal	L 021		

Rec
APR - 4 2016
LIFE SAFETY & CONSTRUCTION

Illinois Department of Public Health

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L 021	Continued From page 1 exits, smoke barriers, or hazardous area enclosures, if held open, is arranged to close automatically by the actuation of the manual fire alarm system and either smoke detectors arranged to detect smoke on either side of the opening or a complete automatic sprinkler system. 20.2.2.3, 21.2.2.3 This Regulation is not met as evidenced by: Based on observations, the facility failed to maintain proper door configurations in fire rated barriers. This deficient practice could affect patients, staff and visitors, if fire and smoke were allowed to spread beyond the location of fire origin. Findings include: On 2/17/2016 at 9:50 AM while accompanied by the C.M. the surveyor observed cross corridor doors which were on magnetic hold open devices. The door configuration does not comply with 21.3.7.7 for the location of smoke detectors to be placed on either side of the smoke barrier door in a distance to comply with NFPA 72 1999 2-10.6.5.1. The surveyor observed two cross corridor doors with this non compliant condition.	L 021	The clinic manager will be responsible for ensuring the life safety code requirements of licensure are met. Clinic manager has solicited bids from 3 companies to move/add smoke detectors to comply with finding. All companies have been to the site. Awaiting the written bids and will select one and have work completed within 30 days of submission of this report. In order to ensure further compliance with this requirement the clinic manager will conduct life safety code inspections on a quarterly basis as part of quality assurance.	04/29/16
L 029	38.2.1/39.3.2 HAZARDOUS AREAS 39.3.2.1 Hazardous Areas: Hazardous areas that include, but are not limited to general storage, boiler or furnace rooms, and maintenance shops shall be protected in accordance with Section 8.4. High hazard areas shall comply with 39.3.2.2.	L 029	The clinic manager will be responsible for ensuring compliance with 39.3.2.2.-Hazardous Areas.	04/29/16

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L 029	Continued From page 2 This Regulation is not met as evidenced by: Based on observation These deficiencies could affect any patients, staff, or visitors in the building because they could be prevented from exiting the building under emergency conditions. Findings include: A. On 02/17/2016, while accompanied by the C.M., the surveyor observed hazardous areas which are not separated from the means of egress corridor to comply with 8.2.3.2.3 Locations observed include: 1. Clean storage rooms adjacent to the three O.R.'s lack self closing doors. 2. Entry doors to large storage rooms are not 3/4 hour fire rated self closing doors. 3. Entry doors to large storage rooms lack fire rated metal frames.	L 029	Landlord (Huber Brothers) measured for doors and frames per findings on March 3, 2016. Landlord will solicit bids to share with WWH. Clinic manager will work with landlord to review bids and ensure completion. Bids reviewed and order placed within 30 days of submitting this report. The clinic manager along with the landlord will oversee the installation process to ensure compliance with this requirement.	
L 032	20.2.4/21.2.4 TWO REMOTE EXITS At least two exits, located remote from each other are provided for each floor or fire section of the building. 20.2.4.1,20.2.4.2,20.2.4.3/21.2.4.1, 21.2.4.2 21.2.4.3 This Regulation is not met as evidenced by: Based on observation, not all exit paths are constructed or maintained to provide readily accessed exits. These deficiencies could affect any patients, staff, or visitors in the building	L 032	The clinic manager is responsible for ensuring compliance with 20.2.4/21.2.4 - Two remote exits. Landlord (Huber Brothers) installed one-operation locks as described in finding. Clinic staff and independent contractors have been informed of this change and are familiar with the operations of the new locks.	02/29/16

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L 032	Continued From page 3 because they could be prevented from exiting the building under emergency conditions. Findings include: On 02/17/2016, while accompanied by the C.M., the surveyor observed exterior egress doors which are equipped with both a lockset and a separate thumbturn deadbolt, thus requiring two operations to exit the building as prohibited by 7.2.1.5.4. Locations observed include: A. 10:40 AM, interior exit door from the corridor located adjacent to large storage rooms. This corridor leads from the surgery corridor.	L 032	In order to monitor compliance with this requirement the clinic manager will ensure the locks are working properly on a quarterly basis. Any need for repairs will be addressed during QA meetings.	
L 046	20.2.9.1/21.2.9.1 Emergency Illumination Emergency lighting shall be provided in accordance with 7.9 and 21.2.9.2. This Regulation is not met as evidenced by: Based on document review, the facility failed to provide monthly and annual testing of emergency lighting with battery back up. The documentation provided is incomplete. This deficient practice could affect all patients, staff and visitors during a fire emergency if lighting is not available. Findings include: A. On 02/17/2016, at 10:15am, with the C.M present, the surveyor reviewed the documentation of testing for the previous 12 months. The surveyor finds the documentation of testing does not comply with 9.7.3 of NFPA 101. 1. The documentation for annual testing is lacking. Documents with a list was observed however the documentation fails to indicate that	L 046	The clinic manager will be responsible for ensuring compliance with this requirement. Landlord (Huber Brothers) repaired/ replaced lighting. Oberlander Alarm Systems performed testing service as described in findings. Attached is Oberlander's documentation of this service. Whole Woman's Health leadership was unable to locate previous documentation from National Health Care (NHC). Attached is documentation that will be used going forward for monthly and annual testing. Lighting repaired and replaced Feb. 29, 2016. Annual inspection completed March 3, 2016.	02/29/16 03/03/16

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L 046	Continued From page 4 the devices were tested for 90 minutes and fails to identify what a pass/fail criteria is. 2. There is no documentation which indicates the procedure used for testing monthly or annually.	L 046	In order to monitor compliance, the clinic manager will work with vendors to ensure proper testing and documentation and will oversee monthly and annual testing and documentation.	
L 050	21.7.1.2 FIRE DRILLS Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift, using the fire alarm system, except at night. The staff is familiar with procedures and is aware that drills are part of established routine. 21.7.1.2 This Regulation is not met as evidenced by: Based on a document review of fire drill testing, the surveyor finds that fire drills are not conducted and documented. Findings include: A: On 02/17/2016, at 9:20am, with the C.M. present, the surveyor reviewed fire alarm documents for the previous twelve months. The surveyor determined that fire drills are not conducted in accordance with 21.7.1.2 of NFPA 101. Although the provider indicates that fire drills take place, documentation is incomplete and does not indicate the following: 1. Indicate that the fire alarm was activated by indicating which device was utilized. 2. Indicate that staff heard the fire alarm system. 3. Indicate that the fire alarm monitoring service received the alarm signal created from	L 050	The clinic manager will be responsible for conducting unannounced fire drills on a quarterly basis and document the results. WWH fire safety policy and drill documentation forms are attached. Documentation implemented immediately. The clinic manager will conduct and document drill during week of March 7, 2016 and quarterly thereafter.	03/09/16

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L 050	Continued From page 5 each fire drill. 4. Indicate that the staff observed all components of the fire alarm system operated as required, i.e. doors closed, horns sounded and strobe lights were activated. 5. Indicate the date and time of the fire drill.	L 050		
L 061	20.3.4/21.3.2 FIRE ALARM SYSTEM A manual fire alarm system, not a pre-signal type, is provided to automatically warn the building occupants. The fire alarm system is arranged to automatically transmit an alarm to summon the fire department. 20.3.4 and 21.3.4 This Regulation is not met as evidenced by: The surveyor finds that documentation of testing of the fire alarm system is incomplete Findings include: A. On 02/17/2016, at 9:40am, with the C.M. present, the surveyor reviewed the documentation of testing of the fire alarm system for the previous 12 months. The surveyor finds the testing does comply with NFPA 72 - 1999. The surveyor finds that documentation of testing of the fire alarm was performed on a semiannual basis. The documentation is limited in scope and unsigned by the company representative conducting the inspection. The documents lack the following minimum information in accord with table 7-3.1: 1. Battery testing is incomplete and does not include discharge testing (minimum 30 minutes). 2. Not all components of the system are	L 061	The clinic manager will be responsible for ensuring compliance with Fire Alarm Systems per 20.3.4/21.3.2. B. Clinic manager has solicited bids from 3 companies to add remote annunciator in the reception area and repair/replace panel to ensure output and functioning of horns and strobes to comply with findings. All companies have been to the site. Awaiting the written bids and will select one and have work completed within 30 days of submission of this report. Clinic manager will work with vendor to ensure future testing and documentation is completed.	04/29/16

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L 051	Continued From page 6 indicated to be tested, there is no indication that the magnetic hold opens are included in the test. 3. Testing of the remote annunciator is not indicated. 4. Functional test of the smoke detectors is not indicated. 5. Semiannual sensitivity testing of the smoke detectors is not indicated. B. On 02/17/2016, at 9:45am, with the C.M. present, the surveyor reviewed the documentation of testing of the fire alarm system for the previous 12 months. The surveyor finds that the fire alarm system remote annunciator is located at an entry door to the building which is no longer used by the facility. The current location does not comply with NFPA 72 1999 1-5.7.1.1, NFPA 101 9.6.7.5 and 9.6.7.6. for the proper location of a device at a supervised area (nurse station, control station etc.). C. On 02/17/2016 at 11:45am, with the C.M. present, the surveyor observed the location of the fire alarm control panel within the laundry room which is an area that is not continuously occupied during operating hours. The room contains a heat detector, however, this configuration does not comply with NFPA 72 for a fire alarm control panel which lacks dedicated smoke detection.	L 051	Clinic manager will work with vendor to ensure future testing and documentation is completed.	
L 064	9.7.4.1 FIRE EXTINGUISHERS Portable fire extinguishers are provided. 8.7.4.1 and 9.7.4.1 This Regulation is not met as evidenced by:	L 064	The clinic manager will be responsible for ensuring compliance with upkeep of Fire Extinguishers per 9.7.4.1	04/28/15

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L 064	Continued From page 7 Based on record review, the facility failed to properly maintain portable fire extinguishers to comply with NFPA 1010 2000 Edition 21.3.5.2 and NFPA 10. This deficient practice could affect patients as well as in indeterminable number of staff and visitors if the fire extinguishers failed. A. On 02/17/2016 while accompanied by the facility C.M. the surveyor observed that the facility was unable to produce the annual certified maintenance records for the extinguishers as required by NFPA 10, 1998, 4-4.1. B. On 02/17/2016 while accompanied by the facility C.M. the surveyor observed that the facility was unable to produce the 6-year hydrostatic testing records for the extinguishers as required by NFPA 10, 1998, 4-4.3.	L 064	A. Annual maintenance record from Getz Fire Equipment Company is attached. Manager will create a file so records are easily accessible. B. B. 6-year testing recorded on the same maintenance record attached to A. Next inspection/service due April 2016. The clinic manager will monitor compliance by inspecting the equipment on a quarterly basis during Quality Assurance meetings.	
L 114	21.3.7.1 TENANT SEPARATION WALL Ambulatory health care occupancies are separated from other tenants and occupancies by fire barriers with at least a one-hour fire resistance rating. Doors in such barriers have at least a 20 minute fire protection rating and are equipped with a positive latch and closing device. Vision panels, if provided in fire barriers or doors therein, are fixed wired glass limited to 1,296 sq. in. per panel. 20.3.7.1 and 21.3.7.1 This Regulation is not met as evidenced by: Based on staff interview, the facility failed to indicate how the ASTC is separated into smoke compartments by a minimum 1-hour rated construction. This condition could affect all staff,	L 114	The cinic manager will be responsible for ensuring compliance with the Tenant Separation Wall requirement per 21.3.7.1 A. Landlord (Huber Brothers) confirms that smoke barrier wall is in place. They report that all walls in the corridor go all the way to the deck to create a sealed smoke barrier. Detectors on both sides would alarm and doors would release and shut. Clinic manager will request confirmation in writing from the landlord and will hold an in-service with staff about its location and purpose.	03/03/16

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L 114	Continued From page 8 visitors and patients during a fire/smoke emergency within the facility and delay evacuation from one compartment to the adjacent. The findings are: A. On 02/17/2016 at 10:00am during document review accompanied by the facility C.M. the definitive location of the required smoke barrier wall(s) was not readily known by staff available. Building plans were reviewed, but the available plans did not identify the smoke barrier wall(s) to comply with 21.3.7.1 and 21.3.7.2. Documentation provided by the facility indicates there is a smoke barrier, however, there is no evidence that staff are educated and are familiar as to the exact location and purpose of a smoke barrier. B. On 02/17/2016 at 11:00am during the facility walk through while accompanied by the facility C.M. the surveyor observed tenant separation walls. The surveyor observed large unoccupied storage rooms located on the other side of recovery and surgery corridor. The surveyor was informed these spaces are not associated with the facility. The concrete block separation wall which may be part of the 1-hour fire rated smoke barrier as well as being a tenant separation wall was incomplete due to a large sheet metal duct penetration which was open to the storage room and lacked a smoke damper installation.	L 114	B. Landlord (Huber Brothers) installed smoke damper on duct. Date completed – A. Will complete within 30 days of submission of report. B. March 3, 2016	

rlander Alarm Systems, Inc
8 W. Altorfer Drive
Peoria IL 61615
(309)676-3535

Oberlander Alarm Systems, Inc.

Technician Scheduled: Kerry Ginder Service ID: 2814

Work Order #: 31608 Requested By: Rita On: Feb 29, 2016 Sched. For: 03/03/2016 09:00 AM

WHOLE WOMENS HEALTH OF PEORIA
7406 N UNIVERSITY
PEORIA, IL 61614

Sched. Inst:
Slot:
Priority: 3
Directions :

Panel Type
Map Location Panel Location
Town Code DEFAULT Phone: (309)691-9019 PhoneDCU:

CSID OA-1092
Siren

☐ New ☐ Add ☐ Repair ☐ False Alarm ☐ Bypass/Dis ☐ Clear ☐ GF ☐ Vandalism ☐ Water Damage ☐ Lightning ☐ Emergency Call ☐ Warranty ☐ COD

Conditions
Fire Inspection with Sensitivity Testing
Address issues found deficient during last inspection

Description of Service Type
Service Call to Premises

Comments
Deficiencies are listed on attached pages.

Actual Work Performed: Did inspection of fire alarm system. Tested all devices including Maglock release and door holder releases. Replaced panel rear heat with Smoke per inspector. Did find that the panel bell output is pulsed not steady. Will need to also add 2 new Smokes per inspector and a new Keypad at the rear entrance.

Labor 8.45

Arrived	9:00
Departed	12:00
Hours On-Site	12:15
Technicians	

Material Used

Quantity	Description	Per Unit	Total
1-2WD	Smoke		

Charges

Trip Charge	
Labor	
Materials	
Sub-Total	
Tax(@ 8.25%)	
Total Due	
[ ] Cash [ ] Check #	

Acknowledgement
I acknowledge the satisfactory completion of the work as described above and receipt of an exact and completely filled in copy of this work order repair form.

Charges for normal repairs NOT covered by a comprehensive service agreement

[redacted] 3-3-16

Subscribers Signature Date Coverage

<FOR OFFICE USE> System Info:

Americans United for Life

Service, repairs and/or additions require payment upon completion. Thank you! Payment upon completion helps to keep our (and your) service costs down.

INSPECTION AND TESTING FORM

Oberlander Alarm Systems, Inc.
2216 W. Altorfer Dr.
Peoria, IL 61615

TYPE TRANSMISSION	SERVICE
___ Multiplex	___ Monthly
X Digital	___ Quarterly
___ Reverse Priority	X Semiannually
___ RF	___ Annually
___ Other (Specify)	___ Other (Specify)

Control Unit Manufacturer: Radionics Model No: 7212
Circuit Styles: Class B
Number of Circuits: 8
Software Rev.:
Last Date System Had Any Service Performed:
Last Date That Any Software or Configuration Was Revised:

PRIOR TO ANY TESTING

NOTIFICATIONS ARE MADE	YES	NO	WHO	TIME
Monitoring Entity	X		DAS / Holl	9:00 a.m.
Building Occupants				
Building Management				
Other (Specify)				
AHJ (Notified) Of Any Impairments				

SYSTEM TESTS AND INSPECTIONS

TYPE	VISIBLE	FUNCTIONAL	COMMENTS
Control Unit	X	X	
Interface Eq.	X	X	
Lamps/LEDS	X	X	
Fuses	X	X	
Primary Power Supply	X	X	
Trouble Signals	X	X	
Disconnect Switches	X	X	
Ground-Fault Monitoring	X	X	

SECONDARY POWER

TYPE	VISIBLE	FUNCTIONAL	COMMENTS
Battery Condition	✓	✓	12.30 after 30 min
Load Voltage			13.90 / 13.55
Discharge Test			13.55 VDC
Charger Test			
Specify Gravity			
TRANSIENT SUPPRESSORS	N/A		
REMOTE ANNUNCIATORS	✓	✓	
NOTIFICATION APPLIANCES			
Audible	✓	✓	
Visual	✓	✓	
Speakers			
Voice Clarity	N/A		

ALARM-INITIATING DEVICES AND CIRCUIT INFORMATION

QUANTITY	CIRCUIT STYLE	
4		Manual Fire Alarm Boxes
8		Ion Detectors
6		Photo Detectors
0		Duct Detectors
0		Heat Detectors
20		Waterflow Switches
2		Supervisory Switches
2		Other (Specify) 2 door holders

maglocks / which did release when fire alarm triggers

SUPERVISORY SIGNAL-INITIATING DEVICES AND CIRCUIT INFORMATION

QUANTITY	CIRCUIT STYLE	
		Building Temp.
		Site Water Temp.
		Site Water Level
		Fire Pump Power
		Fire Pump Running
		Fire Pump Auto Position
		Fire Pump or Pump Controller Trol.
		Fire Pump Running
		Generator In Auto Position
		Generator or Controller Trouble
		Switch Transfer
		Generator Engine Running
		Other (Specify) _____

INITIATING AND SUPERVISORY DEVICE TESTS AND INSPECTIONS

Loc. & S/N	Device Type	Visual Check	Functional Test	Factory Setting	Meas Setting	Pass	Fail

Comments: _____

ALARM NOTIFICATION APPLIANCES AND CIRCUIT INFORMATION

QUANTITY	CIRCUIT STYLE	
3		Horn/Strobes
6		Bells
0		Horns
6		Chimes
2		Strobes
0		Speakers
8		Other (Specify)

No. of alarm notification appliance circuits: 1

Are circuits monitored for integrity? X Yes ___ No

SIGNALING LINE CIRCUITS

Quantity and style (See NFPA 72, Table 3-6) of signaling line circuits connected to system:

Quantity: 2 Styles: Poys

SYSTEM POWER SUPPLIES

a. Primary (Main): Nominal Voltage 165 40 Vac Amps _____

Overcurrent Protection: Type Breaker Amps _____

Location (of Primary Supply Panelboard): _____

Disconnecting Means Location: _____

b. Secondary (Standby): 12 VDC Storage Battery: Amp-Hr. Rating 2-7.2 each

Calculated capacity to operate system in hours:

X 24 60

___ Engine driven generator dedicated to fire alarm system.

Location of fuel storage: _____

TYPE BATTERY

____Nickel-Cadmium
__X__Sealed Lead-Acid
____Lead-Acid
____Other (Specify): _____

c. Emergency or standby system used as a backup to primary power supply, instead of using a secondary power supply:

_____Emergency system described in NFPA 70, Article 700
_____Legally required standby described in NFPA 70, Article 701
_____Optional standby system described in NFPA 70, Article 702, which also meets the performance requirements of Article 700 or 701.

EMERGENCY COMMUNICATIONS EQUIPMENT

	VISUAL	FUNCTION	COMMENTS
Phone Set			
Phone Jacks	X	X	
Off-Hook Indicator			
Amplifier(s)			
Tone Generator(s)			
Call-in Signal			
System Performance			

INTERFACE EQUIPMENT

	VISUAL	DEVICE OPERATION	COMMENTS
(Specify)			
(Specify)			
(Specify)			

SPECIAL HAZARD SYSTEMS

(Specify)			
(Specify)			
(Specify)			

Special Procedures: _____

Comments: _____

SUPERVISING STATION MONITORING

	YES	NO	TIME	COMMENTS
Alarm Signal	X		11:00	
Alarm Restoration	X			
Trouble Signal	X			
Supervisory Signal	X			
Supervisory Restoration	X			

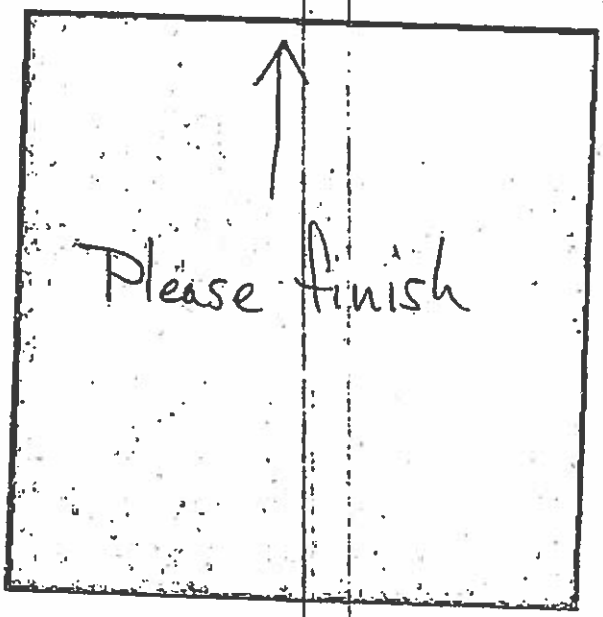
NOTIFICATIONS THAT TESTING IS COMPLETE

	YES	NO	WHO	TIME
Building Management	X			
Monitoring Agency	X		Holly / OAS	
Building Occupants	N/A			
Other (Specify) _____				

The following did not operate correctly: Horns and Strobes were not working properly because the output from our panel is pulsed instead of steady

System test start time: Date: 3-3-16 Time: 9:00

System restored to normal operation: Date: 3-3-16 Time: 12:00



Americans United for Life

INITIATING AND SUPERVISORY DEVICE TESTS AND INSPECTIONS

Loc & S/N	Device Type	Visual Check	Functional Test	Factory Setting	Meas. Setting	Pass	Fail
Back Hall/North	Photo	(✓)	(✓)	1.5-3.0	2.75	(✓)	( )
East Hall	Phot	(✓)	(✓)	1.5-3.0	2.75	(✓)	( )
Front Hall	"	(✓)	(✓)	1.5-3.0	2.83	(✓)	( )
West Hall	"	(✓)	(✓)	1.5-3.0	2.87	(✓)	( )
& Back reception	"	(✓)	(✓)	1.0-4.0	2.73	(✓)	( )
Panel Room	"	(✓)	(✓)	1.0-4.0	2.68	( )	( )
		( )	( )			( )	( )
		( )	( )			( )	( )
		( )	( )			( )	( )
		( )	( )			( )	( )
		( )	( )			( )	( )
		( )	( )			( )	( )
		( )	( )			( )	( )
		( )	( )			( )	( )
		( )	( )			( )	( )
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		( )	( )			( )	( )
		( )	( )			( )	( )
		( )	( )			( )	( )
		( )	( )			( )	( )
		( )	( )			( )	( )

COMMENTS: _____

Americans United for Life

Whole Woman's Health of Peoria, LLC

Emergency Lighting Check

Year_____ Date_____

Lights checked are listed as:

#1 Front Door #2&3 Reception #4 Back Door #5 Hallway (Counseling)
#6 Hallway (Handicap) #7&8 Recovery Room #9 Handicap Hallway

Annual Check: 90 minute test

#1 #2 #3 #4 #5 #6 #7 #8 #9

Monthly Check: A light in the Exit Signs will be checked for proper function. If a bulb is out it will be replaced and noted.

Jan: #1 #2 #3 #4 #5 #6 #7 #8 #9

Comments:_____
_____

Feb: #1 #2 #3 #4 #5 #6 #7 #8 #9

Comments:_____
_____

March: #1 #2 #3 #4 #5 #6 #7 #8 #9

Comments:_____
_____

April: #1 #2 #3 #4 #5 #6 #7 #8 #9

Comments:_____
_____

May: #1 #2 #3 #4 #5 #6 #7 #8 #9

Comments:_____
_____

Whole Woman's Health of Peoria, LLC

June: #1 #2 #3 #4 #5 #6 #7 #8 #9

Comments:_____

_____

July: #1 #2 #3 #4 #5 #6 #7 #8 #9

Comments:_____

_____

August: #1 #2 #3 #4 #5 #6 #7 #8 #9

Comments:_____

_____

Sept: #1 #2 #3 #4 #5 #6 #7 #8 #9

Comments:_____

_____

Oct: #1 #2 #3 #4 #5 #6 #7 #8 #9

Comments:_____

_____

Nov: #1 #2 #3 #4 #5 #6 #7 #8 #9

Comments:_____

_____

Dec: #1 #2 #3 #4 #5 #6 #7 #8 #9

Comments:_____

_____

Americans United for Life

Revised 01/2015
Adopted from NHC on 5/13/15 AF

Quarterly Fire Drill Record

Whole Woman's Health of Peoria

Date and time: _____

Topics Covered:

1. Indicate which device was utilized to activate the fire alarm._____
2. Indicate that staff heard the fire alarm system. If yes, check here ____ If no, indicate where in the building they did not hear the alarm.

   _____
3. Confirm that the fire alarm monitoring service received the alarm signal created from each fire drill. If yes, check here ____. If no, indicate that alarm monitoring service was contacted to address the problem and confirm solution.

   _____
4. Indicate that the staff observed all components of the fire alarm system operated as required, i.e. doors closed, horns sounded and strobe lights were activated. If yes, check here. If no, indicate which components did not function and plan for service from alarm company._____

Attendee's Signature **Job Title/ Position**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Trainers & Qualifications: _____

_____

Americans United for Life

GETZ FIRE EQUIPMENT COMPANY

March 13, 2015

Salesman/Tech: 107 Mike Lockwood
Service Frequency: Annual
Service Month: April

SO #: SO1-650788
Date Completed: 4-28-15

SERVICE ORDER

11663
NATIONAL HEALTHCARE
7405 N UNIVERSITY, SUITE D
PEORIA, IL 61614

11663-00
NATIONAL HEALTHCARE
7405 N UNIVERSITY, SUITE D
PEORIA, IL 61614

Phone : (309) 691-9073

Payment Terms : N30 Net 30
Past Due Amount : 0.00
E-Mail Address:
Tax Area Code: ILPEO

Sold By : Mike Lockwood
Service Contact :
Service Contact Phone No. :

Qty	Item #	Description	Price Each	Total	Qty	Item #	Description	Price Each	Total
9	AM15100	ANNUAL SERVICE PORTABLE FIRE EXTI	5.50	49.50					
1	AM15040	ANNUAL SERVICE HALON 1/4-20 LB	5.50	5.50			225.00		
4	P11330	PREFORMED PACKING	5.00	20.00			20.00		
1	P11670	VALVE REBUILD MISC BRAND					5.00		
4	P1100	INSTALLATION LABOR FOR PARTS	Sheet Above						
1	TD18020	RECOVERY & REFILL CLEAN AGENT 13-2							
4	SC100	VERIFICATION OF SERV COLLAR/NFPA-1	1.50	6.00					
1	TC1100	ON SITE SERVICE	30.00	30.00					
1	FAC	FUEL ADJUSTMENT CHARGE	5.00	5.00					
4	TD1000	bypass mount to use FX	32.00	128.00					
4	VR1000	valve reconditioned	4.00	16.00					

POSTED

☐ Deficiencies:

☐ PO Required : No

PO Expiration Date :

Purchase Order # :

Total:
Tax:
Grand Total:

X [redacted] 4-28-15 Pam Krider

Customer Signature Date Print Name

A service charge at the rate of 2% per month (24% annually) will be made on all invoices not paid within 30 days.

In the event the buyer fails to perform its obligation, seller may recover the price and expenses, including reasonable attorney's fees and other cost of enforcing its rights.

Fire Safety Policy

It is the policy of this facility to conduct a fire drill or handle a fire in such a manner as to preserve lives, prevent undue panic, and control the spread of fire. Each employee will be aware of fire exits, fire extinguishers, the proper procedure for ensuring fire safety, and the steps to be taken in case of fire. It is not the intent of this policy that any staff member endangers him/herself; rather, the intent is to ensure the safety of both staff and patients.

In the event of fire, it is our policy for all employees and patients to immediately evacuate the premises and contact the fire department by calling 911.

☐X **This facility has a fire alarm system. In case of fire immediately activate the alarm. If you have any questions regarding use, ask our Safety/Health Manager.**

After evacuation, the staff and patients will assemble for a "head count" at the following location: Primary Evacuation Location: Empty Parking Lot Two Doors North.

Once the "head count" is complete, the Clinic Manager (or his/her designee) will allow everyone to reenter the building after receiving the "all clear" from the fire department. Fire drills will be held regularly and at least annually to ensure that staff understands the proper procedure in case of fire.

☐ N/A **This facility has an automatic sprinkler system. It will be maintained in a reliable condition at all times. Records of inspection are kept**
_____.

This office has _9_ portable fire extinguisher(s). They are located: (1) Front Waiting Area, (2) Front Office Area, (3) Front Hallway by Manager's Office, (4) Lab, (5) End of Counseling Hallway, (6) Outside Pre-Op waiting area, (7) by exit door facing University St. (8) End of OR hallway near Recovery, (9) in Recovery room (this unit is the Halon1/4-20lb extinguisher.

The fire extinguishers are checked annually by a licensed service professional and records of the inspections are maintained on-site or attached to each fire extinguisher. Our Safety/ Health Manager is responsible for checking the gauge(s) on a regular basis to verify that the units are fully charged. Any fire extinguishers not properly charged or missing from their designated place will be reported to the Safety/Health Manager for immediate service or replacement.

While it is not their jobs to fight fires, it is the policy of this facility that all employees will be trained in the use of a fire extinguisher and retrained at their annual OSHA training. Any questions will be addressed to the Safety/ Health Manager.

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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7003195	26992	1/5/17

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Whole Women's Health of Peoria	7405 N. University, Peoria, Illinois, 61614

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
T000	A complaint survey was conducted 1/2/17 through 1/5/17. The Pregnancy termination Center was not in compliance with Illinois Administrative Code: TITLE 77: PUBLIC HEALTH CHAPTER I: DEPARTMENT OF PUBLIC HEALTH SUBCHAPTER e: VITAL RECORDS PART 505 PREGNANCY TERMINATION REPORT CODE, as evidenced by:			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE Holly Arnold

TITLE Clinic Manager

DATE 2-1-2017

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7003195	26992	1/5/17

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Whole Women's Health of Peoria	7405 N. University, Peoria, Illinois, 61614

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
T025	205.410 a) Equipment shall be in good working order and shall be available in numbers sufficient to provide quality patient care based on the types of procedures to be performed in the facility. a) Monitoring equipment, suction apparatus, oxygen and related items shall be available within the surgical and postoperative recovery areas. Cardiac and pulmonary resuscitation equipment shall be available in all facilities. This Regulation is not met as evidence by: Based on observation, document review and staff interview, it was determined the Pregnancy Termination Center (PTC) failed to ensure medical equipment is inspected and maintained to ensure safety. This has the potential to affect all patients receiving care from the PTC. Findings include: 1. During a tour of the PTC conducted on 1/3/17 at 11:00 AM with the Director of Clinical Services (E #1), three (3) operating rooms had no documentation of preventative maintenance completed on any of the suction machines available for use. 2. Facility policy reviewed 1/5/17 at approximately 11:00 AM titled "Review Equipment maintenance records" states "Make sure annual maintenance is up-to-date on all medical equipment". 3. An interview with E #1 was conducted on 1/5/17 at 11:30 AM. E #1 stated that no answer concerning no documentation found for preventative maintenance for the suction machines.		The Clinic Manager is responsible for ensuring that preventative maintenance is completed on all equipment. The Clinic Manager contacted the maintenance company while the IDPH inspector was on site. The technician explained it was an oversight during their previous visit to inspect all the clinic equipment. The Clinic Manager scheduled the technician to return to inspect the 3 suction machines on January 17, 2017. The inspection report is attached. The Clinic Manager will ensure all future preventative maintenance is completed per Whole Woman's Health policy by communicating to the maintenance company all the equipment that is to be inspected.	January 17, 2017

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE Holly Wusfeld TITLE Clinic Manager DATE 2-1-2017

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7003195	26992	1/5/17

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Whole Women's Health of Peoria	7405 N. University, Peoria, Illinois, 61614

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
T028	205.410 d) d) The facility shall have written procedures to assure the safety in storage and use of all narcotics and medications in accordance with State and federal law. This Regulation is not met as evidence by: Based on observation, document review and staff interview, it was determined the Pregnancy Termination Center (PTC) failed to ensure outdated drugs were not available for use in patient care area. This has the potential to affect all patients receiving medications from the PTC. Findings include: 1. During a tour of the PTC conducted on 1/3/17 at 11:00 AM with the Director of Clinical Services (E #1), four boxes of equate (220 milligrams) 150 count with an expiration date of 11/16 were found in a patient medication closet. 2. Facility policy reviewed 1/5/17 at approximately 11:00 AM states Medication Therapy Practices Medication Inventory and Audit "2. All expired medications and supplies will be disposed according to WWH wasting medication procedure". Wasting Medication "1. All expired non controlled medications should remain in the original bottle, and be disposed into the Medical RX disposal container. This container will be removed from the faciliy be a specialized contracted company for proper disposal". 3. E #1 was interviewed during the tour and E#1 stated that the medication should have been removed per policy.		The Clinic Manager is responsible for ensuring that expired medications are wasted per WWH policy. The expired medications in question were disposed of via the medical waste company per WWH policy. Oral medications will no longer be stored in the stock closet. All oral medications will be stored and locked in the medication cabinets in the recovery room. The Clinic Manager will conduct an in-service with staff to review the WWH policy and ensure that expired medications are disposed of per WWH policy. Completion date: Medications moved to locked medication cabinets on January 6, 2017. In-service to be completed on February 1, 2017.	January 6, 2017. February 1, 2017.

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE Kelly Winfield

TITLE Clinic Manager

DATE 2-1-2017

MAYFIELD MEDICAL SERVICES

MULTIPLE EQUIPMENT FORM

Practice: Whole Women's Health
Street: 7405 N University
City/ST/Zip: Peoria IL

Contact: Holly
E-mail/Fax hworsfold@wohlewomanshealth.com
Phone # 309-691-9019

Location	Equipment	Mfg	Model #	S/N	Pwr Cord m ohms	Ext Lead micr oA	Fault MicroA		Current in amps	Service Comments Pass/Fail	Action Item	Insp Int	MMS Tag	Next PM Due
							Gnd	Gnd & Neut						
OR 3	Suction Pump	Berkely	SV 10	6971	120	16	32	0	N/A	Pass	N	A	N/A	Jan-18
OR 2	Suction Pump	Berkely	VC-II	4326	210	25	52	116	N/A	Pass	N	A	N/A	Jan-18
OR 1	Suction Pump	Berkely	VC-II	2633	170	27	76	137	N/A	Pass	N	A	N/A	Jan-18

ITEMS NEEDING ACTION

Requested Inspection Interval

Q = Quarterly
S = Semi Annual
A = Annual
B = Biannual

Technician: Lucas Martin

Date: 01/10/2017

Test equipment used

Safety Analyzer

United for Americans

Thank You for using Mayfield Medical Services, Inc!!

Phone: 800-667-3570 *www.mayfieldmedical.com*

2018 JUN 15 P 1:18

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7003195	26336, 32189	3/23/18

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Whole Women's Health of Peoria, LLC	7405 N University, Suite D, Peoria, Illinois 61614

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
TOOD	A Licensure survey was conducted 3/22/18 thru 3/23/18. The Facility was not in compliance with the requirements for Title 77: Public Health Chapter 1: Department of Public Health Subchapter b: Hospital and Ambulatory Care Facilities Part 205 Ambulatory Surgical Treatment Center Licensing Requirements as evidenced by: Abbreviations: ACLS- advanced cardiac life support AED- automated external defibrillator ASI- active status indicator CV- curriculum vitae DOH- date of hire DOS- date of service E- employee FPPE- Focused Professional Practice Evaluation IV- intravenous LPN- Licensed Practical Nurse MD- Medical Director mcg- microgram(s) mg- milligram(s) ml-milliliter(s) POC- products of conception Pt(s)- patient(s) QAQI- Quality Assessment and Quality Improvement RN- Registered Nurse V- volt			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE

TITLE

COO

DATE

5.31.2018

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7003195	26336, 32189	3/23/18

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Whole Women's Health of Peoria, LLC	7405 N University, Suite D, Peoria, Illinois 61614

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
T012	205.230 a) 1-3 The owner or manager of the ambulatory surgical treatment center shall maintain proper standards of professional work in the facility. a) A qualified consulting committee shall be appointed in writing by the management or owner of the ambulatory surgical treatment center and shall establish and enforce standards for professional work in the facility and standards of competency for physicians... 2) The qualified consulting committee shall review the... procedures for granting privileges, and the quality of the surgical procedures performed. The reviews shall be documented in the minutes. This Regulation is not met as evidence by: Based on document review and interview, it was determined for 3 of 3 (MD#1, MD#2, and MD#3) physicians providing medical and surgical pregnancy terminations, the Facility failed to ensure its credentialing procedure was implemented, monitored, and maintained. This has the potential to affect all patients serviced by the Facility, currently a monthly average of approximately 44 Medical termination and 44 Surgical termination patients. Findings include: 1. The Facility policy titled "Credentialing Committee" (updated 8/24/16) was reviewed on 3/22/18. The policy stated "All physicians seeking practice privileges... will be reviewed by the credentialing committee... is led by the Medical Director... All physicians with admitting privileges at (the Facility) will undergo peer review on an annual basis." 2. The QAQI Program (also the Facility qualified consulting committee) was reviewed on 3/22/18 through 3/23/18. The program lacked any credentialing information for granting privileges and monitoring the quality of the medical and surgical procedures performed.	T012	The Leadership Team and the Credentialing Committee of Whole Woman's Health of Peoria is responsible for the operation of the facility, including its compliance with Illinois State regulations. Please see the specific plan of correction for each deficiency under the appropriate tag below. The Clinic Manager and the Medical Director of Whole Woman's Health of Peoria are responsible for ensuring the implementation of this plan of correction. 1. During its May 30, 2018 meeting, the Credentialing Committee reviewed our internal policy for conducting peer reviews. The Committee has established that by June 15, 2018, the Medical Advisory Board of Whole Woman's Health, LLC will lead a peer review focusing on Whole Woman's Health of Peoria's providers. Whole Woman's Health LLC is contracted to serve as the management company of Whole Woman's Health of Peoria. The peer review will focus on 5% of each providers' Q1 2018 surgical and medical abortion procedures. Furthermore, at such time a new provider is hired at the facility it is the task of the credentialing committee to ensure that each provider has a peer review conducted on an annual basis and documentation maintained in their personnel file. The meeting minutes reflect that the credentialing committee calendar has noted that MD #1 next review is due in Q2 of 2019. As for future annual peer reviews for MD # 2 and MD #3, their tenure with Whole Woman's Health of Peoria concluded at the end of April 2018. The Credentialing Committee of Whole Woman's Health of Peoria will not schedule further peer reviews after the completion of the June 2018 review.	May 31, 2018

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE

TITLE: COO

DATE: 5.31.18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
7003195	26336, 32189	3/23/18

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Whole Women's Health of Peoria, LLC	7405 N University, Suite D, Peoria, Illinois 61614

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
T012	205.230 a) 1-3 (continued): 3. An interview was conducted with the Clinic Manager (E#1) on 3/23/18 at approximately 10:00 AM. E#1 reviewed the Credentialing Committee policy and the QAQI Program. E#1 stated "We don't have a Credentialing Committee and we haven't done any privileges for the physicians (MD#1, #2, and #3)" and verbally agreed the QAQI Program lacked any credentialing information for granting privileges and monitoring the quality of the medical and surgical procedures performed. E#1 stated "We thought that if they (the physician) were privileged at a Hospital that we did not need to do it (privileges) for here."	T012	2. The Whole Woman's Health of Peoria's credentialing Committee has established processes and procedures to ensure providers are granted clinical privileges before the provider starts their clinical activities at the facility. Whole Woman's Health of Peoria's credentialing process has existed since 2015 and is centralized in our corporate headquarters. Our established practice for credentialing a provider involves the following procedures: validation of the provider's current medical licensure including DEA, authentication of work history and current work status, appraisal of medical certification and evaluation of current hospital privileges. Additionally, Whole Woman's Health's attorney conducts extensive criminal background checks before a provider is submitted to the Credentialing Committee for approval and privileging. Our credentialing process is documented on our MD File Checklist. Furthermore, the WWH of Peoria Credentialing Committee, along with Whole Woman's Health's Human Resources department, has established procedures for credentialing documentation for a prospective provider. The procedures will allow the Committee to approve and grant privileges prior to the start of a new provider's clinical activities. At its May 30TH, 2018 meeting the Whole Woman's Health of Peoria Credentialing Committee reviewed the Credentialing folders for the following staff providers: MD#1 was originally granted privileges at Whole Woman's Health of Peoria's facility on June 18, 2015. (See attachment) His credentialing folder includes copies of his CV, current medical and DEA license, malpractice insurance and a Delineation of Privileges. MD#2 was originally granted privileges at Whole Woman's Health of Peoria's facility on September 12, 2017. (See attachment) Her credentialing folder includes copies of her CV, current medical and DEA license, malpractice insurance and a Delineation of Privileges. MD#3 was originally granted privileges at Whole Woman's Health of Peoria's facility on January 22,2018. (See attachment) His credentialing folder includes copies of his CV, current medical and DEA license, malpractice insurance and a Delineation of Privileges.	May 31,2018

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE

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5.31.18

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
7003195	26336, 32189	3/23/18

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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T013	205.230 a) 4-6 4) Physicians seeking practice privileges at the facility shall provide their credentials. The credentials committee shall periodically reappraise and review physician credentials and shall identify and record specific practice privileges pursuant to the Health Care Professional Credentials Data Collection Code. A record of accepted practice privileges shall be available for facility staff use and for public information within the facility. This Regulation is not met as evidence by: Based on document review and interview, it was determined for 3 of 3 (MD#1, MD#2 and MD#3) physicians who provide medical and surgical terminations at the Facility, the Facility failed to ensure credentials were reviewed by the Credentialing Committee and specific practice privileges were identified and recorded. This has the potential to affect all patients serviced by the Facility, currently a monthly average of approximately 44 Medical termination and 44 Surgical termination patients. Findings include: 1. The policy titled "Credentialing Committee" (updated 8/24/16) was reviewed on 3/23/18. The policy required "All physicians seeking privileges... will be reviewed by the credentialing committee...When a physician applies for privileges ... the following will be noted and placed in the physician's file; 1. CV (Curriculum Vitae- a short account of one's career and qualifications prepared by an applicant for a position) 2. Current MD License 3. State Hospital affiliation 4. Malpractice coverage 5. ACLS Certification 6. Delineation of Privileges 7. Letter granting privileges... All Physicians... will undergo peer review on an annual basis." 2. The QAQI meeting minutes dated 12/2015 through 12/2017 were reviewed on 3/22/18. The minutes lacked documentation the physician's credentials were reviewed upon application. The meeting minutes lacked documentation a peer review had been conducted annually for MD#1.	T013	1. Whole Woman's Health of Peoria did comply with this requirement however the documents were stored at Whole Woman's Health Corporate headquarters. During its May 30, 2018 meeting, the Credentialing Committee reviewed our internal policies and procedures regarding the credentialing and recredentialing of providers. As outlined in the procedures, on an annual basis, the Committee will review each providers personnel file to update and verify their credentialing documents. This documentation includes medical licensure, medical certification and privileging documents. Also, during the time of a provider's recredentialing, the Committee will perform a clinical review of a portion their surgical and medication charts. 2. In the attached documents, Whole Woman's Health of Peoria has included copies of MD#1, MD#2, and MD #3's credentialing documentation not made available to the surveyor during the onsite audit. The materials were stored off site at the time of the audit. MD #2 MD # 2's tenure with Whole Woman's Health concluded at the end of April 2018. However, Whole Woman's Health of Peoria has reached out MD # 2's to request documentation of granted privileges from the outlying hospital. MD #3 MD # 3 tenure with Whole Woman's Health concluded at the end of April 2018. However, Whole Woman's Health of Peoria has reached out MD # 3 to request documentation of grated privileges from the outlying hospital.	May 30,2018

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T013	205.230 a) 4-6 (continued) 3. The Physician files were reviewed on 3/22/18. The physician files lacked the following documentation: a) MD#1 DOH: 6/18/15 (1) no Delineation of Privileges and no annual peer review. (2) The "Independent Contractor Agreement Medical Director/Consultant" with effective date of June 1, 2017 lacked the President's signature and lacked the printed name, address, and email address and did not indicate any privileges. b) MD#2 DOH: 6/ 28/17 (1) No CV, no Delineation of Privileges, and no letter granting privileges. (2) There was a signature sheet, dated effective 9/20/17, which lacked what the "Agreement" was. (3) The outlying Hospital privilege letter, dated 9/9/16, stated privileges were approved effective 9/9/16 and "will be on Focused Professional Practice Evaluation (FPPE) for 6-months. This process is implemented for all initially requested privileges." The letter did not state what the approved privileges were and there was no documentation to indicate whether MD#2's privileges were continued after the 6-month FPPE at the outlying Hospital. c) MD#3 DOH: 1/17/18 (1) No CV, no Delineation of Privileges, and no letter granting privileges. (2) There was no "Agreement". (3) The outlying Hospital privilege letter, dated 11/24/17, stated the Hospital "has approved your reappointment application". The letter did not state what the approved privileges were. 4. During an interview throughout 3/23/18, E#1 verbally agreed the credentials for MD#1, MD#2, and MD#3 had not been reviewed by the QAQI committee, there was no Credentialing Committee, there were no CVs for MDs #2 and #3, there were no delineation of specific privileges and no letters granting privileges for all three physicians, the "Agreement" for MD#1 was incomplete, the signature sheet lacked an "Agreement" for MD#2, and there was no "Agreement" for MD#3.			

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Americans United for Life

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T014	205.230 b)1-3 b) A qualified physician shall be designated as the medical director. 1) The medical director shall secure compliance with the policies and procedures pertaining to medical and surgical procedures, approved by the qualified consulting committee. 2) The medical director shall implement medical policies and procedures contained in the facility's policies and procedures manual (Section 205.240) governing the professional personnel involved directly in the care of patients undergoing surgical procedures, including their preoperative and postoperative care and follow-up. 3) The medical director shall establish and secure compliance with standards for patient observation by nursing personnel during the postoperative period. This Regulation is not met as evidence by: Based on document review and interview, it was determined the Facility failed to ensure the Medical Director "Agreement" was completed. This has the potential to affect all patients serviced by the Facility, currently a monthly average of approximately 44 Medical termination and 44 Surgical termination patients. Findings include: 1. The "Independent Contractor Agreement Medical Director/Consultant" with MD#1, effective date of June 1, 2017, was reviewed on 3/23/18. The "President" signature was blank. The "Print the Name of the Physician... Address... Email..." were blank. 2. An interview was conducted with the Clinic Manager (E#1) on 3/23/18 at approximately 12:00 PM. E#1 reviewed MD#1's Medical Director agreement and verbally agreed it lacked the President's signature and MD#1's printed name, address, and email address and that all of these items were suppose to be present and were not.	T014	In the attached documents, Whole Woman's Health of Peoria has included a copy of the Medical Director's Agreement. The signed document was housed at Whole Woman's Health's head quarter's office.	

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T022	205.330 a) & b) a) At least one registered professional nurse with postgraduate education or experience in surgical nursing shall direct and supervise the nursing personnel and the nursing care of patients and shall be on duty at all times on the premises when patients are present... This Regulation is not met as evidence by: Based on interview, observation, and interview, it was determined the Facility failed to ensure a RN was on duty at all times on the premises when patients were present. This has the potential to affect all patients serviced by the Facility, currently a monthly average of approximately 44 Medical termination and 44 Surgical termination patients. Findings include: 1. An interview was conducted with the Clinic Manager (E#1- LPN) on 3/22/18 at approximately 10:30 AM. E#1 stated the following: a. E#1(LPN) is the only full-time employee. b. Staff included 2 RNs, 1 LPN, and 6 Patient Advocates (direct care, unlicensed) c. Facility is open 6 days per week, Monday thru Saturday 9:00 AM and 5:00 PM; exception Wednesdays: 8:00 AM to 5:00 PM. (1) Monday and Friday- LPN only- patients that walk in with questions, if treatment requested (Medical termination), calls in a second person (Patient Advocate). (2) Tuesday and Thursday- LPN and two Patient Advocates: Telemedicine for Medical Terminations. (3) Wednesday- All staff- 2 RNs, LPN, and 6 Patient Advocates: Surgical and Medical terminations. 2. During observations conducted throughout 3/22/18, the Clinic Manager (E#1) and the Patient Advocate (E#2) were observed providing care to patients requesting medical pregnancy terminations. There was no RN on duty and on the premises while the patients were present.	T022	Whole Woman's Health of Peoria has always had an RN present onsite during procedural abortions and has added RN staff to the schedule for non-procedural visits as well.	May 31,2018

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T022	205.330 a) & b) (continued) 3. The staffing schedules for October 2017 thru March 2018 were reviewed on 3/22/18 and concurred with E#1's interview that no RN on duty at all times on the premises when patients are present. "We only have RNs here on surgical days or if I need extra help some times."			

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T025	205.410 a) Equipment shall be in good working order and shall be available in numbers sufficient to provide quality patient care based on the types of procedures to be performed in the facility. a) Monitoring equipment, suction apparatus, oxygen and related items shall be available within the surgical and postoperative recovery areas. Cardiac and pulmonary resuscitation equipment shall be available in all facilities. This Regulation is not met as evidence by: Based on observation, document review, and interview, it was determined the Facility failed to ensure patient care equipment was maintained and available for patient use. This has the potential to affect all patients serviced by the Facility, currently a monthly average of approximately 44 Medical termination and 44 Surgical termination patients. Findings include: 1. During an observational tour on 3/22/18 at approximately 12:00 PM, the AED was observed to be available for patient use, was observed to be non-operational, and was unable to be powered on. The battery was observed to be in a separate case next to the AED case. 2. The "Defibtech DDU-120 Fully Automatic External Defibrillator User Manual" was reviewed during the tour. The Manual stated on page 29-30 "5.1 Self-Tests... The unit also automatically performs daily, weekly... Self-Tests as long as a non-depleted 9V battery is present... 5.2 Routine Maintenance... daily... Check that Active Status Indicator (ASI) is flashing green... 5.2.1 Checking Active Status Indicator... If it is flashing red or not flashing at all, the AED needs attention..."	T025	Under the supervision of the Medical Director, the Clinic Manager will be responsible for ensuring all equipment is in good working order and monitored per factory manual. On March 28, 2018, an in-service was conducted with all staff to review the maintenance protocol. A daily AED testing log was also implemented, and staff were trained on its use. The Clinic Manager will review the log weekly to ensure compliance. See attached documentation.	3/28/2018

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T025	205.410 a) (continued) 3. An interview was conducted with the Clinic Manager (E#1) during the tour. E#1 reviewed the AED Manual and stated the AED was checked monthly during the crash cart check and was unaware of the daily checks to ensure the automated self check was successfully completed and operational. E#1 verbally agreed the AED was available for patient use; non-operational, and daily checks had not been conducted for functionality and should have been.			

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T026	205.410 b) 1-3 b) The facility shall have written policies and procedures and shall maintain documentation governing the care, use, decontamination, sterilization, storage and disposal of all materials to ensure that an adequate supply of sterile equipment, instruments and supplies is available for each procedure... 1) Staff orientation and in-service training to understand and implement facility policies and procedures for infection control, and to adhere to manufacturer's instructions for receiving, decontaminating, cleaning, preparing, sterilizing and high-level disinfection, handling, storage and quality control of equipment, supplies and instruments... This Regulation is not met as evidence by: Based on observation, document review, and interview, it was determined the Facility failed to ensure patient care equipment was appropriately sterilized prior to patient use. This has the potential to affect all patients serviced by the Facility, currently a monthly average of approximately 44 Medical termination and 44 Surgical termination patients. Findings include: 1. An observational tour of the sterilization area was conducted on 3/22/18 at approximately 11:15 AM. A Pelton Crane autoclave and a Tuttnauer autoclave were observed present and available for use. 2. The following documents were reviewed during the tour: a. The Biological Monitoring test reports, dated 4/1/17 to 6/30/17, noted a failed biological test on 5/5/17, on 5/11/17, and on 5/18/17 for the Pelton Crane autoclave. b. The Autoclave Load Log noted the Pelton Crane autoclave was utilized for instrument sterilization on 5/5/17, 5/10/17, 5/11/17, 5/18/17, 5/24/17, and 5/25/17, after the biological indicator tests had failed. The log lacked documentation the instruments potentially not sterilized in the Pelton autoclave during the 5/5/17 through 5/25/17 period were removed from services and/or were reprocessed in the appropriately functioning Tuttnauer autoclave. The log documentation of the	t026	The Medical Director reviewed the charts of the 40 surgical abortion patients seen between 4/1/2017 and 6/30/2017. According to the patients' medical charts and the facility's complication log, the facility did not receive any reports of patient complication. Additionally, of the 40 surgical abortion seen during this period, three returned for a follow-up exam. During the follow-up visit, complications from the procedure were not found. Under the direction of the Medical Director, the clinical team and the Clinic manager is responsible for ensuring the proper disinfection, sterilization, decontamination, and storage of sterile equipment. The Clinic Manager held an in-service to review Whole Woman's Health of Peoria policies and procedures for sterilizing instruments. Specifically, the Clinic Manager reviewed Whole Woman's Health's spore testing procedure and the maintenance instruction from the autoclave manual. Documentation of service for the machine is attached. Documentation of in-service training attached	May 10 2018

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T026	205.410 b) 1-3 (continued) temperatures and pressures from 3/24/17 through 5/25/17 were reviewed to have no significant variance. c. The POC (Product of Conception) Log noted that between 5/10/17 and 5/25/17, forty patients underwent a surgical pregnancy termination and therefore were potentially exposed to non-sterilized instruments. 3. The policy titled "Decontamination, Disinfection, Sterilization, and Storage of Sterile Supplies" (updated 8/25/16) was reviewed on 3/22/18. The policy stated "Biological Indicators... A. These indicators will be included in one run each day of use per sterilizer... C. If a test is positive, the sterilizer will immediately be taken out of service and will not be put back into service until it has been serviced and successfully tested." 4. During an interview on 3/22/18 at approximately 11:40 AM, E#3 (Patient Advocate/ Sterilization) stated the "Maintenance Man came to check the autoclave when the tests failed. (Maintenance man) said the (Pelton) autoclave's temperature dial had been accidentally lowered and the autoclave didn't reach the required temperature. That's why the biological test failed." 5. During an interview on 3/23/18 at approximately 3:00 PM, E#1 stated "I thought the autoclave had been taken out of service and all the instruments were reprocessed." E#1 reviewed the logs and verbally agreed the Pelton autoclave had been utilized to sterilize equipment during the timeframe of the failed biological tests and shouldn't have been. E#1 verbally agreed the log didn't note an increased utilization or number of load contents sterilized in the Tuttnauer autoclave to indicate potentially contaminated equipment were pulled from service and resterilized.			

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T028	205.410 d) d) The facility shall have written procedures to assure the safety in storage and use of all narcotics and medications in accordance with State and federal law. This Regulation is not met as evidence by: A. Based on observation, document review, and interview, it was determined the Facility failed to ensure its policy on multidose vials was followed to prevent the potential for cross contamination. This has the potential to affect all patients serviced by the Facility, currently a monthly average of approximately 44 Medical termination and 44 Surgical termination patients. Findings include: 1. An observational tour of the medication storage area was conducted on 3/22/18 at approximately 12:10 PM with the Clinic Manager (E#1). The following were observed in the medication cabinet: One open 0.5 mg/5 ml vial of Flumazenil dated as opened 2/10/18 and no date as to when to dispose of it; one open Flumazenil 0.5 mg/5 ml, dated as opened 1/17/18 and labeled "Do not use after 10/2018 (the manufacturer expiration date on the vial)"; and one open Midazolem 50 mg/10 ml with no date as to when opened. 2. The Facility policy titled "Medication Therapy Practices" (reviewed 9/2015) was reviewed on 3/22/18 at approximately 2:00 PM. The policy stated "4) When a multi dose vial is opened the staff drawing the medication will document the open date, expiration date (28 days from the open date) and initials." 3. An interview was conducted with E#1 during the tour. E#1 observed the one open vial with no date as to when opened and the two open vials, opened greater than 28 days, available for patient use. E#1 stated "I thought we could use them (the open vials) until the expiration date (manufacturer expiration date). I didn't realize the policy said 28 days (after opened)."	T028	Whole Woman's Health of Peoria has established policies and procedures for medication storage and administration. The Medical Director and the Clinic Manager are responsible for ensuring that the nursing staff follow Whole Woman's Health's Medication Therapy Practices. On May 16th, 2018, the Clinic Manager conducted an in-service training to review the Medication Therapy Practices policy. The training focused on medication storage and labeling, management of expired medications and proper techniques for drawing up IV medications. On a weekly basis, the clinic manager will audit the facility's medication storage for compliance.	May 16,2018

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T028	205.410 d) d) The facility shall have written procedures to assure the safety in storage and use of all narcotics and medications in accordance with State and federal law. This Regulation is not met as evidence by: B. Based on observation and interview, it was determined the Facility failed to ensure syringes were stored to prevent the potential for cross-contamination. This has the potential to affect all patients serviced by the Facility, currently a monthly average of approximately 44 Medical termination and 44 Surgical termination patients. Findings include: 1. An observational tour of the medication storage area was conducted on 3/22/18 at approximately 12:10 PM with the Clinic Manager (E#1). A locked box with injectable medications was observed in the medication cabinet with six open, unpackaged three milliliter syringes with needles attached. 2. An interview was conducted with E#1 during the tour. E#1 observed the six open, unpackaged three milliliter syringes with needles attached and stated "We open them (take them out of their individual plastic packages)and put them in the box so they are ready to be used. I didn't know we couldn't do that." E#1 verbally agreed there was no way to determine whether the syringes had been used or not.			

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T044	205.530 a) a) Surgical procedures shall be performed only by a qualified physician, dentist or podiatrist within the limits of the defined specific surgical practice privileges that have been granted to that individual by the consulting committee or a committee designated by the consulting committee. This Regulation is not met as evidence by: Based on document review and interview, it was determined for 3 of 3 (MDs #1, #2, and #3) physicians, who perform surgical terminations, the Facility failed to ensure surgical procedures were by qualified physicians within the defined specific surgical practice privileges that have been granted to that individual by the committee designated by the consulting committee. This has the potential to affect all patients undergoing a surgical pregnancy termination by the Facility, currently approximately 44 patients monthly. Findings Include: 1. The surgical termination statistics for MDs #1, #2, and #3 were reviewed on 3/23/18 at approximately 11:00 AM. The statistics stated the following average of surgical pregnancy terminations per MD: a. MD#1: Between 10/2017 thru 3/23/2018- a monthly average of approximately 40 per month. b. MD#2: Between 9/2017 thru 2/2018 (has not worked in March)- a monthly average of approximately 9 per month. c. MD#3: Between 1/2018 and 2/2018 (has not worked in March)- a monthly average of approximately 11 per month. 2. See citation at T012. 3. See citation at T013.	T044	In the attached documents, Whole Woman's Health of Peoria has included a copy of the privileging documentation for MD #1, MD #2, and MD #3. The signed document was housed at Whole Woman's Health's head quarter's office.	May 30,2018

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE

TITLE

COO

DATE

5.31.18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7003195	26336, 32189	3/23/18

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Whole Women's Health of Peoria, LLC	7405 N University, Suite D, Peoria, Illinois 61614

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T046	205.530 b) 2 A-D 2) Anesthesia may be administered only by the following persons, each having been granted specific anesthesia privileges by the consulting committee or a committee designated by the consulting committee... B) A physician licensed to practice medicine in all its branches. This Regulation is not met as evidence by: Based on document review and interview, it was determined for 3 of 3 (MD#1, MD#2, and MD#3) Physicians who administer and/or supervise IV conscious sedation, the Facility failed to ensure IV conscious sedation was administered and/or supervised only by physicians who had been granted specific privileges for IV conscious sedation. This was evident in 3 of 3 (Pt #6, Pt#7, and Pt#8) patients who underwent surgical pregnancy terminations and has the potential to affect all surgical patients serviced by the Facility, currently a monthly average of approximately 44 surgical pregnancy termination patients. Findings include: 1. The policy titled "Protocol for Conscious IV (Intravenous) Sedation" (reviewed on 2/2012) was reviewed on 3/23/18. The policy stated "Monitoring of IV conscious sedation is done by the doctor prior to the start of the procedure, during the procedure, and at the end of the procedure." 2. The QAQI Meeting Minutes, dated 12/2015 through 12/2017, were reviewed on 3/22/18. The Minutes lacked documentation that anesthesia (IV conscious sedation) privileges had been granted to MD#1, MD#2 or MD#3. 3. Three of three (MD#1, MD#2, and MD#3) Physician files reviewed on 3/22/18 lacked documentation that anesthesia (conscious sedation) privileges were requested and/or approved.	T046	In the attached documents, Whole Woman's Health of Peoria has included a copy of the privileging documentation for MD #1, MD #2, and MD #3. The signed document existed at the time of the survey. However, it was housed at Whole Woman's Health's head quarter's office.	05/31/2018

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[signature]	COO	5.31.18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7003195	26336, 32189	3/23/18

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	205.530 b) 2 A-D (continued)			
T045	4. The clinical records of Pt#6, Pt#7, and Pt#8 were reviewed throughout 3/22/18 and 3/23/18 and noted IV conscious sedation was administered during a surgical pregnancy termination under the supervision of MD#1. a) Pt #6, admitted 2/28/18 b) Pt #7, admitted 2/27/18 c) Pt #8, admitted 2/28/18 5. The "Custom Referral Analysis" forms for MD#2 and MD#3 were reviewed on 3/23/18 and stated the following IV conscious sedation: a. MD#2- Between 9/2017 and 2/2018, IV conscious sedation was performed for forty one out of fifty two surgical pregnancy terminations. b. MD#3- Between 1/2018 and 2/2018, IV conscious sedation was performed for twenty one out of twenty one surgical pregnancy terminations. 6. The 2016 and 2017 quarterly statistics were reviewed on 3/22/18 to 3/23/18. The statistics stated the following: a. In 2016, IV sedation was utilized in 454 out of 634 surgical terminations. b. In 2017, IV sedation was utilized in 390 out of 484 surgical terminations. 7. During an interview throughout the day on 3/23/18, E#1 had reviewed the patient records and physician statistics and verbally agreed the specific privileges for conscious sedation had not been delineated and approved and should have been for MD#1, MD#2 and MD#3.			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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T054	205.530 d) d) All x-rays, except those exempted by the consulting committee and as specified in the facility's policies and procedures manual, shall be read by a physician... whom shall have practice privileges at the facility... A copy of the x-ray report shall be filed in the patient's clinical record within seven days. This Regulation is not met as evidence by: Based on document review and interview, it was determined for 3 of 3 (MD#1, MD#2, and MD#3) physicians who review obstetric ultrasounds, the Facility failed to ensure qualified physicians applied for and were granted privileges reading ultrasounds. This was evident in 10 of 10 (Pt#1, Pt #2, Pt #3, Pt #4, Pt #5, Pt #6, Pt #7, Pt #8, Pt #9, and Pt #10) patients who underwent either Medical or Surgical terminations and has the potential to affect all patients serviced by the Facility, currently approximately 44 Medical and 44 Surgical terminations monthly. Findings include: 1. Ten of ten records reviewed 3/22/18 thru 3/23/18 stated the ultrasound was read by the physician (MD#1) as follows: a. Pt #1 DOS: 3/22/18 b. Pt #2 DOS: 3/22/18 c. Pt #3 DOS: 3/1/18 d. Pt #4 DOS: 3/6/18 e. Pt #5 DOS: 3/1/18 f. Pt #6 DOS: 2/28/18 g. Pt #7 DOS: 2/28/18 h. Pt #8 DOS: 2/28/18 i. Pt #9 DOS: 2/27/18 j. Pt #10 DOS: 2/28/18	T054	In the attached documents, Whole Woman's Health of Peoria has included a copy of the privileging documentation for MD #1, MD #2, and MD #3. The signed document existed at the time of the survey but was housed at Whole Woman's Health's head quarter's office.	5/31/2018

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE

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3.31.18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
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	205.530 d) (continued)			
T05A	2. The "Custom Referral Analysis" for MD#2 and MD#3 were reviewed on 3/23/18. The statistics stated the following: a. MD#1- between 10/2017 and 3/2018 read approximately 517 ultrasounds. b. MD#2- between 9/2017 and 2/2018 read approximately 66 ultrasounds. c. MD#3- between 9/2017 and 2/2018 read approximately 34 ultrasounds. 3. The QAQI Meeting Minutes, dated 12/2015 through 12/2017, were reviewed on 3/22/18. The Minutes lacked documentation that ultrasound performance and/or reading privileges had been granted to MD#1, MD#2 or MD#3. 4. Three of three (MD#1, MD#2, and MD#3) Physician files reviewed on 3/22/18 lacked documentation that privileges to perform and/or read ultrasounds had been requested and/or approved. 5. During an interview throughout the day on 3/23/18, E#1 had reviewed the patient records and physician statistics and verbally agreed the specific privileges for performing and/or reading ultrasounds had not been requested and approved and should have been for MD#1, MD#2 and MD#3.			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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T059	205.540 d) 1-3 See section 205.710 b) 2 for compliance with 205.740 d) or follow 205.540 d) 1-3 d) To ensure availability of follow-up care at a hospital, the ambulatory surgical treatment center shall provide written documentation of one of the following: 1) A transfer agreement with a hospital within approximately 15-30 minutes travel time of the facility; 2) A statement that the medical director of the facility has full admitting privileges at a hospital within approximately 15-30 minutes travel time and that he/she will assume responsibility for all facility patients requiring follow-up care; or 3) A statement that each staff physician, dentist, or podiatrist has admitting privileges in a hospital within 15-30 minutes travel time of the facility. OR Section 205.710 b) 2) 2) Compliance with Section 205.540(d) is not required, if the medical director or a physician practicing at the facility has a professional working relationship or agreement, maintained in writing at the facility and verifiable by the Department, with a physician who does have admitting or practice privileges at a licensed hospital within 15 minutes from the facility and who will assume responsibility for all facility patients requiring such follow-up care. This Regulation is not met as evidence by: Based on document review and interview, it was determined for 3 of 3 (MD#1/ Medical director, MD#2, and MD#3) physicians providing medical and surgical pregnancy terminations, the Facility failed to ensure the medical director or the practicing physicians have full admitting privileges to a hospital within approximately 15-30 minutes travel time of the facility or have a professional working relationship or agreement with a physician who does have admitting or practice privileges at a licensed hospital within 15 minutes from the facility who will assume responsibility for all facility patients requiring follow-up care. This has the potential to affect all patients serviced by the Facility, currently a monthly average of approximately 44 medical termination and 44 surgical termination patients.	T059	Whole Woman's Health of Peoria complies with requirement (205.540d) by maintaining at transfer agreement with Methodist Medical Center of Illinois which states in section 1.4 that "patients may likewise be transferred from the Facility (Whole Woman's Health of Peoria) to the Hospital (Methodist), following the same processes outlined in this Agreement." The above-mentioned agreement was presented to the surveyor at the time on the site visit on March 23, 2018 and request that this deficiency be removed.	

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3.29.18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
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	205.540 d) 1-3 (continued)			
T059	Findings include: 1. Physician file review indicated MD#1/Medical Director, MD#2, and MD#3 did not have admitting privileges at a hospital within approximately 15-30 minutes travel time from the facility. 2. No documentation could be produced indicating an agreement with a physician who does have admitting or practice privileges at a licensed hospital within 15 minutes from the facility who would assume responsibility for any facility patient requiring follow-up care if needed. 3. An interview was conducted with the clinic Manager (E #1) on 3/23/18 at approximately 10:30 AM. E#1 confirmed the above findings.			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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T076	205.610 a) & b) a) The ASTC shall maintain accurate and complete clinical records for each patient, and all entries in the clinical record shall be made at the time the surgical procedure is performed and when care, treatment, medications, or other medical services are given. The record shall include, but not be limited to, the following:... 2) Admitting information including patient history, physical examination findings, diagnosis or need for medical services... This Regulation is not met as evidence by: A. Based on interview , observation, and document review, it was determined for 2 of 2 (Pts #1 and #2) patients observed during telemedicine medical abortion procedure, the Facility failed to ensure that all patient medical histories were reviewed by the telemedicine physician prior to the telemedicine medical abortion procedure. This has the potential to affect all patients who undergo a medical pregnancy termination via telemedicine by the Facility, approximately 44 patients monthly. Findings include: 1. An interview was conducted with the Clinic Manager (E#1) directly after the observation of Pt #1 and Pt#2's telemedicine medical abortions. When asked which forms were emailed to the telemedicine physician (MD#1), E#1 pulled three forms out of each record and stated "these are emailed to (MD#1) after the ultrasound and lab (laboratory) testing are done while the patient is in the Intake Room". The forms were titled: "Medical History", that is completed by the patient and the nurse or patient advocate; "Ultrasound Report"; and "Medication Abortion Record", with the first section completed by the nurse and patient advocate, at times. 2. Pt #1 and Pt #2's records were reviewed with E#1 during the interview. The following were identified: a. Two additional forms were observed in both telemedicine medical abortion records: (1) The "Medication Abortion Consent", which included a questionnaire/	T076	The entire clinical team at Whole Woman's Health of Peoria is responsible for ensuring the accuracy of each patient's medical records. It is Whole Woman's Health of Peoria's practice to employ a "Telemife checklist" to ensure that providers are presented with a complete patient medical record when providing Telemedicine medical abortion services. In addition, on May 16, 2018, the Clinic Manager conducted an in-service training with the clinical team to review the required chart documentation for a Telemedicine medical abortion procedure. Specifically, the training focused on the required chart documents to present to the telemedicine provider and how to properly document an electronic signature within the medical record.	May 16,2018

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5.3.18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
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T076	205.610 a) & b) A. (continued) consent portion and a medical history portion. (2)The "Contraceptive History & Screening" form with contraceptive history and another medical history. b. Neither of the additional forms medical histories matched the medical history emailed to the physician. c. Both forms stated they were electronically signed by the physician (handwritten by E#1) and were dated the day of the procedure. E#1 stated "(MD#1) does not see these (forms). We just put that they are signed electronically because I thought (MD#1)'s email would cover them too. I didn't realize the medical histories didn't match what we were emailing (MD#1). 3. A follow-up interview was conducted with E#1on 3/22/18 at approximately 3:00 PM. E#1 stated any patient who underwent the telemedicine medical abortion would have the above three medical histories in their records and re-confirmed these medical histories did not match and that MD#1 does not see the "Medication Abortion Consent" or the "Contraceptive History & Screening" form when telemedicine is performed. "If (MD#1) is here and does it (a medical abortion), (MD#1) may or may not see the forms. Again, we just put that they are electronically signed by (MD#1)."			

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Illinois Department of Public Health

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T076	205.610 a) & b) a) The ASTC shall maintain accurate and complete clinical records for each patient... The record shall include, but not be limited to, the following: 4) Signed informed consent; This Regulation is not met as evidence by: B. Based on observation, document review, and interview, it was determined for 2 of 2 (Pts #1 and #2) telemedicine medical abortions observed, the Facility failed to ensure the informed consent accurately reflected patient instructions. This has the potential to affect all patients who undergo a medical pregnancy termination via telemedicine by the Facility, approximately 44 patients monthly. Findings include: 1. An observation of Pt #1's counseling session with the Patient Advocate (E#2-unlicensed care provider) was observed on 3/22/18 at approximately 11:20 AM. E#2 instructed Pt #1 that Pt #1 could choose to administer the Misoprostol either bucally or vaginally and instructed how to do both of these and stated "You can do whichever you feel most comfortable with." Pt #1's telemedicine medical abortion procedure was observed on 3/22/18 at approximately 12:05 PM. The Clinic Manager (E#1) was observed to ask Pt #1 "Have you decided which way you are going to take the misoprostol... bucally or vaginally?" Pt #1 stated "I didn't realize I could do it vaginally until (E#2) said I could. I haven't really decided." 2. Pt #2's telemedicine medical abortion procedure was observed on 3/22/18 at approximately 12:20 PM. E#1 was observed to ask Pt #2 "Have you decided which way you are going to take the misoprostol... bucally or vaginally?" Pt #2 stated "I'm going to do it vaginally this time I think. I haven't decided."	T076	During the week of June 18th, 2018, Whole Woman's Health, LLC's clinical trainer is scheduled to perform an on-site training with the clinical team of the facility. A portion of the training will focus on Medical Abortion counseling and informed consent. In addition to the training session, the clinical trainer will perform post-training evaluation of the clinical staff. Whole Woman Health's of Peoria's Medication Abortion Consent and Patient instruction forms do address the "Off-Label" use of Mifepristone. (See attachment)	June 20,2018

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	205.610 a) & b) 6. (continued)			
T076	3. The Medication Abortion Consents for Pt#1 and Pt #2 were reviewed E#1 on 3/22/18. The Consents, signed by the physician, stated "I understand that I must place 4 tablets of misoprostol (Cytotec) 200 mcg bucally (between cheeks and gums) 24 to 48 hrs (hours) after taking the mifepristone (Mifeprex)." The "Using Mifepristone "Off-Label"" form, signed by the physician stated the misoprostol was to be administered bucally. Neither consent stated anything about taking the misoprostol vaginally and there was no physician order that Pt #1 could take the misoprostol vaginally. 4. An interview was conducted with E#1 during the record reviews for Pts #1 and #2. E#1 stated "I don't think we realized that the consents don't talk about the vaginal option and they should. We do talk to the patients about it and (MD#1) doesn't always ask them about it (the misoprostol and the route it will be taken)."			

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T076	205.610 a) & b) a) The ASTC shall maintain accurate and complete clinical records for each patient... 6) Signed physician orders; This Regulation is not met as evidence by: C. Based on document review and interview, it was determined the Facility failed to ensure its "Standing Orders" were current and accurately authenticated. This has the potential to affect all patients serviced by the Facility, currently a monthly average of approximately 44 medical termination and 44 surgical termination patients. Findings include: 1. The following Standing Orders were reviewed on 3/22/18 at approximately 2:55 PM. a. The "Standing Orders for Surgical Abortion" stated they were revised 4/2016 by (E#1). The physician signature was dated "5/22/22" by E#1. b. The "Standing Orders for Medical Abortion with Mifeprex" stated they were reviewed September 2015 by the previous Clinic Manager and "The patient must be 9 weeks LMP (last menstrual period) or fewer by ultrasound." The physician signature was dated 5/22/15. An interview was conducted with E#1 on 3/23/18 at approximately 9:00 AM. E#1 reviewed the Standing Orders and stated "That's a mistake (the date on the surgical abortion standing orders). I have correct ones. E#1 further stated "The medical abortions can be done up to 10 weeks. I should have the correct one for that too." 2. On 3/23/18 at approximately 9:30 AM, E#1 presented a revised set of standing orders for both surgical and medical abortions. The following were noted: a. The "Standing Orders for Surgical Abortion" were dated 3/22/18. The physician was not present in the Facility on 3/22/18 to authenticate the orders.	T076	During its May 30, 2018 committee meeting, the Quality Committee reviewed the standing orders for Surgical and Medication Abortion services. As a result of the meeting, MD1 (Medical Director) updated the standing orders. The revised standing orders are attached.	5/30/2018

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T076	205.610 a) & b) C. (continued) b. The "Standing Orders for Medical Abortion with Mifeprex" was the same form (no change in the LMP) with the physician signature but the date was blank. 3. A follow-up interview was conducted with E#1 on 3/23/18 at approximately 12:00 PM. E#1 reviewed both sets of standing orders and verbally agreed the forms were not updated accurately and were not authenticated accurately and should be.			

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Whole Women's Health of Peoria, LLC	7405 N University, Suite D, Peoria, Illinois 61614

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
T076	205.610 a) & b) a) The ASTC shall maintain accurate and complete clinical records for each patient... 6) Signed physician orders; This Regulation is not met as evidence by: D. Based on observation, document review, and interview, it was determined for 4 of 5 (Pts #1, #2, #3, and #5) telemedicine medical abortion patients, the Facility failed to ensure physician orders were accurate. This has the potential to affect all patients who undergo a medical pregnancy termination via telemedicine by the Facility, approximately 44 patients monthly. Findings include: 1. Two telemedicine medical abortion procedures (Pts #1 and #2) were observed on 3/22/18 between approximately 12:05 PM and 12:25 PM. E#1 was observed to contact MD#1 via iPad and was the only nurse scheduled and present in the Facility. 2. The telemedicine medical abortion procedure orders for Pts #1, #2, #3, and #5 were reviewed on 3/23/18 at approximately 9:30 AM with E#1. Each stated "Sent from my iPhone ... I authorize (E#5) to dispense 200 mg of Mifeprex for the patient to take PO (by mouth) in the clinic, and 800 mcg (micrograms) of Misoprostol to take home with instructions on how to administer the medication..." a. Pt #1 and Pt #2 Date of Service: 3/22/18. b. Pt #3 and Pt #5 Date of Service: 3/1/18. 3. The staffing schedule for 3/1/18 reviewed on 3/23/18 at approximately 10:00 AM. E#5 was not scheduled to work on 3/1/18. 4. An interview was conducted with E#1 on 3/23/18 at approximately 10:00 AM. E#1 stated "(MD#1) has two orders in the iPhone, one for me and one for (E#5). (MD#1) must have hit the wrong one. They should all say my name. (E#5) wasn't here."	T076	On May 31st, 2018, the Medical Director conducted an in-service training with the clinical team to review the required chart documentation for a Tele medicine medical abortion procedure. Specifically, the training focused on the proper techniques required to document an electronic signature within the medical record.	May 31, 2018

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE

TITLE

5.31.18

DATE

COJ

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7003195	26336, 32189	3/23/18

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Whole Women's Health of Peoria, LLC	7405 N University, Suite D, Peoria, Illinois 61614

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
T076	205.610 a) & b) a) The ASTC shall maintain accurate and complete clinical records for each patient... 6) Signed physician orders; This Regulation is not met as evidence by: D. Based on observation, document review, and interview, it was determined for 4 of 5 (Pts #1, #2, #3, and #5) telemedicine medical abortion patients, the Facility failed to ensure physician orders were accurate. This has the potential to affect all patients who undergo a medical pregnancy termination via telemedicine by the Facility, approximately 44 patients monthly. Findings include: 1. Two telemedicine medical abortion procedures (Pts #1 and #2) were observed on 3/22/18 between approximately 12:05 PM and 12:25 PM. E#1 was observed to contact MD#1 via iPad and was the only nurse scheduled and present in the Facility. 2. The telemedicine medical abortion procedure orders for Pts #1, #2, #3, and #5 were reviewed on 3/23/18 at approximately 9:30 AM with E#1. Each stated "Sent from my iPhone ... I authorize (E#5) to dispense 200 mg of Mifeprex for the patient to take PO (by mouth) in the clinic, and 800 mcg (micrograms) of Misoprostol to take home with instructions on how to administer the medication..." a. Pt #1 and Pt #2 Date of Service: 3/22/18. b. Pt #3 and Pt #5 Date of Service: 3/1/18. 3. The staffing schedule for 3/1/18 reviewed on 3/23/18 at approximately 10:00 AM. E#5 was not scheduled to work on 3/1/18. 4. An interview was conducted with E#1 on 3/23/18 at approximately 10:00 AM. E#1 stated "(MD#1) has two orders in the iPhone, one for me and one for (E#5). (MD#1) must have hit the wrong one. They should all say my name. (E#5) wasn't here."	T076	Whole Woman's Health of Peoria has always had an RN present onsite during procedural abortions and has added RN staff to the clinic schedule of non-procedural visits as well.	May 30th, 2018

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE — TITLE — DATE

COO — 5.31.18

Whole Woman's Health

Standing Orders for Surgical Abortion:
Dr. Y Shah
Dr. L Lauren
Dr. B Brown

Pre-Operative:

- The patient will receive an ultrasound to approximate gestation and to confirm an intrauterine pregnancy.
- The patient's medical history will be reviewed and the following will be documented and reviewed by MD:
    - Current or past history of seizures
    - Current vaginal infection
    - Recent hospitalization
    - Obstetrical/pregnancy history including C-sections
    - Major psychiatric illness
    - Any major surgery or medical condition
    - Any other abnormal aspects of medical history
    - Methadone or other opioid or anti-opoid medications
- The patient will receive lab work to establish the following:
    - Blood pressure with systolic between 90-140, diastolic between 50-90
    - Pulse between 50-120
    - Temperature between 96.8-100.4
    - Hemoglobin < 8
    - RH factor in blood (if negative and <12 weeks gestation the patient receives 50 mcg IM of Micrhogam, if >12 weeks gestation the patient receives 300 mcg IM of Rhogam)
    - The physician will be consulted if any of these values lie outside the normal range.
- The patient will receive counseling regarding alternatives to abortion, risks and benefits of abortion, the abortion procedure, and birth control methods. After counseling, the counselor will obtain written consent if an abortion is sought.

Preoperative Medications:

- The patient may receive preoperative medications as follows:
- Ativan 1 or 2mg
- Metronidazole (Flagyl) 500 mg p.o. x one.
- If the patient weighs 124 pounds or less she will receive 25 mg Promethazine p.o.; if she weighs 125 pounds or more she will receive 50 mg Promethazine p.o.
- If nausea prevents the patient from tolerating p.o. meds she may receive 25 mg Promethazine IM.
- If the patient does not receive Promethazine, or she is driving herself, she may receive 4mg Ondansetron (Zofran) p.o.
- 800 mg Ibuprofen; if the patient is allergic to Ibuprofen she may receive 1000 mg Acetaminophen.
- If the patient is driving herself she may receive 1,000 mg acetaminophen p.o. and 30-60 mg Ketorolac IM.
- If a patient is anxious she may receive 5 mg Diazepam p.o.
- If a patient receives Promethazine, any IV sedation, or Diazepam, she will be unable to drive after the procedure and will need to arrange transportation with a driver with whom she is acquainted (e.g., she cannot take a taxi home unescorted)
- A patient will receive 600 mcg Misoprostol buccally 90 minutes pre-op if:
  The patient's ultrasound measurement indicates 12 weeks LMP or greater.
  The patient had laminaria inserted by the physician to prepare her cervix.

If a patient requests IV sedation she may receive medications as follows:

- 10 mg of Nubain IVP over 1-2 minutes.
- 2 to 2.5 mg of Versed (at doctor's discretion) IVP over 1-2 minutes.
- 0.4mg Atropine IVP over 1-2 minutes.

Or:

- Start Fentanyl 50- 100 mcg (at doctor's discretion) IVP over 1-2 minutes. Add 50 mg.
- 2 to 2.5 mg of Versed (at doctor's discretion) IVP over 1-2 minutes.
- 0.4mg Atropine IVP over 1-2 minutes.
- Diazepam 5 mg as per MD's orders.
- If the patient is breastfeeding she will be instructed to discard her breastmilk for 24 hours after the procedure.

Revised 5/30/2018 -SS

- 5cc of either heparin solution (Heplock) or saline will be used to start the patient's IV before the procedure.
- If a patient experiences a vaso/vagal response she will receive 0.4mg Atropine IM or IV push by the doctor or by his/her appointee as directed by the doctor.
- In the event of an adverse reaction to Nubain , 0.4 mg of Narcan (Naloxone) IV/IM will be given.
- In the event of an adverse reaction to Versed, 0.2mg of Romazicon (Flumazenil) IV/IM will be given.
- During the procedure the patient will receive a paracervical block administered by the physician using 20 -25cc of premixed formula. The formula will be:
  45cc 1%Lidocaine
  5cc Sodium Bicarbonate
  +/- epi 1:100, 000

The patient's blood pressure, respirations, LOC, pulse and O2 saturation will be measured before, during, and after the surgical procedure.

Prescriptions may be given as follows:

- Contraceptive medication of patient's choice at doctor's discretion. Medication selected/given: documented on abortion record.
- Naproxen 500 mg # 30 q 12 hrs. PRN pain.
- Metronidazole 500 mg #4, 2 tabs po with food. 2 tabs 1 hr later.
- Methergine 0.2mg #8 1 tab po q 6 hrs. while awake, as per doctor's discretion
- If the patient tests positive for a UTI, the patient will receive a prescription for Macrobid 100 mg #14 1 cap bid for 7 days.
- Patient may receive an additional prescription if she experiences increased pain post-operatively:
  Percocet 5/325 #10 prn
- The patient may receive a prescription for Diflucan (150 mg #1, 1 refill) if she experiences a yeast infection post-operatively.

Aftercare Room

- Patients may be discharged from the recovery room when:
  - Blood pressure with systolic between 90-140, diastolic between 50-90
  - Pulse between 50-120
  - Temperature between 96.8-100.4°F. Patients who did not receive misoprostol pre-op with a temperature of 100.4 to 101.0°F should receive 2 grams of Rocephin after one hour and then may be discharged. Patients who did receive misoprostol pre-op with a temperature of 100.4 to 101.0°F should receive 500 mg of Acetaminophen 30-60 minutes after the temperature reading; if temperature is dropping patients may be discharged.
  - Bleeding is moderate or less
  - LOC is 10
  - Pain is controlled
  - Patient is ambulatory w/o dizziness
  - The patient is tolerating liquids and solids
  - The post-procedure care instruction sheet has been reviewed and given to the patient
  - The patient has received her prescriptions
- The following medications may be administered in the aftercare room:
  - Atropine 0.4 mg IV/IM
  - Phenergan 25 mg PO/suppository/IM
  - Methergine 0.2 mg PO/IM
  - Narcan (naloxone) 0.4 mg IV/IM
  - Romazicon 0.2 mg IV/IM
  - DMPA (Depo Provera) 150 mg IM
  - Pitocin 10 units IM
- Patients who received IV sedation will be observed in the recovery room for at least 45 minutes; patients who do not receive IV sedation will be observed in the recovery room for 45 minutes (or longer at doctor's discretion)

Deviations from standing orders per attending physician:

MD Signature: _____ Date: 5.30.18

Revised 5/30/2018 -SS

Whole Woman's Health

Standing Orders for Medical Abortion with Mifeprex:
Dr. Y Shah
Dr. L Lauren
Dr. B Brown

See also:
Protocol for Medical Abortion
Protocol for In-Office Insertion of Cytotec
Policy for Management of Mifeprex Log

Pre-Abortion

- The patient will receive an ultrasound to approximate gestation and to confirm an intrauterine pregnancy. The patient must be 10 weeks LMP or fewer by ultrasound.
- The patient's medical history will be documented and reviewed by the MD:
    - Hemorrhagic disorders or concurrent anticoagulant therapy
    - Chronic adrenal failure
    - Heart or respiratory disease
    - Liver or kidney disease
    - Concurrent long-term systemic corticosteroid therapy
    - Confirmed or suspected ectopic pregnancy or undiagnosed adnexal mass
    - Inherited blood or bleeding disorders
    - IUD in place (must be removed)
    - Known allergy to Mifepristone, Misoprostol, or other prostaglandin
    - Sickle Cell Anemia, Leukemia, or Thalassemia
    - Inflammatory bowel disease
    - Seizure disorder or Epilepsy not controlled by medication
    - She is suffering from concurrent illness with significant diarrhea. Misoprostol often causes diarrhea.
    - She is suffering from systemic illness (consult the physician to determine the safest abortion method given her illness).
    - Any major surgery or medical condition
    - Any other abnormal aspects of medical history
- The patient will receive lab work to establish the following:
    - Blood pressure with systolic between 90-140, diastolic between 50-90
    - Pulse between 50-120
    - Temperature between 96.8-100.4
    - Hemoglobin >8
    - RH factor in blood (if negative and <12 weeks the patient receives 50 mcg IM of Micrhogam)
    - The physician will be consulted if any of these values lie outside the normal range.
- The patient will receive counseling regarding alternatives to abortion, risks and benefits of abortion, the abortion procedure, and birth control methods. After counseling, the counselor will obtain written consent if an abortion is sought.

The patient will receive pre abortion medications as follows:

- Metronidazole 500mg p.o. x one OR Levoflaxcin500mg given 1/2 hour before procedure PO
- If nausea prevents the patient from tolerating PO meds she may receive 25 mg promethazine IM, or .4mg Zofran.
- If the patient receives promethazine, she will be unable to drive herself home and will need to arrange transportation with a driver with whom she is acquainted (e.g., she cannot take a taxi home unescorted).

The patient will receive 200 mg Mifeprex (mifepristone), in the office, as directed by the physician.
The patient will be given 800 mcg Misoprostol and instructed to insert it buccally or vaginally 24-48 hours after taking Mifeprex. See *Protocol for Medical Abortion* for guidelines as to days, times, and location.

Prescriptions may be given as follows:

- Contraceptive medication of patient's choice at doctor's discretion
- Tylenol #3, #10, 1 tab q 6 hrs for pain OR
- Percocet #10, 1-2 tabs q. 4-6 prn hrs. for pain. If the patient is allergic to Percocet she may be given Ibuprofen 800 mg #10 q 4-6 hours prn cramping
- Promethazine 25mg #10, 1 tab q 4 hrs. prn for nausea.

Deviations from standing orders per attending physician:

MD Signature: _____ Date: 5.30.18

Revised 5/30/2018-SS

Americans United for Life

Whole Woman's Health of Peoria
Transforming Healthcare One Woman at a Time
7405 N. University St. Ste. D, Peoria IL, 61614

June 18, 2015

Dear Dr. Shah,

The present serves as notification that you have been granted active admitting privileges at Whole Woman's Health of Peoria, LLC. These privileges extend for the duration of your independent contact agreement.

Thank you,

[redacted]

Amy Hagstrom Miller, CEO
Chairperson, Governing Body
Whole Woman's Health

Americans United for Life

State of Illinois

Department of Financial and Professional Regulation

Division of Professional Regulation

LICENSE NO
036.046989

The person, firm, or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

EXPIRES
07/31/2020

LICENSED PHYSICIAN AND SURGEON

YOGENDRA A SHAH MD
1602 21ST ST
GRANITE CITY, IL 62040-5304

BRYAN A. SCHNEIDER
SECRETARY

JESSICA BAER
DIRECTOR

The official status of this license can be verified at www.idfpr.com

11685404

Cut on Dotted Line

For future reference, IDFPR is now providing each person/business a unique identification number, 'Access ID', which may be used in lieu of a social security number, date of birth or FEIN number when contacting the IDFPR. Your Access ID is: 1404669

LICENSE NO
036.046989

Department of Financial and Professional Regulation
Division of Professional Regulation

LICENSED PHYSICIAN AND SURGEON

YOGENDRA A SHAH MD

EXPIRES
07/31/2020

SIGN:_____

BRYAN A. SCHNEIDER
SECRETARY

JESSICA BAER
DIRECTOR

The official status of this license can be verified at www.idfpr.com

Cut on Dotted Line

Americans United for Life

368/656 1:4

SHAH, YOGENDRA AMBALAL MD
1602 21ST STREET
GRANITE CITY, IL 62040-0000

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
AS7925259	02-29-2020	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	02-09-2017

SHAH, YOGENDRA AMBALAL MD
1602 21ST STREET
GRANITE CITY, IL 62040-0000

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D C 20537

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
AS7925259	02-29-2020	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	02-09-2017

SHAH, YOGENDRA AMBALAL MD
1602 21ST STREET
GRANITE CITY, IL 62040-0000

Sections 304 and 1008 (21 USC 824 and 958 of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance

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Form DEA-223 (9/2018)

CURICULUM VITAE

NAME: Yogendra Shah, M.D.F.A.C.O.G.

DATE: [redacted]

PLACE OF BIRTH: [redacted]

MARTIAL STATUS: [redacted]

UNIVERSITIES ATTENDED:

S.P. University
V.V. Nagar, Gurjarat, India

Pre-Medical-May 1965
Faculty of Science, M.S. University

Doctor of Medicine-October 1969
M.S. University School of Medicine, India

PROFESSIONAL TRAINING

INTERNSHIP: Type-Rotating
S.S.G. Hospital
Baroda, Gurjarat, India

Mount Sinai Hospital Medical Center
Chicago, Illinois
July 1971-June 1972

RESIDENCY: Type-Pathology (One Year)
Methodist Hospital of Central Illinois
Peoria, Illinois
July 1972-June 1973

Type-Obstetrics and Gynecology
Homer G. Phillips Hospital
St. Louis, Missouri
July 1973-June 1976

FELLOWSHIP: Clinic Obstetrics and Gynecology
St. Luke's Hospital West
Chesterfield, Missouri
July 1976-June 1977

BOARD STATUS: Board Ceertified-November 9, 1979
American Board of Obstetrics & Gynecology

Voluntarily Re-certified - June 26, 1995
Voluntarily Re-certified - 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014

FELLOWSHIP: American College of Obstetricians and Gynecology
December 1980

EXPERIENCE: Family Planning Medical Officer
Sadhli, Gujarat, India
January 1971 - May 1971

Private Practice
3165 Myrtle Avenue
Granite City, Illinois 62040
July 1977 - 2015

HONORS
AND AWARDS: Higher Education and Scholarship
Gujarat Government, India
June 1964- October 1969

Americans United for Life

COMMITTE

MEMBERSHIP: Chairman-Department of OB/GYN
Anderson Hospital
1994-1996

Executive Committee
Anderson Hospital
1194-1996

Chairman-Department of OB/GYN
Gateway Regional Medical Center
(Formerly St. Elizabeth Medical Center)
1991-2000
Performance Improvement Committee
1991-2000
Credential Committee-Member
Gateway Regional Medical Center
2003 - Present
Various Committees Member - Gateway Regional and Anderson Hospital
1977- Present

STATE LICENSES: Flex, June 1973- Missouri and Illinois

HOSPITAL PRIVLEGES: Gateway Regional Medical Center (Formerly St. Elizabeth Medical Center)

Active Staff - 1977 - 2015
Courtesy 2015- Present

Oliver Anderson Hospital - Active Staff
1977-2015

PAPERS PUBLISHED: Bibliographies

"Outpatient Laparoscopy with Local Anesthesia"
International Journal of Gynecology and Obstetrics

Volume 17, Number 4, January-February 1980

p379-381

"Combined Intra and Extra-Uterine Pregnancy"

A Diagnostic Challenge

Journal of Reproductive Medicine

Volume 25, Number 5, November 1980

p290-292

MEDICAL DIRECTOR: Whole Woman's Health of Peoria – June 2015 - Present

The Hope Clinic for Women - July 1987- Present

Madison County Urban League - 1998 - 2015

Americans United for Life

Whole Woman's Health of Peoria

DELINEATION OF CLINICAL PRIVILEGES

Gynecological

Applicant	Date
Dr. Yogendra Shah	05-30-2018

The granting, reviewing and changing of clinical Privileges will be in accordance with the Medical Staff Bylaws. Assignment of such clinical Privileges will be based on documentation of individual's education, clinical training, demonstrated skills, and capacity to manage procedurally related complications. Indicate procedures ***requested*** for which you *do* wish to be credentialed. Return this form with your application.

Gynecological	Requested	Privileges Granted as initialed by MAB	
		Approved	Denied
GENERAL PRIVILEGES			
General Clinical Privileges customary to the practice of obstetrics and gynecology			
Outpatient	Yash S	HW	
SPECIFIC PRIVILEGES			
Ultrasound			
Reading and interpret first and second trimester ultrasound	Yash S	HW	
OBSTETRICAL SURGICAL PROCEDURES			
Abortion Spontaneous	Yash S		
1st trimester	Yash S	HW	
2nd trimester		HW	
Induced			
Medication Abortion	Yash S	HW	
1st trimester	Yash S	HW	
2nd trimester	Yash S	HW	
Dilation and extraction	Yash S	HW	
Amniocentesis	Yash S	HW	
Invitro fertilization	Yash S	HW	

I certify that I am competent to perform the procedures requested by virtue of my education, training and experience.

Applicant's Signature	Date
Y. a. Shah	05/30/2018

I certify that the applicant named above has met the requirements for approval of the requested Privileges.

For Administrative Purposes Only

Clinical Privileges recommendations approved by Governance.

Governance Representative Holly Warfield Date 5/20/18

Whole Woman's Health of Peoria

DELINEATION OF CLINICAL PRIVILEGES
Continuum of Depth of Sedation / Analgesia

Applicant Dr. Yogendra Shah	Date 05/29/2018

The granting, reviewing and changing of clinical Privileges will be in accordance with the Medical Staff Bylaws. Assignment of such clinical Privileges will be based on documentation of individual's education, clinical training, demonstrated skills, and capacity to manage procedurally related complications. Indicate procedures ***requested*** for which you *do* wish to be credentialed. Return this form with your application.

Procedures Depth of Sedation Continuum		Privileges Granted as initialed by MAB	
	Requested	Approved	Denied
Minimal sedation / Anxiolysis	Yes	HW	
Moderate Sedation / Analgesia	Yes	HW	
General Anesthesia	No	HW	

Credentialing Criteria: Required documentation for initial and renewal privileging of sedation:

Minimal: Appropriate narcotics licensing
Moderate: Demonstration of current clinical competence and ACLS **(Provide list of verifiable successful performance of 10 procedures involving moderate sedation in the last 12 months if requested)**

If you choose to apply for this Privileges, please submit documentation as indicated above. Please also indicate the number of times moderate sedation was administered by you over the last 12 month:

	0-10	11-25	26+
Moderate Sedation/Analgesia	_____	_____	_____

Please document any complications or adverse outcomes encountered over the last 12 months and list at which facility these cases were performed:

_____

_____

_____

Please document your level of certification: _____ BCLS ✓ ACLS

NOTE: All doctors are encouraged to maintain ACLS certification in conjunction with their sedation/analgesia Privileges.

I attest that I am qualified and competent to perform the Class of Anesthesia I have indicated on the Delineation of Privileges for Sedation. I understand by requesting and/or signing does not automatically grant this Privileges.

Applicant's Signature	Date
Y G Shah	5-30-18

A. For Administrative Purposes Only

Clinical Privileges recommendations approved by Governance	
Governance Representative Holly Wrapled	Date 5-30-18

Client#: 238549 WHOLEWOMANS

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 8/15/2017

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Marsh & McLennan Agency LLC
One Executive Drive
Somerset, NJ 08873

CONTACT NAME:
PHONE (A/C, No, Ext): **FAX (A/C, No):**
E-MAIL ADDRESS: somersetclsupport@mma-ne.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A: Landmark American Insurance Com	33138
INSURER B:	
INSURER C:	
INSURER D:	
INSURER E:	
INSURER F:	

INSURED
Whole Woman's Health of Peoria, LLC
7405 North University #D
Peoria, IL 61614

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
	GEN'L AGGREGATE LIMIT APPLIES PER						PERSONAL & ADV INJURY	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						GENERAL AGGREGATE	$
	OTHER:						PRODUCTS - COMP/OP AGG	$
	AUTOMOBILE LIABILITY							$
	☐ ANY AUTO						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ALL OWNED AUTOS ☐ SCHEDULED AUTOS						BODILY INJURY (Per person)	$
	☐ HIRED AUTOS ☐ NON-OWNED AUTOS						BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY						PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ Y / N (Mandatory in NH)	N/A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Professional Liability			LHM832377 Retro Date	06/24/2017 06/24/2015	06/24/2018	$1,000,000 Each Claim $3,000,000 Aggregate	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Evidence of Insurance

CERTIFICATE HOLDER
Whole Woman's Health of Peoria, LLC
7405 North University #D
Peoria, IL 61614

CANCELLATION
SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
Wm. G. Gilardi

Americans United for Life

NSMXE

Whole Woman's Health of Peoria
7405 N. University St., Peoria, IL 61614
(309) 691-9073

September 12, 2017

Dear Dr. L. Laursen,

This letter serves as notification that you have been granted active admitting privileges at Whole Woman's Health of Peoria. These admitting privileges will be due for review on September 12, 2018.

Thank you,

[redacted]

Amy Hagstrom Miller, CEO
Chairperson, Governing Board
Whole Woman's Health of Peoria

Americans United for Life

Whole Woman's Health of Peoria, LLC

DELINEATION OF CLINICAL PRIVILEGES

Gynecological

Applicant	Date
Dr. Laura Larsen	5.30.18

The granting, reviewing and changing of clinical Privileges will be in accordance with the Medical Staff Bylaws. Assignment of such clinical Privileges will be based on documentation of individual's education, clinical training, demonstrated skills, and capacity to manage procedurally related complications. Indicate procedures *requested* for which you *do* wish to be credentialed. Return this form with your application.

Outpatient		
Reading first and second trimester ultrasound		
1st trimester		
2nd trimester		
Medication Abortion		
1st trimester		
2nd trimester		
Dilation and extraction		

I certify that the applicant named above has met the requirements for approval of the requested Privileges.

! For Administrative Purposes Only !

Clinical Privileges recommendations approved by Governance	
Governance Representative	Date 5.30.18

Whole Woman's Health of Peoria

DELINEATION OF CLINICAL PRIVILEGES
Continuum of Depth of Sedation / Analgesia

Applicant Dr. Laura Laursen	Date 5.30.18

The granting, reviewing and changing of clinical Privileges will be in accordance with the Medical Staff Bylaws. Assignment of such clinical Privileges will be based on documentation of individual's education, clinical training, demonstrated skills, and capacity to manage procedurally related complications. Indicate procedures *requested* for which you *do* wish to be credentialed. Return this form with your application.

Procedures Depth of Sedation Continuum	Privileges Granted as Initialed by Chairperson	
	Approved	Denied
Minimal sedation / Anxiolysis	[illegible]	
Moderate Sedation / Analgesia	[illegible]	
General Anesthesia		[illegible]

Credentialing Criteria: Required documentation for initial and renewal privileging of sedation:

Minimal: Appropriate narcotics licensing
Moderate: Demonstration of current clinical competence and ACLS (Provide list of verifiable successful performance of 10 procedures involving moderate sedation in the last 12 months if requested)

If you choose to apply for this Privileges, please submit documentation as indicated above. Please also indicate the number of times moderate sedation was administered by you over the last 12 month:

	0-10	11-25	26+
Moderate Sedation/Analgesia	_____	_____	_____

Please document any complications or adverse outcomes encountered over the last 12 months and list at which facility these cases were performed:
N/A

Please document your level of certification: _____ BCLS __X__ ACLS

NOTE: All doctors are encouraged to maintain ACLS certification in conjunction with their sedation/analgesia Privileges.

A. For Administrative Purposes Only

Clinical Privileges recommendations approved by Governance.

Governance Representative [signature] Date 5.30.18

State of Illinois

Department of Financial and Professional Regulation
Division of Professional Regulation

LICENSE NO
036.139557

EXPIRES
07/31/2020

LICENSED PHYSICIAN AND SURGEON

LAURA ELIZABETH LAURSEN MD
LAURA LAURSEN
5841 S MARYLAND AVE MC2050
CHICAGO, IL 60637

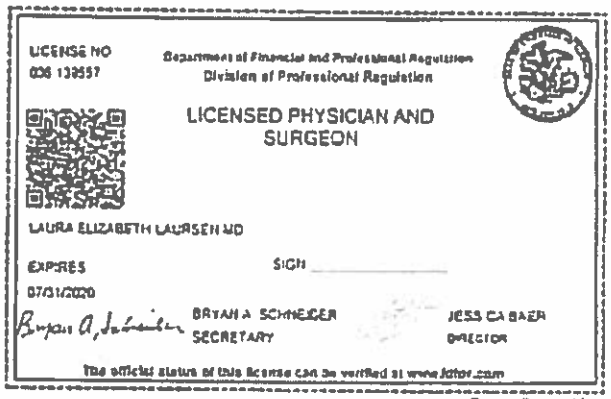
BRYAN A SCHNEIDER
SECRETARY

JESSICA BAER
DIRECTOR

The official status of this license can be verified at www.idfpr.com

Cut on Dotted Line

For future reference, IDFPR is now providing each person/business a unique identification number, 'Access ID', which may be used in lieu of a social security number, date of birth or FEIN number when contacting the IDFPR. Your Access ID is: 3706462



LICENSE NO
036 139557

Department of Financial and Professional Regulation
Division of Professional Regulation

LICENSED PHYSICIAN AND SURGEON

LAURA ELIZABETH LAURSEN MD

EXPIRES
07/31/2020

SIGN _____

BRYAN A SCHNEIDER
SECRETARY

JESSICA BAER
DIRECTOR

The official status of this license can be verified at www.idfpr.com

Cut on Dotted Line

Americans United for Life

Client#: 238649 WHOLEWOMANS

ACORD. CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 09/29/2017

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer any rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Marsh & McLennan Agency LLC
One Executive Drive
Somerset, NJ 08873

CONTACT NAME: Somerset Support Dept.
PHONE (A/C, No, Ext): 732-469-3000 FAX (A/C, No):
E-MAIL ADDRESS: somersetcisupport@mma-ne.com

INSURER(S) AFFORDING COVERAGE — NAIC #
INSURER A: Landmark American Insurance Company — 33138
INSURER B:
INSURER C:
INSURER D:
INSURER E:
INSURER F:

INSURED
Dr. Lauren Laursen
Whole Woman's Health of Peoria, LLC
7405 North University #D
Peoria, IL 61614

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE $
	CLAIMS-MADE OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence) $
							MED EXP (Any one person) $
							PERSONAL & ADV INJURY $
	GEN'L AGGREGATE LIMIT APPLIES PER						GENERAL AGGREGATE $
	POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG $
	OTHER						$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident) $
	ANY AUTO						BODILY INJURY (Per person) $
	OWNED AUTOS ONLY / SCHEDULED AUTOS						BODILY INJURY (Per accident) $
	HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident) $
							$
	UMBRELLA LIAB OCCUR						EACH OCCURRENCE $
	EXCESS LIAB CLAIMS-MADE						AGGREGATE $
	DED RETENTION $						$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY						PER STATUTE / OTH-ER
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	Y / N	N/A				E.L. EACH ACCIDENT $
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE $
							E.L. DISEASE - POLICY LIMIT $
A	Medical Malpractice Claims Made			LHM832377	09/30/2017	09/30/2018	$1,000,000 Occurrance $3,000,000 Aggregate
				Retro Date	09/30/2017		

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Evidence of Insurance for Dr. Laura Laursen

CERTIFICATE HOLDER

Whole Woman's Health of Peoria, LLC
7405 North University #D
Peoria, IL 61614

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS

AUTHORIZED REPRESENTATIVE

Wm. A. Gilbert

NSRDV

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
FL6170194	03-31-2019	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	07-15-2016

LAURSEN, LAURA
5841 S. MARYLAND AVE.,
MC 2050
CHICAGO, IL 60637-0000

CONTROLLED SUBSTANCE/REGULATED CHEMICAL REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

Form DEA 223/511 (4/07)

REPORT

CHANGES

PROMPTLY

REQUESTING MODIFICATIONS TO YOUR REGISTRATION CERTIFICATE

To request a change to your registered name, address, the drug schedule or the drug codes you handle, please

1. visit our web site at deadiversion.usdoj.gov - or
2. call our customer Service Center at 1-(800) 882-9539 - or
3. submit your change(s) in writing to:

Drug Enforcement Administration
P.O. Box 2639
Springfield, VA 22152-2639

See Title 21 Code of Federal Regulations, Section 1301.51 for complete instructions.

You have been registered to handle the following chemical/drug codes:

Whole Woman's Health of Peoria
7405 N. University St., Peoria, IL 61614
(309) 691-9073

January 23,2018

Dear Dr. B. Brown

This letter serves as notification that you have been granted active admitting privileges at Whole Woman's Health of Peoria. These admitting privileges will be due for review on January 23, 2019.

Thank you,

[redacted]

Amy Hagstrom Miller, CEO
Chairperson, Governing Board
Whole Woman's Health of Peoria

Americans United for Life

State of Illinois

Department of Financial and Professional Regulation
Division of Professional Regulation

LICENSE NO.
036.136413

The person, firm, or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below:

EXPIRES
07/31/2020

LICENSED PHYSICIAN AND SURGEON

BENJAMIN PATTERSON BROWN MD
1600 S PRAIRIE AVE
UNIT 1304
CHICAGO, IL 60616

BRYAN A. SCHNEIDER
SECRETARY

JESSICA BAER
DIRECTOR

The official status of this license can be verified at www.idfpr.com

Cut on Dotted Line

For future reference, IDFPR is now providing each person/business a unique identification number, 'Access ID', which may be used in lieu of a social security number, date of birth or FEIN number when contacting the IDFPR. Your Access ID is: 3694800

LICENSE NO.
036 136413

Department of Financial and Professional Regulation
Division of Professional Regulation

LICENSED PHYSICIAN AND SURGEON

BENJAMIN PATTERSON BROWN MD

EXPIRES:
07/31/2020

SIGN: _____

BRYAN A. SCHNEIDER
SECRETARY

JESSICA BAER
DIRECTOR

The official status of this license can be verified at www.idfpr.com

Cut on Dotted Line

Americans United for Life

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
FB5332646	07-31-2018	$731

SCHEDULES	BUSINESS ACTIVITY	EFFECTIVE DATE
2,2N,3 3N,4,5	PRACTITIONER	09-01-2015

BROWN, BENJAMIN P (MD)
UNIVERSITY OF CHICAGO MEDICINE, DEPT OF OBGYN
5841 S MARYLAND AVE
MC2050
CHICAGO, IL 60637

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D C 20537

Section 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended provide that the Attorney General may revoke or suspend a registration to manufacture, distribute dispense, import or export a controlled substance

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

Form DEA-223 (9/2016)

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D C 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
FB5332646	07-31-2018	$731

SCHEDULES	BUSINESS ACTIVITY	EFFECTIVE DATE
2,2N,3 3N,4,5	PRACTITIONER	09-01-2015

BROWN, BENJAMIN P (MD)
UNIVERSITY OF CHICAGO MEDICINE, DEPT OF OBGYN
5841 S MARYLAND AVE
MC2050
CHICAGO, IL 60637

Section 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended provide that the Attorney General may revoke or suspend a registration to manufacture, distribute dispense, import or export a controlled substance

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY AND IT IS NOT VALID AFTER THE EXPIRATION DATE

Americans United for Life

Whole Woman's Health of Peoria, LLC

DELINEATION OF CLINICAL PRIVILEGES

Gynecological

Applicant	Date
Dr. Benjamin Brown	112318

The granting, reviewing and changing of clinical Privileges will be in accordance with the Medical Staff Bylaws. Assignment of such clinical Privileges will be based on documentation of individual's education, clinical training, demonstrated skills, and capacity to manage procedurally related complications. Indicate procedures *requested* for which you *do* wish to be credentialed. Return this form with your application.

Outpatient	Josh	
Reading first and second trimester ultrasound	Josh	
1st trimester	Josh	
2nd trimester	Josh	
Medication Abortion	Josh	
1st trimester	Josh	
2nd trimester	Josh	
Dilation and extraction	Josh	

I certify that the applicant named above has met the requirements for approval of the requested Privileges.

For Administrative Purposes Only

Clinical Privileges recommendations approved by Governance.

Governance Representative [signature] Date 112318

Whole Woman's Health of Peoria

DELINEATION OF CLINICAL PRIVILEGES
Continuum of Depth of Sedation / Analgesia

Applicant Dr. Benjamin Brown	Date 11/23/18

The granting, reviewing and changing of clinical Privileges will be in accordance with the Medical Staff Bylaws. Assignment of such clinical Privileges will be based on documentation of individual's education, clinical training, demonstrated skills, and capacity to manage procedurally related complications. Indicate procedures *requested* for which you *do* wish to be credentialed. Return this form with your application.

Procedures Depth of Sedation Continuum	Privileges Granted as Initialed by Chairperson	
	Approved	Denied
Minimal sedation / Anxiolysis	[illegible]	
Moderate Sedation / Analgesia	[illegible]	
General Anesthesia		[illegible]

Credentialing Criteria: Required documentation for initial and renewal privileging of sedation:

Minimal: Appropriate narcotics licensing
Moderate: Demonstration of current clinical competence and ACLS (Provide list of verifiable successful performance of 10 procedures involving moderate sedation in the last 12 months if requested)

If you choose to apply for this Privileges, please submit documentation as indicated above. Please also indicate the number of times moderate sedation was administered by you over the last 12 month:

	0-10	11-25	26+
Moderate Sedation/Analgesia			

Please document any complications or adverse outcomes encountered over the last 12 months and list at which facility these cases were performed:

N/A

Please document your level of certification: ____ BCLS __X__ ACLS

NOTE: All doctors are encouraged to maintain ACLS certification in conjunction with their sedation/analgesia Privileges.

A. For Administrative Purposes Only

Clinical Privileges recommendations approved by Governance.

Governance Representative [illegible] Date

Client#: 238549 WHOLEWOMAN5

ACORD CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 01/30/2018

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer any rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Marsh & McLennan Agency LLC
One Executive Drive
Somerset, NJ 08873

CONTACT NAME: Somerset Support Dept
PHONE (A/C, No, Ext): 732-469-3000 **FAX (A/C, No):**
E-MAIL ADDRESS: somersetclsupport@mma-ne.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Landmark American Insurance Company	33138
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Dr. Benjamin Brown
Whole Woman's Health of Peoria, LLC
7405 North University #D
Peoria, IL 61614

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						MED EXP (Any one person)	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PERSONAL & ADV INJURY	$
	☐ OTHER						GENERAL AGGREGATE	$
							PRODUCTS - COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY						PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N ☐ (Mandatory in NH)	N / A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Medical Malpractice			LHM832377	01/24/2018	06/24/2018	$1,000,000 Occurrence $3,000,000 Aggregate	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Evidence of Insurance for Dr. Benjamin Brown

CERTIFICATE HOLDER
Whole Woman's Health of Peoria, LLC
7405 North University #D
Peoria, IL 61614

CANCELLATION
SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
Wm. A. Gilbert

Americans United for Life

NSRDV

Whole Woman's Health of Peoria

DELINEATION OF CLINICAL PRIVILEGES
Continuum of Depth of Sedation / Analgesia

Applicant Dr. Benjamin Brown	Date 5.30.18

The granting, reviewing and changing of clinical Privileges will be in accordance with the Medical Staff Bylaws. Assignment of such clinical Privileges will be based on documentation of individual's education, clinical training, demonstrated skills, and capacity to manage procedurally related complications. Indicate procedures *requested* for which you *do* wish to be credentialed. Return this form with your application.

Procedures Depth of Sedation Continuum	Privileges Granted as Initialed by Chairperson	
	Approved	Denied
Minimal sedation / Anxiolysis	[illegible]	
Moderate Sedation / Analgesia	[illegible]	
General Anesthesia		[illegible]

Credentialing Criteria: Required documentation for initial and renewal privileging of sedation:

Minimal: Appropriate narcotics licensing
Moderate: Demonstration of current clinical competence and ACLS (Provide list of verifiable successful performance of 10 procedures involving moderate sedation in the last 12 months if requested)

If you choose to apply for this Privileges, please submit documentation as indicated above. Please also indicate the number of times moderate sedation was administered by you over the last 12 month:

	0-10	11-25	26+
Moderate Sedation/Analgesia			

Please document any complications or adverse outcomes encountered over the last 12 months and list at which facility these cases were performed:
N/A

Please document your level of certification: ____ BCLS __X__ ACLS

NOTE: All doctors are encouraged to maintain ACLS certification in conjunction with their sedation/analgesia Privileges.

A. For Administrative Purposes Only

Clinical Privileges recommendations approved by Governance.

Governance Representative [signature] Date 5.30.18

Whole Woman's Health of Peoria, LLC

DELINEATION OF CLINICAL PRIVILEGES

Gynecological

Applicant	Date
Dr. Benjamin Brown	5.30.18

The granting, reviewing and changing of clinical Privileges will be in accordance with the Medical Staff Bylaws. Assignment of such clinical Privileges will be based on documentation of individual's education, clinical training, demonstrated skills, and capacity to manage procedurally related complications. Indicate procedures *requested* for which you do wish to be credentialed. Return this form with your application.

Outpatient		
Reading first and second trimester ultrasound		
1st trimester		
2nd trimester		
Medication Abortion		
1st trimester		
2nd trimester		
Dilation and extraction		

I certify that the applicant named above has met the requirements for approval of the requested Privileges.

For Administrative Purposes Only

Clinical Privileges recommendations approved by Governance.

Governance Representative [signature] Date 5.30.18

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
					1	2
	TeleMife Dawn RN, Bailey, Kathy		Dr. Shah Full Session All Staff	TeleMife Bonnie RN, Bailey, Kathy		
3	4 No Patients	5	6	7 No Patients	8	9
			Dr. Shah Full Session All Staff	TeleMife Dawn RN, Bailey, Kathy		
10 No Patients	11 No Patients	12	13	14 No Patients	15	16
	Dr. Shah Full Session All Staff	Training All Staff	Training All Staff	TeleMife Dawn RN, Bailey, Kathy	TeleMife 10 AM to 1:00 PM Dawn RN , Bailey, Kathy	
17	18	19	20	21	22	23
		TeleMife Dawn RN, Bailey, Kathy	Dr. Shah Full Session All Staff	TeleMife Bonnie RN, Bailey, Kathy		
24 No Patients	25	26	27	28 No Patients	29	30

JUNE

2018

NOTES:

Dawn looking into June 12

Americans United for Life

	1	2	3	4	5	
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

MAY 2018

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

JULY 2018

th

Whole Woman's Health of Peoria, LLC

Policy – Safe Injection Practices

Purpose

The purpose of this policy is to define and describe practices necessary to safeguard Whole Woman's Health patients and care-givers from the transmission of infection due to unsafe injection practices.

Definitions

Aseptic Technique
A set of specific practices and procedures performed under carefully controlled conditions with the goal of minimizing contamination by pathogens.

Multi-dose Vial (MDV)
A multi-dose vial is a vial of liquid medication intended for parenteral administration (injection or infusion) that contains more than one dose of medication. Multi-dose vials are labeled as such by the manufacturer and typically contain an antimicrobial preservative to help prevent the growth of bacteria. The preservative has no effect on viruses and does not protect against contamination when healthcare personnel fail to follow safe injection practices.

Single Dose Vial (SDV): A single-dose or single-use vial is a vial of liquid medication intended for parenteral administration (injection or infusion) that is meant for use in a single patient for a single case/procedure/injection. Single-dose or single-use vials are labeled as such by the manufacturer and typically lack an antimicrobial preservative.

Policy

1. Aseptic Technique is used for in the handling, preparing, and storing of medications and injection equipment/supplies.

2. Needles and Syringes

    a. The rubber septum on a medication vial and diluents is disinfected with 70% alcohol and allowed to dry prior to piercing.
    b. Needles, cannulae and syringes are sterile, single-use items. They should never be reused for another patient nor to access a medication or solution that might be used for a subsequent patient. This includes manufacturer prefilled syringes and cartridge devices such as insulin pens.
    c. Never administer medications from a single syringe to multiple patients, even if the needle or cannula on the syringe is changed.
    d. Remove sterile needle/cannula and/or syringe from package just prior to use.
    e. Needles and syringes are not to be stored unwrapped as sterility cannot be assured.

Implemented 10/25/2017 -AHM
Revised 04/05/2018-SS

Whole Woman's Health of Peoria, LLC
Telemife Checklist

□ Patient checks in, and completes paperwork.

□ Patient comes in for ultrasound: Sono tech sends the image to WWH email labeling the message with the patient's last name and first initial.

□ Patient receives lab. – Patient Advocate

□ Patient receives counseling. – Patient Advocate

□ Patient receives H&P. - Provider

□ Patient goes to Intake. – Patient Advocate

□ While at intake, staff scans the sono image, medical abortion record, medical history, contraceptive history form and medical abortion consent to the physician on schedule with the subject line: patient's last name and first initial.

□ Patient returns to consult room, meets with provider for an overview of the next steps:

- Meet with MD
- Answer any questions
- Authorize provider to give out the medication

□ Provider connects with the MD, presents the case, introduces patient.

□ MD authorizes provider to give medication, and sends electronic signature to WWH email:

"I, Dr._____ Authorize_____ to dispense the medical abortion pill and misoprostol medication to Ms._____ to be taken following the instructions given on site.

Signed: _____"

□ Provider dispenses medication, documents the medical abortion record.

□ Staff prints all electronic signatures, place them in the respective patient files, makes sure all records are completed, audited, and filed.

□ Delete the following electronic files once you have ensured all electronic signatures have been filed:

- From Email: All sent files, All received files.
- From desktop: All patient information.

□ Wrap up your day, do a little dance, pat yourself in the back, and go home ☺

Americans United for Life

Created April 16, 2015- AF

Standing Orders for Surgical Abortion:
Dr. Y Shah
Dr. L Lauren
Dr. B Brown

Pre-Operative:

- The patient will receive an ultrasound to approximate gestation and to confirm an intrauterine pregnancy.
- The patient's medical history will be reviewed and the following will be documented and reviewed by MD:
    - Current or past history of seizures
    - Current vaginal infection
    - Recent hospitalization
    - Obstetrical/pregnancy history including C-sections
    - Major psychiatric illness
    - Any major surgery or medical condition
    - Any other abnormal aspects of medical history
    - Methadone or other opioid or anti-opoid medications
- The patient will receive lab work to establish the following:
    - Blood pressure with systolic between 90-140, diastolic between 50-90
    - Pulse between 50-120
    - Temperature between 96.8-100.4
    - Hemoglobin < 8
    - RH factor in blood (if negative and <12 weeks gestation the patient receives 50 mcg IM of Micrhogam, if >12 weeks gestation the patient receives 300 mcg IM of Rhogam)
    - The physician will be consulted if any of these values lie outside the normal range.
- The patient will receive counseling regarding alternatives to abortion, risks and benefits of abortion, the abortion procedure, and birth control methods. After counseling, the counselor will obtain written consent if an abortion is sought.

Preoperative Medications:

- The patient may receive preoperative medications as follows:
- Ativan 1 or 2mg
- Metronidazole (Flagyl) 500 mg p.o. x one.
- If the patient weighs 124 pounds or less she will receive 25 mg Promethazine p.o.; if she weighs 125 pounds or more she will receive 50 mg Promethazine p.o.
- If nausea prevents the patient from tolerating p.o. meds she may receive 25 mg Promethazine IM.
- If the patient does not receive Promethazine, or she is driving herself, she may receive 4mg Ondansetron (Zofran) p.o.
- 800 mg Ibuprofen; if the patient is allergic to Ibuprofen she may receive 1000 mg Acetaminophen.
- If the patient is driving herself she may receive 1,000 mg acetaminophen p.o. and 30-60 mg Ketorolac IM.
- If a patient is anxious she may receive 5 mg Diazepam p.o.
- If a patient receives Promethazine, any IV sedation, or Diazepam, she will be unable to drive after the procedure and will need to arrange transportation with a driver with whom she is acquainted (e.g., she cannot take a taxi home unescorted)
- A patient will receive 600 mcg Misoprostol buccally 90 minutes pre-op if:
  The patient's ultrasound measurement indicates 12 weeks LMP or greater.
  The patient had laminaria inserted by the physician to prepare her cervix.

If a patient requests IV sedation she may receive medications as follows:

- 10 mg of Nubain IVP over 1-2 minutes.
- 2 to 2.5 mg of Versed (at doctor's discretion) IVP over 1-2 minutes.
- 0.4mg Atropine IVP over 1-2 minutes.

Or:

- Start Fentanyl 50- 100 mcg (at doctor's discretion) IVP over 1- 2 minutes. Add 50 mg
- 2 to 2.5 mg of Versed (at doctor's discretion) IVP over 1-2 minutes.
- 0.4mg Atropine IVP over 1-2 minutes.
- Diazepam 5 mg as per MD's orders.
- If the patient is breastfeeding she will be instructed to discard her breastmilk for 24 hours after the procedure.

- 5cc of either heparin solution (Heplock) or saline will be used to start the patient's IV before the procedure.
- If a patient experiences a vaso/vagal response she will receive 0.4mg Atropine IM or IV push by the doctor or by his/her appointee as directed by the doctor.
- In the event of an adverse reaction to Nubain , 0.4 mg of Narcan (Naloxone) IV/IM will be given.
- In the event of an adverse reaction to Versed, 0.2mg of Romazicon (Flumazenil) IV/IM will be given.
- During the procedure the patient will receive a paracervical block administered by the physician using 20 -25cc of premixed formula. The formula will be:
  45cc 1%Lidocaine
  5cc Sodium Bicarbonate
  +/- epi 1:100, 000

The patient's blood pressure, respirations, LOC, pulse and O2 saturation will be measured before, during, and after the surgical procedure.

Prescriptions may be given as follows:

- Contraceptive medication of patient's choice at doctor's discretion. Medication selected/given: documented on abortion record.
- Naproxen 500 mg # 30 q 12 hrs. PRN pain.
- Metronidazole 500 mg #4, 2 tabs po with food. 2 tabs 1 hr later.
- Methergine 0.2mg #8 1 tab po q 6 hrs. while awake, as per doctor's discretion
- If the patient tests positive for a UTI, the patient will receive a prescription for Macrobid 100 mg #14 1 cap bid for 7 days.
- Patient may receive an additional prescription if she experiences increased pain post-operatively:
  Percocet 5/325 #10 prn
- The patient may receive a prescription for Diflucan (150 mg #1, 1 refill) if she experiences a yeast infection post-operatively.

Aftercare Room

- Patients may be discharged from the recovery room when:
  - Blood pressure with systolic between 90-140, diastolic between 50-90
  - Pulse between 50-120
  - Temperature between 96.8-100.4°F. Patients who did not receive misoprostol pre-op with a temperature of 100.4 to 101.0°F should receive 2 grams of Rocephin after one hour and then may be discharged. Patients who did receive misoprostol pre-op with a temperature of 100.4 to 101.0°F should receive 500 mg of Acetaminophen 30-60 minutes after the temperature reading; if temperature is dropping patients may be discharged.
  - Bleeding is moderate or less
  - LOC is 10
  - Pain is controlled
  - Patient is ambulatory w/o dizziness
  - The patient is tolerating liquids and solids
  - The post-procedure care instruction sheet has been reviewed and given to the patient
  - The patient has received her prescriptions
- The following medications may be administered in the aftercare room:
  - Atropine 0.4 mg IV/IM
  - Phenergan 25 mg PO/suppository/IM
  - Methergine 0.2 mg PO/IM
  - Narcan (naloxone) 0.4 mg IV/IM
  - Romazicon 0.2 mg IV/IM
  - DMPA (Depo Provera) 150 mg IM
  - Pitocin 10 units IM
- Patients who received IV sedation will be observed in the recovery room for at least 45 minutes; patients who do not receive IV sedation will be observed in the recovery room for 45 minutes (or longer at doctor's discretion)

Deviations from standing orders per attending physician:

MD Signature: _____ Date: S. 30. 18

Standing Orders for Medical Abortion with Mifeprex:
Dr. Y Shah
Dr. L Lauren
Dr. B Brown

See also:
Protocol for Medical Abortion
Protocol for In-Office Insertion of Cytotec
Policy for Management of Mifeprex Log

Pre-Abortion

- The patient will receive an ultrasound to approximate gestation and to confirm an intrauterine pregnancy. The patient must be 10 weeks LMP or fewer by ultrasound.
- The patient's medical history will be documented and reviewed by the MD:
    - Hemorrhagic disorders or concurrent anticoagulant therapy
    - Chronic adrenal failure
    - Heart or respiratory disease
    - Liver or kidney disease
    - Concurrent long-term systemic corticosteroid therapy
    - Confirmed or suspected ectopic pregnancy or undiagnosed adnexal mass
    - Inherited blood or bleeding disorders
    - IUD in place (must be removed)
    - Known allergy to Mifepristone, Misoprostol, or other prostaglandin
    - Sickle Cell Anemia, Leukemia, or Thalassemia
    - Inflammatory bowel disease
    - Seizure disorder or Epilepsy not controlled by medication
    - She is suffering from concurrent illness with significant diarrhea. Misoprostol often causes diarrhea.
    - She is suffering from systemic illness (consult the physician to determine the safest abortion method given her illness).
    - Any major surgery or medical condition
    - Any other abnormal aspects of medical history
- The patient will receive lab work to establish the following:
    - Blood pressure with systolic between 90-140, diastolic between 50-90
    - Pulse between 50-120
    - Temperature between 96.8-100.4
    - Hemoglobin >8
    - RH factor in blood (if negative and <12 weeks the patient receives 50 mcg IM of Micrhogam)
    - The physician will be consulted if any of these values lie outside the normal range.
- The patient will receive counseling regarding alternatives to abortion, risks and benefits of abortion, the abortion procedure, and birth control methods. After counseling, the counselor will obtain written consent if an abortion is sought.

The patient will receive pre abortion medications as follows:

- Metronidazole 500mg p.o. x one OR Levoflaxcin500mg given 1/2 hour before procedure PO
- If nausea prevents the patient from tolerating PO meds she may receive 25 mg promethazine IM, or .4mg Zofran.
- If the patient receives promethazine, she will be unable to drive herself home and will need to arrange transportation with a driver with whom she is acquainted (e.g., she cannot take a taxi home unescorted).

The patient will receive 200 mg Mifeprex (mifepristone), in the office, as directed by the physician.
The patient will be given 800 mcg Misoprostol and instructed to insert it buccally or vaginally 24-48 hours after taking Mifeprex. See *Protocol for Medical Abortion* for guidelines as to days, times, and location.

Prescriptions may be given as follows:

- Contraceptive medication of patient's choice at doctor's discretion
- Tylenol #3, #10, 1 tab q 6 hrs for pain OR
- Percocet #10, 1-2 tabs q. 4-6 prn hrs. for pain. If the patient is allergic to Percocet she may be given Ibuprofen 800 mg #10 q 4-6 hours prn cramping
- Promethazine 25mg #10, 1 tab q 4 hrs. prn for nausea.

Deviations from standing orders per attending physician:

MD Signature: _____ Date: 5.30.18

Revised 5/30/2018-SS

Whole Woman's Health of Peoria, LLC
Telemife Checklist

□ Patient checks in, and completes paperwork.

□ Patient comes in for ultrasound: Sono tech sends the image to WWH email labeling the message with the patient's last name and first initial.

□ Patient receives lab. – Patient Advocate

□ Patient receives counseling. – Patient Advocate

□ Patient receives H&P. - Clinician

□ Patient goes to Intake. – Patient Advocate

□ While at intake, staff scans the sono image, medical abortion record, medical history, contraceptive history form and medical abortion consent to the physician on schedule with the subject line: patient's last name and first initial.

□ Patient returns to consult room, meets with clinician for an overview of the next steps:

- Clinician connects with the MD, presents the case, introduces patient.
- MD answers patient's questions
- Authorize Clinician to give out the medication

□ MD authorizes clinican to give medication, and sends electronic signature to WWH email:

"I, Dr. _____ Authorize_____ to dispense the medical abortion pill and misoprostol medication to Ms._____ to be taken following the instructions given on site.

Signed: _____"

□ Clinician dispenses medication, documents the medical abortion record.

□ Staff prints all electronic signatures, place them in the respective patient files, makes sure all records are completed, audited, and filed.

□ Delete the following electronic files once you have ensured all electronic signatures have been filed:

- From Email: All sent files, All received files.
- From desktop: All patient information.

□ Wrap up your day, do a little dance, pat yourself in the back, and go home ☺

Americans United for Life

Created June 15, 2018- SS

Void

Whole Woman's Health of Peoria, LLC
Telemife Checklist

□ Patient checks in, and completes paperwork.

□ Patient comes in for ultrasound: Sono tech sends the image to WWH email labeling the message with the patient's last name and first initial.

□ Patient receives lab. – Patient Advocate

□ Patient receives counseling. – Patient Advocate

□ Patient receives H&P. - Provider

□ Patient goes to Intake. – Patient Advocate

□ While at intake, staff scans the sono image, medical abortion record, medical history, contraceptive history form and medical abortion consent to the physician on schedule with the subject line: patient's last name and first initial.

□ Patient returns to consult room, meets with provider for an overview of the next steps:

- Meet with MD
- Answer any questions
- Authorize provider to give out the medication

□ Provider connects with the MD, presents the case, introduces patient.

□ MD authorizes provider to give medication, and sends electronic signature to WWH email:

"I, Dr. _____ Authorize_____ to dispense the medical abortion pill and misoprostol medication to Ms._____ to be taken following the instructions given on site.

Signed: _____"

□ Provider dispenses medication, documents the medical abortion record.

□ Staff prints all electronic signatures, place them in the respective patient files, makes sure all records are completed, audited, and filed.

□ Delete the following electronic files once you have ensured all electronic signatures have been filed:

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- From desktop: All patient information.

□ Wrap up your day, do a little dance, pat yourself in the back, and go home ☺

Americans United for Life

Created April 16, 2015- AF

Whole Woman's Health of Peoria
7405 N. University St., Peoria, IL 61614
(309) 691-9073

January 23,2018

Dear Dr. B. Brown

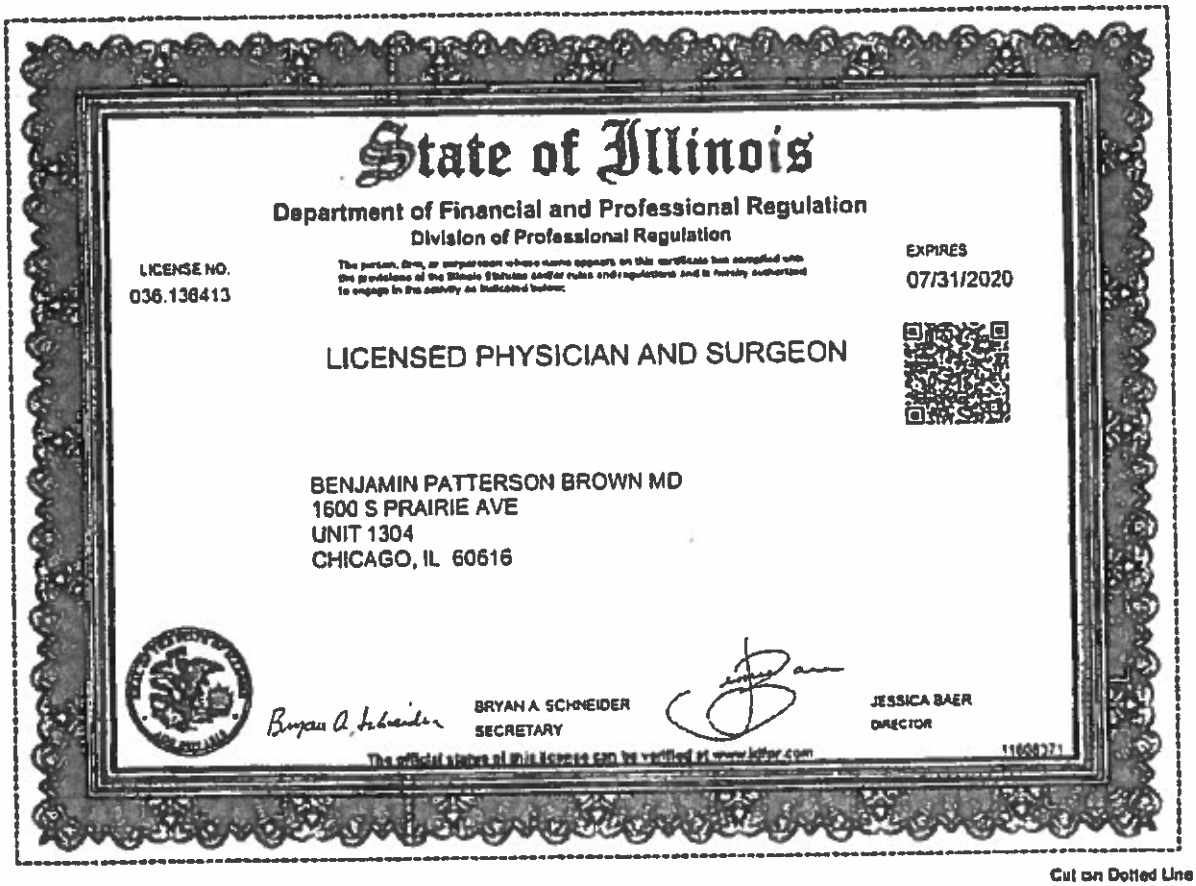
This letter serves as notification that you have been granted active admitting privileges at Whole Woman's Health of Peoria. These admitting privileges will be due for review on January 23, 2019.

Thank you,

[redacted]

Amy Hagstrom Miller, CEO
Chairperson, Governing Board
Whole Woman's Health of Peoria

Americans United for Life



State of Illinois

Department of Financial and Professional Regulation
Division of Professional Regulation

LICENSE NO.
036.138413

The person, firm, or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below:

EXPIRES
07/31/2020

LICENSED PHYSICIAN AND SURGEON

BENJAMIN PATTERSON BROWN MD
1600 S PRAIRIE AVE
UNIT 1304
CHICAGO, IL 60616

BRYAN A. SCHNEIDER
SECRETARY

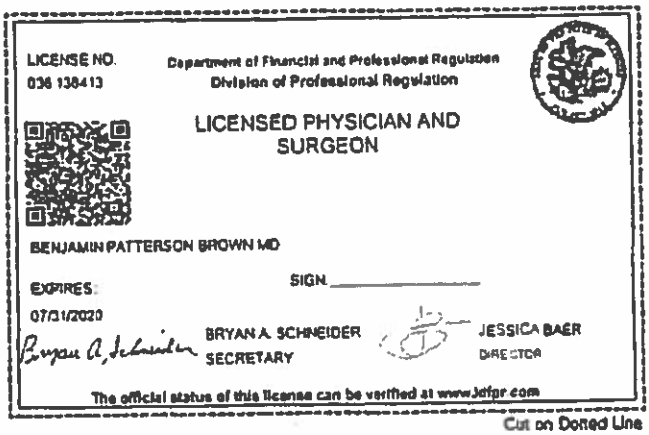
JESSICA BAER
DIRECTOR

The official status of this license can be verified at www.idfpr.com

116088271

Cut on Dotted Line

For future reference, IDFPR is now providing each person/business a unique identification number, 'Access ID', which may be used in lieu of a social security number, date of birth or FEIN number when contacting the IDFPR. Your Access ID is: 3694800



LICENSE NO.
036 138413

Department of Financial and Professional Regulation
Division of Professional Regulation

LICENSED PHYSICIAN AND SURGEON

BENJAMIN PATTERSON BROWN MD

EXPIRES:
07/31/2020

SIGN _____

BRYAN A. SCHNEIDER
SECRETARY

JESSICA BAER
DIRECTOR

The official status of this license can be verified at www.idfpr.com

Cut on Dotted Line

Americans United for Life

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D C 20537

DEA REGISTRATION NUMBER: FB5333648
FEE EXPIRES: 07-31-2018
FEE PAID: $731

SCHEDULES: 2,2N,3, 3N,4,5
BUSINESS ACTIVITY: PRACTITIONER
BSAE DATE: 09-01-2015

BROWN, BENJAMIN P (MD)
UNIVERSITY OF CHICAGO MEDICINE, DEPT OF OB/GYN
5841 S MARYLAND AVE
MC2050
CHICAGO, IL 60637

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY. AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

Form DEA-223 (9/2016)

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
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Americans United for Life

Whole Woman's Health of Peoria, LLC

DELINEATION OF CLINICAL PRIVILEGES

Gynecological

Applicant	Date
Dr. Benjamin Brown	1/23/18

The granting, reviewing and changing of clinical Privileges will be in accordance with the Medical Staff Bylaws. Assignment of such clinical Privileges will be based on documentation of individual's education, clinical training, demonstrated skills, and capacity to manage procedurally related complications. Indicate procedures *requested* for which you *do* wish to be credentialed. Return this form with your application.

Outpatient	Yes	
Reading first and second trimester ultrasound	Yes	
1st trimester	Yes	
2nd trimester	Yes	
Medication Abortion	Yes	
1st trimester	Yes	
2nd trimester	Yes	
Dilation and extraction	Yes	

I certify that the applicant named above has met the requirements for approval of the requested Privileges.

For Administrative Purposes Only

Clinical Privileges recommendations approved by Governance.

Governance Representative [signature] Date 1/23/18

Whole Woman's Health of Peoria

DELINEATION OF CLINICAL PRIVILEGES
Continuum of Depth of Sedation / Analgesia

Applicant Dr. Benjamin Brown	Date 11/23/18

The granting, reviewing and changing of clinical Privileges will be in accordance with the Medical Staff Bylaws. Assignment of such clinical Privileges will be based on documentation of individual's education, clinical training, demonstrated skills, and capacity to manage procedurally related complications. Indicate procedures *requested* for which you *do* wish to be credentialed. Return this form with your application.

Procedures Depth of Sedation Continuum	Privileges Granted as Initialed by Chairperson	
	Approved	Denied
Minimal sedation / Anxiolysis		
Moderate Sedation / Analgesia		
General Anesthesia		

Credentialing Criteria: Required documentation for initial and renewal privileging of sedation:

Minimal: Appropriate narcotics licensing
Moderate: Demonstration of current clinical competence and ACLS (Provide list of verifiable successful performance of 10 procedures involving moderate sedation in the last 12 months if requested)

If you choose to apply for this Privileges, please submit documentation as indicated above. Please also indicate the number of times moderate sedation was administered by you over the last 12 month:

	0-10	11-25	26+
Moderate Sedation/Analgesia			

Please document any complications or adverse outcomes encountered over the last 12 months and list at which facility these cases were performed:

N/A

Please document your level of certification: ___ BCLS X ACLS

NOTE: All doctors are encouraged to maintain ACLS certification in conjunction with their sedation/analgesia Privileges.

A. For Administrative Purposes Only

Clinical Privileges recommendations approved by Governance.

Governance Representative _____ Date _____

Client#: 238549 WHOLEWOMAN5

ACORD CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 01/30/2018

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer any rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Marsh & McLennan Agency LLC One Executive Drive Somerset, NJ 08873	CONTACT NAME: Somerset Support Dept PHONE (A/C, No, Ext): 732-469-3000 FAX (A/C, No): E-MAIL ADDRESS: somersetclsupport@mma-ne.com	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : Landmark American Insurance Company	33138
INSURED Dr. Benjamin Brown Whole Woman's Health of Peoria, LLC 7405 North University #D Peoria, IL 61614	INSURER B :	
	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	☐ OTHER							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ N / A						E.L. EACH ACCIDENT	$
	(Mandatory in NH)						E.L. DISEASE - EA EMPLOYEE	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - POLICY LIMIT	$
A	Medical Malpractice			LHM832377	01/24/2018	06/24/2018	$1,000,000 Occurrence $3,000,000 Aggregate	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Evidence of Insurance for Dr. Benjamin Brown

CERTIFICATE HOLDER

Whole Woman's Health of Peoria, LLC
7405 North University #D
Peoria, IL 61614

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Wm. R. Clark

Americans United for Life

Whole Woman's Health of Peoria

DELINEATION OF CLINICAL PRIVILEGES
Continuum of Depth of Sedation / Analgesia

Applicant Dr. Benjamin Brown	Date 5.30.18

The granting, reviewing and changing of clinical Privileges will be in accordance with the Medical Staff Bylaws. Assignment of such clinical Privileges will be based on documentation of individual's education, clinical training, demonstrated skills, and capacity to manage procedurally related complications. Indicate procedures *requested* for which you *do* wish to be credentialed. Return this form with your application.

Procedures Depth of Sedation Continuum	Privileges Granted as initialed by Chairperson	
	Approved	Denied
Minimal sedation / Anxiolysis	[signature]	
Moderate Sedation / Analgesia	[signature]	
General Anesthesia		[signature]

Credentialing Criteria: Required documentation for initial and renewal privileging of sedation:

Minimal: Appropriate narcotics licensing
Moderate: Demonstration of current clinical competence and ACLS (Provide list of verifiable successful performance of 10 procedures involving moderate sedation in the last 12 months if requested)

If you choose to apply for this Privileges, please submit documentation as indicated above. Please also indicate the number of times moderate sedation was administered by you over the last 12 month:

	0-10	11-25	26+
Moderate Sedation/Analgesia	_____	_____	_____

Please document any complications or adverse outcomes encountered over the last 12 months and list at which facility these cases were performed:

N/A

Please document your level of certification: _____BCLS __X__ACLS

NOTE: All doctors are encouraged to maintain ACLS certification in conjunction with their sedation/analgesia Privileges.

A. For Administrative Purposes Only

Clinical Privileges recommendations approved by Governance.

Governance Representative [signature] Date 5.30.18

Whole Woman's Health of Peoria, LLC

DELINEATION OF CLINICAL PRIVILEGES

Gynecological

Applicant	Date
Dr. Benjamin Brown	5.30.18

The granting, reviewing and changing of clinical Privileges will be in accordance with the Medical Staff Bylaws. Assignment of such clinical Privileges will be based on documentation of individual's education, clinical training, demonstrated skills, and capacity to manage procedurally related complications. Indicate procedures *requested* for which you *do* wish to be credentialed. Return this form with your application.

Outpatient	[illegible]	
Reading first and second trimester ultrasound	[illegible]	
1st trimester	[illegible]	
2nd trimester	[illegible]	
Medication Abortion	[illegible]	
1st trimester	[illegible]	
2nd trimester	[illegible]	
Dilation and extraction	[illegible]	

I certify that the applicant named above has met the requirements for approval of the requested Privileges.

For Administrative Purposes Only

Clinical Privileges recommendations approved by Governance.

Governance Representative [illegible] Date 5.30.18

Whole Woman's Health of Peoria
7405 N. University St., Peoria, IL 61614
(309) 691-9073

September 12, 2017

Dear Dr. L. Laursen,

This letter serves as notification that you have been granted active admitting privileges at Whole Woman's Health of Peoria. These admitting privileges will be due for review on September 12, 2018.

Thank you,

[redacted]

Amy Hagstrom Miller, CEO
Chairperson, Governing Board
Whole Woman's Health of Peoria

Americans United for Life

Whole Woman's Health of Peoria, LLC

DELINEATION OF CLINICAL PRIVILEGES

Gynecological

Applicant	Date
Dr. Laura Larsen	5.30.18

The granting, reviewing and changing of clinical Privileges will be in accordance with the Medical Staff Bylaws. Assignment of such clinical Privileges will be based on documentation of individual's education, clinical training, demonstrated skills, and capacity to manage procedurally related complications. Indicate procedures requested for which you do wish to be credentialed. Return this form with your application.

Outpatient	LL	
Reading first and second trimester ultrasound	LL	
1st trimester	LL	
2nd trimester	LL	
Medication Abortion	LL	
1st trimester	LL	
2nd trimester	LL	
Dilation and extraction	LL	

I certify that the applicant named above has met the requirements for approval of the requested Privileges.

For Administrative Purposes Only

Clinical Privileges recommendations approved by Governance

Governance Representative [signature] Date 5.30.18

Whole Woman's Health of Peoria

DELINEATION OF CLINICAL PRIVILEGES
Continuum of Depth of Sedation / Analgesia

Applicant Dr. Laura Laursen	Date 5.30.18

The granting, reviewing and changing of clinical Privileges will be in accordance with the Medical Staff Bylaws. Assignment of such clinical Privileges will be based on documentation of individual's education, clinical training, demonstrated skills, and capacity to manage procedurally related complications. Indicate procedures *requested* for which you *do* wish to be credentialed. Return this form with your application.

Procedures Depth of Sedation Continuum	Privileges Granted as Initialed by Chairperson	
	Approved	Denied
Minimal sedation / Anxiolysis	[illegible]	
Moderate Sedation / Analgesia	[illegible]	
General Anesthesia		[illegible]

Credentialing Criteria: Required documentation for initial and renewal privileging of sedation:

Minimal: Appropriate narcotics licensing
Moderate: Demonstration of current clinical competence and ACLS (Provide list of verifiable successful performance of 10 procedures involving moderate sedation in the last 12 months if requested)

If you choose to apply for this Privileges, please submit documentation as indicated above. Please also indicate the number of times moderate sedation was administered by you over the last 12 month:

	0-10	11-25	26+
Moderate Sedation/Analgesia	_____	_____	_____

Please document any complications or adverse outcomes encountered over the last 12 months and list at which facility these cases were performed:
N/A

Please document your level of certification: _____ BCLS __X__ ACLS

NOTE: All doctors are encouraged to maintain ACLS certification in conjunction with their sedation/analgesia Privileges.

A. For Administrative Purposes Only

Clinical Privileges recommendations approved by Governance.

Governance Representative [illegible] Date 5.30.18

State of Illinois

Department of Financial and Professional Regulation

Division of Professional Regulation

LICENSE NO
036.139557

EXPIRES
07/31/2020

LICENSED PHYSICIAN AND SURGEON

LAURA ELIZABETH LAURSEN MD
LAURA LAURSEN
5841 S MARYLAND AVE MC2050
CHICAGO, IL 60637

BRYAN A SCHNEIDER
SECRETARY

JESSICA BAER
DIRECTOR

The official status of this license can be verified at www.idfpr.com

Cut on Dotted Line

For future reference, IDFPR is now providing each person/business a unique identification number, 'Access ID', which may be used in lieu of a social security number, date of birth or FEIN number when contacting the IDFPR. Your Access ID is: 3706462

LICENSE NO
036.139557

Department of Financial and Professional Regulation
Division of Professional Regulation

LICENSED PHYSICIAN AND SURGEON

LAURA ELIZABETH LAURSEN MD

SIGN _____

EXPIRES
07/31/2020

BRYAN A SCHNEIDER
SECRETARY

JESSICA BAER
DIRECTOR

The official status of this license can be verified at www.idfpr.com

Cut on Dotted Line

Americans United for Life

Client#: 238649 WHOLEWOMANS

ACORD. CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 09/29/2017

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer any rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Marsh & McLennan Agency LLC
One Executive Drive
Somerset, NJ 08873

CONTACT NAME: Somerset Support Dept.
PHONE (A/C, No, Ext): 732-469-3000 FAX (A/C, No):
E-MAIL ADDRESS: somersetcisupport@mma-ne.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Landmark American Insurance Company	33138
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Dr. Lauren Laursen
Whole Woman's Health of Peoria, LLC
7406 North University #D
Peoria, IL 61614

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	COMMERCIAL GENERAL LIABILITY CLAIMS-MADE / OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY / PRO-JECT / LOC / OTHER						EACH OCCURRENCE $ DAMAGE TO RENTED PREMISES (Ea occurrence) $ MED EXP (Any one person) $ PERSONAL & ADV INJURY $ GENERAL AGGREGATE $ PRODUCTS - COMP/OP AGG $
	AUTOMOBILE LIABILITY ANY AUTO / OWNED AUTOS ONLY / SCHEDULED AUTOS / HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Ea accident) $ BODILY INJURY (Per person) $ BODILY INJURY (Per accident) $ PROPERTY DAMAGE (Per accident) $
	UMBRELLA LIAB / EXCESS LIAB OCCUR / CLAIMS-MADE DED / RETENTION $						EACH OCCURRENCE $ AGGREGATE $
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y / N If yes, describe under DESCRIPTION OF OPERATIONS below	N/A					PER STATUTE / OTH-ER E.L. EACH ACCIDENT $ E.L. DISEASE - EA EMPLOYEE $ E.L. DISEASE - POLICY LIMIT $
A	Medical Malpractice Claims Made			LHM832377	09/30/2017	08/24/2018	$1,000,000 Occurrence $3,000,000 Aggregate Retro Date 09/30/2017

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Evidence of Insurance for Dr. Laura Laursen

CERTIFICATE HOLDER

Whole Woman's Health of Peoria, LLC
7406 North University #D
Peoria, IL 61614

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
Wm. A. Gilbert

Americans United for Life

NSRDV

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
FL6170194	03-31-2019	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	07-15-2016

LAURSEN, LAURA
5841 S. MARYLAND AVE.,
MC 2050
CHICAGO, IL 60637-0000

CONTROLLED SUBSTANCE/REGULATED CHEMICAL REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

Form DEA 223/511 (4/07)

REPORT

CHANGES

PROMPTLY

REQUESTING MODIFICATIONS TO YOUR REGISTRATION CERTIFICATE

To request a change to your registered name, address, the drug schedule or the drug codes you handle, please

1. visit our web site at deadiversion.usdoj.gov - or
2. call our customer Service Center at 1-(800) 882-9539 - or
3. submit your change(s) in writing to:

Drug Enforcement Administration
P.O. Box 2639
Springfield, VA 22152-2639

See Title 21 Code of Federal Regulations, Section 1301.51 for complete instructions.

You have been registered to handle the following chemical/drug codes:

Whole Woman's Health of Peoria
Transforming Healthcare One Woman at a Time
7405 N. University St. Ste. D, Peoria IL, 61614

June 18, 2015

Dear Dr. Shah,

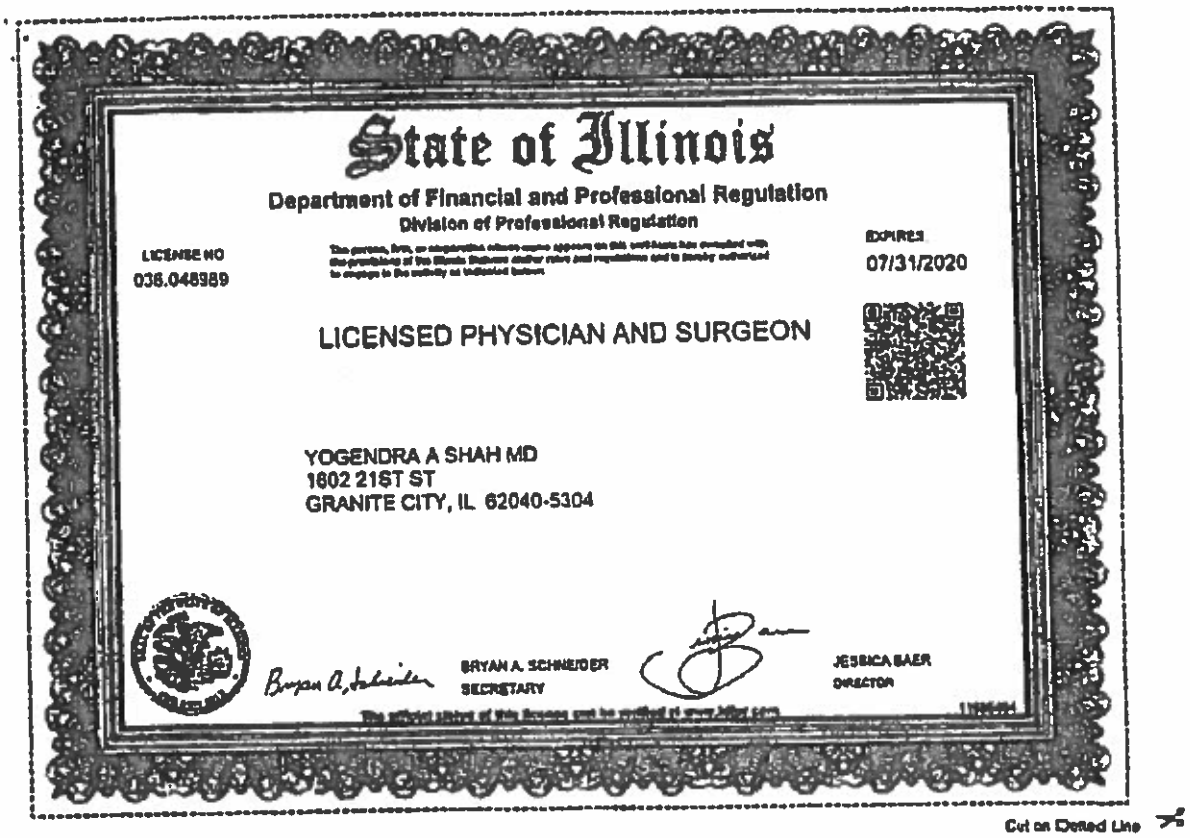
The present serves as notification that you have been granted active admitting privileges at Whole Woman's Health of Peoria, LLC. These privileges extend for the duration of your independent contact agreement.

Thank you,

[redacted]

Amy Hagstrom Miller, CEO
Chairperson, Governing Body
Whole Woman's Health

Americans United for Life



State of Illinois

Department of Financial and Professional Regulation
Division of Professional Regulation

LICENSE NO
036.048989

EXPIRES
07/31/2020

LICENSED PHYSICIAN AND SURGEON

YOGENDRA A SHAH MD
1602 21ST ST
GRANITE CITY, IL 62040-5304

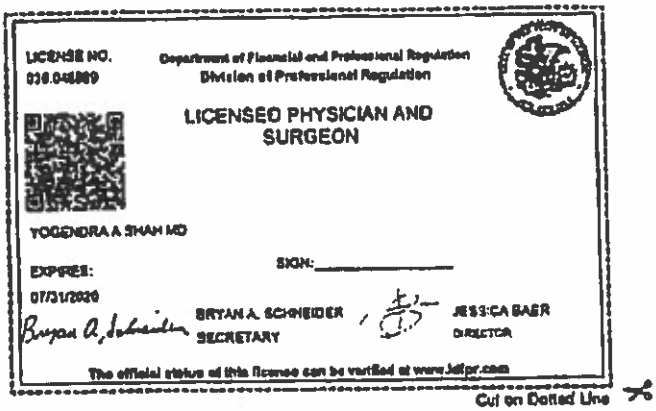
BRYAN A. SCHNEIDER
SECRETARY

JESSICA BAER
DIRECTOR

The official status of this license can be verified at www.idfpr.com

Cut on Dotted Line

For future reference, IDFPR is now providing each person/business a unique identification number, 'Access ID', which may be used in lieu of a social security number, date of birth or FEIN number when contacting the IDFPR. Your Access ID is: 1404669



LICENSE NO.
036.048989

Department of Financial and Professional Regulation
Division of Professional Regulation

LICENSED PHYSICIAN AND SURGEON

YOGENDRA A SHAH MD

EXPIRES:
07/31/2020

SIGN:_____

BRYAN A. SCHNEIDER
SECRETARY

JESSICA BAER
DIRECTOR

The official status of this license can be verified at www.idfpr.com

Cut on Dotted Line

Americans United for Life

SHAH, YOGENDRA AMBALAL MD
1602 21ST STREET
GRANITE CITY, IL 62040-0000

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
AS7925259	02-29-2020	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	02-09-2017

SHAH, YOGENDRA AMBALAL MD
1602 21ST STREET
GRANITE CITY, IL 62040-0000

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D C 20537

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
AS7925259	02-29-2020	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	02-09-2017

SHAH, YOGENDRA AMBALAL MD
1602 21ST STREET
GRANITE CITY, IL 62040-0000

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE

Form DEA-223 (9/2016)

CURICULUM VITAE

NAME: Yogendra Shah, M.D.F.A.C.O.G.

DATE: [redacted]

PLACE OF BIRTH:

MARTIAL STATUS:

UNIVERSITIES ATTENDED:

S.P. University
V.V. Nagar, Gurjarat, India

Pre-Medical-May 1965
Faculty of Science, M.S. University

Doctor of Medicine-October 1969
M.S. University School of Medicine, India

PROFESSIONAL TRAINING

INTERNSHIP: Type-Rotating
S.S.G. Hospital
Baroda, Gurjarat, India

Mount Sinai Hospital Medical Center
Chicago, Illinois
July 1971-June 1972

RESIDENCY: Type-Pathology (One Year)
Methodist Hospital of Central Illinois
Peoria, Illinois
July 1972-June 1973

Type-Obstetrics and Gynecology
Homer G. Phillips Hospital
St. Louis, Missouri
July 1973-June 1976

FELLOWSHIP: Clinic Obstetrics and Gynecology
St. Luke's Hospital West
Chesterfield, Missouri
July 1976-June 1977

BOARD STATUS: Board Ceertified-November 9, 1979
American Board of Obstetrics & Gynecology

Voluntarily Re-certified - June 26, 1995
Voluntarily Re-certified - 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014

FELLOWSHIP: American College of Obstetricians and Gynecology
December 1980

EXPERIENCE: Family Planning Medical Officer
Sadhli, Gujarat, India
January 1971 - May 1971

Private Practice
3165 Myrtle Avenue
Granite City, Illinois 62040
July 1977 - 2015

HONORS AND AWARDS: Higher Education and Scholarship
Gujarat Government, India
June 1964 - October 1969

Americans United for Life

COMMITTE

MEMBERSHIP: Chairman-Department of OB/GYN

Anderson Hospital

1994-1996

Executive Committee

Anderson Hospital

1194-1996

Chairman-Department of OB/GYN

Gateway Regional Medical Center

(Formerly St. Elizabeth Medical Center)

1991-2000

Performance Improvement Committee

1991-2000

Credential Committee-Member

Gateway Regional Medical Center

2003 - Present

Various Committees Member - Gateway Regional and Anderson Hospital

1977- Present

STATE LICENSES: Flex, June 1973- Missouri and Illinois

HOSPITAL PRIVLEGES: Gateway Regional Medical Center (Formerly St. Elizabeth Medical Center)

Active Staff - 1977 - 2015

Courtesy 2015- Present

Oliver Anderson Hospital - Active Staff

1977-2015

PAPERS PUBLISHED: Bibliographies

"Outpatient Laparoscopy with Local Anesthesia"

International Journal of Gynecology and Obstetrics

Volume 17, Number 4, January-February 1980

.p379-381

"Combined Intra and Extra-Uterine Pregnancy"

A Diagnostic Challenge

Journal of Reproductive Medicine

Volume 25, Number 5, November 1980

p290-292

MEDICAL DIRECTOR: Whole Woman's Health of Peoria – June 2015 - Present

The Hope Clinic for Women - July 1987- Present

Madison County Urban League - 1998 - 2015

Americans United for Life

Whole Woman's Health of Peoria

DELINEATION OF CLINICAL PRIVILEGES

Gynecological

Applicant	Date
Dr. Yogendra Shah	05-30-2018

The granting, reviewing and changing of clinical Privileges will be in accordance with the Medical Staff By laws. Assignment of such clinical Privileges will be based on documentation of individual's education, clinical training, demonstrated skills, and capacity to manage procedurally related complications. Indicate procedures ***requested*** for which you *do* wish to be credentialed. Return this form with your application.

Gynecological	Requested	Privileges Granted as initialed by MAB	
		Approved	Denied
GENERAL PRIVILEGES			
General Clinical Privileges customary to the practice of obstetrics and gynecology			
Outpatient	Yogi	HW	
SPECIFIC PRIVILEGES			
Ultrasound			
Reading and interpret first and second trimester ultrasound	Yogi	HW	
OBSTETRICAL SURGICAL PROCEDURES			
Abortion Spontaneous	Yogi		
1st trimester	Yogi	HW	
2nd trimester		HW	
Induced			
Medication Abortion	Yogi	HW	
1st trimester	Yogi	HW	
2nd trimester	Yogi	HW	
Dilation and extraction	Yogi	HW	
Amniocentesis	Yogi	HW	
Invitro fertilization	Yogi	HW	

I certify that I am competent to perform the procedures requested by virtue of my education, training and experience.

Applicant's Signature	Date
Y. a. Shah	05/30/2018

I certify that the applicant named above has met the requirements for approval of the requested Privileges.

For Administrative Purposes Only

Clinical Privileges recommendations approved by Governance.	
Governance Representative Holly Wuefel	Date 5/20/18

Whole Woman's Health of Peoria

DELINEATION OF CLINICAL PRIVILEGES
Continuum of Depth of Sedation / Analgesia

Applicant	Dr. Yogendra Shah	Date 05/29/2018

The granting, reviewing and changing of clinical Privileges will be in accordance with the Medical Staff Bylaws. Assignment of such clinical Privileges will be based on documentation of individual's education, clinical training, demonstrated skills, and capacity to manage procedurally related complications. Indicate procedures ***requested*** for which you ***do*** wish to be credentialed. Return this form with your application.

Procedures Depth of Sedation Continuum	Requested	Privileges Granted as initialed by MAB	
		Approved	Denied
Minimal sedation / Anxiolysis	YSS	HW	
Moderate Sedation / Analgesia	YSS	HW	
General Anesthesia	YSS	HW	

Credentialing Criteria: Required documentation for initial and renewal privileging of sedation:

Minimal: Appropriate narcotics licensing
Moderate: Demonstration of current clinical competence and ACLS **(Provide list of verifiable successful performance of 10 procedures involving moderate sedation in the last 12 months if requested)**

If you choose to apply for this Privileges, please submit documentation as indicated above. Please also indicate the number of times moderate sedation was administered by you over the last 12 month:

	0-10	11-25	26+
Moderate Sedation/Analgesia	_____	_____	_____

Please document any complications or adverse outcomes encountered over the last 12 months and list at which facility these cases were performed:

_____

_____

_____

Please document your level of certification: _____ BCLS ✓ ACLS

NOTE: All doctors are encouraged to maintain ACLS certification in conjunction with their sedation/analgesia Privileges.

I attest that I am qualified and competent to perform the Class of Anesthesia I have indicated on the Delineation of Privileges for Sedation. I understand by requesting and/or signing does not automatically grant this Privileges.

Applicant's Signature	Date
Y G Shah	5-30-18

A. For Administrative Purposes Only

Clinical Privileges recommendations approved by Governance.

Governance Representative Holly Wrafter Date 5-30-18

Client#: 236549 WHOLEWOMANS

ACORD. CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 8/15/2017

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Marsh & McLennan Agency LLC
One Executive Drive
Somerset, NJ 08873

CONTACT NAME:
PHONE (A/C, No, Ext): FAX (A/C, No):
E-MAIL ADDRESS: somersetcisupport@mma-ne.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A: Landmark American Insurance Com	33138
INSURER B:	
INSURER C:	
INSURER D:	
INSURER E:	
INSURER F:	

INSURED
Whole Woman's Health of Peoria, LLC
7405 North University #D
Peoria, IL 61614

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	CLAIMS-MADE OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER						GENERAL AGGREGATE	$
	POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS / NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$
	DED RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						PER STATUTE OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	N/A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Professional Liability			LHM832377 Retro Date	06/24/2017 06/24/2015	06/24/2018	$1,000,000 Each Claim $3,000,000 Aggregate	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Evidence of Insurance

CERTIFICATE HOLDER

Whole Woman's Health of Peoria, LLC
7405 North University #D
Peoria, IL 61614

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Wm. A. Gilardi

NSMXE

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
					1	2
	TeleMife Dawn RN, Bailey, Kathy		Dr. Shah Full Session All Staff	TeleMife Bonnie RN, Bailey, Kathy		
3	4	5	6	7	8	9
	Dr. Shah Full Session All Staff		Dr. Shah Full Session All Staff	TeleMife Dawn RN, Bailey, Kathy		
10	11	12	13	14	15	16
	Dr. Shah Full Session All Staff	Training All Staff	Training All Staff	TeleMife Dawn RN, Bailey, Kathy	TeleMife 10 AM to 1:00 PM Dawn RN , Bailey, Kathy	
17	18	19	20	21	22	23
		TeleMife Dawn RN, Bailey, Kathy	Dr. Shah Full Session All Staff	TeleMife Bonnie RN, Bailey, Kathy		
24	25	26	27	28	29	30

JUNE

2018

NOTES:

Dawn looking into June 12, 22

Americans United for Life

MAY 2018

	1	2	3	4	5	
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

JULY 2018

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

th

Whole Woman's Health of Peoria, LLC

Policy – Safe Injection Practices

Purpose

The purpose of this policy is to define and describe practices necessary to safeguard Whole Woman's Health patients and care-givers from the transmission of infection due to unsafe injection practices.

Definitions

Aseptic Technique
A set of specific practices and procedures performed under carefully controlled conditions with the goal of minimizing contamination by pathogens.

Multi-dose Vial (MDV)
A multi-dose vial is a vial of liquid medication intended for parenteral administration (injection or infusion) that contains more than one dose of medication. Multi-dose vials are labeled as such by the manufacturer and typically contain an antimicrobial preservative to help prevent the growth of bacteria. The preservative has no effect on viruses and does not protect against contamination when healthcare personnel fail to follow safe injection practices.

Single Dose Vial (SDV): A single-dose or single-use vial is a vial of liquid medication intended for parenteral administration (injection or infusion) that is meant for use in a single patient for a single case/procedure/injection. Single-dose or single-use vials are labeled as such by the manufacturer and typically lack an antimicrobial preservative.

Policy

1. Aseptic Technique is used for in the handling, preparing, and storing of medications and injection equipment/supplies.

2. Needles and Syringes

    a. The rubber septum on a medication vial and diluents is disinfected with 70% alcohol and allowed to dry prior to piercing.
    b. Needles, cannulae and syringes are sterile, single-use items. They should never be reused for another patient nor to access a medication or solution that might be used for a subsequent patient. This includes manufacturer prefilled syringes and cartridge devices such as insulin pens.
    c. Never administer medications from a single syringe to multiple patients, even if the needle or cannula on the syringe is changed.
    d. Remove sterile needle/cannula and/or syringe from package just prior to use.
    e. Needles and syringes are not to be stored unwrapped as sterility cannot be assured.

Implemented 10/25/2017 -AHM
Revised 04/05/2018-SS

f. Do not leave needles or other devices left inserted in any vial septum for multiple withdrawals.
g. Do not prepare medication in one syringe to transfer to another syringe unless specifically called for in the reconstitution of a medication
h. Do not draw solution out of another syringe through a rubber stopper

3. Vials, ampules and pre-filled syringes
   a. Use single-dose vials for parenteral medications whenever possible.
   b. Single dose (single use) medication vials/ampoules/prefilled syringes are used for only one patient.
   c. Do not administer medications from single-dose vials, ampoules or prefilled syringes to multiple patient or combine leftover contents for later use.
   d. Any medication left over in a single-dose container after patient use must be discarded. It cannot be stored for future use, even on the same patient.
   e. Medications are not to be stored in caregiver or provider clothing or pockets.
   f. Limit the use of multidose vials and dedicate them to a single patient, whenever possible.
      i. If multidose vials must be used, both the needle or cannula and syringe used to access the multidose vial must be sterile.
      ii. Multi-dose vials to be used for more than one patient are kept in a centralized medication area.
   g. Dispose of opened multidose vials 28 days after opening, unless specified otherwise by the manufacturer, or sooner if sterility is questioned or compromised. Vials must be labeled with the "do not use after" date when opened.
      i. Exception: Vaccines do not follow 28 date discard. Vaccines follow manufacturers' expiration date.
   h. Follow manufacturer's instructions for refrigeration.
   i. Open vials brought in from patient's home are prohibited.

Americans United for Life

Implemented 10/25/2017 -AHM
Revised 04/05/2018-SS

Whole Woman's Health of Peoria
Transforming Healthcare One Woman at a Time
7405 N. University St. Ste. D, Peoria IL, 61614

June 18, 2015

Dear Dr. Shah,

The present serves as notification that you have been granted active admitting privileges at Whole Woman's Health of Peoria, LLC. These privileges extend for the duration of your independent contact agreement.

Thank you,

[redacted]

Amy Hagstrom Miller, CEO
Chairperson, Governing Body
Whole Woman's Health

Americans United for Life

Whole Woman's Health of Peoria
7405 N. University St., Peoria, IL 61614
(309) 691-9073

May 30, 2018

Dear Dr. Yogendra Shah,

This letter serves as notification that you have been granted active admitting privileges at Whole Woman's Health of Peoria. You also serve as the Medical Director for the clinic. These admitting privileges will be due for review on May 31, 2019.

Thank you,

[redacted]

Amy Hagstrom Miller, CEO
Chairperson, Governing Board
Whole Woman's Health of Peoria

Americans United for Life

INDEPENDENT CONTRACTOR AGREEMENT
MEDICAL DIRECTOR/CONSULTANT

The Independent Contractor Agreement (the "Agreement") is entered into by and between Whole Woman's Health of the Peoria, LLC ("WWH") and the physician who executes this Agreement (the "Physician").

RECITALS:

A. WWH is a Illinois limited liability company that operates a woman's medical clinic.

B. The Physician is presently licensed by the Illinois State Board of Medical Practice to practice medicine in the State of Illinois.

C. WWH desires to obtain the services of the Physician, and the Physician desires to perform certain services as an independent contractor for WWH according to the terms, conditions, and provisions set out in this Agreement.

NOW, THEREFORE, in consideration of the mutual promises set forth herein, the parties agree as follows:

ARTICLE I
TERM AND TERMINATION

The term of this Agreement shall be for one (1) year commencing on the Effective Date of this Agreement. This Agreement may be terminated by either party upon thirty (30) days' written notice to the other party. This Agreement shall be automatically renewed for additional one year terms, unless either party provides the other party written notice of termination thirty (30) days before the end of the then applicable term.

ARTICLE II
STATUS AND DUTIES

2.01. Independent Contactor: The parties agree that the relationship between them is that of independent contractors. It is hereby understood and agreed that WWH may not and will not supervise, manage, operate, control, or direct the activities of the Physician, nor can WWH control the means by which the Physician performs his obligations under the terms of this Agreement.

2.02. Part-time Contractor: WWH hereby agrees to contract with the Physician on an as-needed basis, and the Physician hereby agrees to perform services and duties under this Agreement on an as-needed basis as an independent contractor and not as a common law employee, an agent, or a partner of WWH. The Physician agrees to provide WWH with thirty (30) days notice or arrange for coverage if the Physician will have to miss a day that the Physician has previously agreed to work in order to enable WWH to find a substitute.

2.03. **Medical Director:** The Doctor will serve as Medical Director for the LLC. The responsibilities of the Medical Director are as follows:

(a) Supervision of medical services provided at the facility, including; nursing, clinical, and laboratory.

(b) Supervision of controlled substances – medications/logs.

(c) Supervise quality assurance by participating in quarterly meetings, random chart reviews, complication and re-suction reviews, and periodic meetings with other facility providers (if needed).

(d) Provide for or assist in arranging after hours coverage support for WWH staff/nurse on call – for patient problems and possible emergencies.

(e) Maintain standing orders for routine patient care provided by ancillary staff, nurse triage, routine follow-up visits, pre and post op medications, and related matters.

(e) Be an available resource for Nurse Practitioner, nursing team and clinic staff for both the Gyn and Abortion Care practice.

(f) CLIA – function as Laboratory Director. Review CLIA compliance and proficiency testing as required.

(g) Help the recruit providers for the facility as needed.

(h) Network within the medical community in the facility's service area.

(i) Participate in regulatory inspection process, including, but not limited to CLIA and NAF.

(j) Review services offered, research and recommend new services or changes to protocols, materials, administration, dosing, and similar matters.

(k) Annual review of facility practice guidelines, procedures and protocols.

(l) Review crash cart and evaluate facility preparedness for an emergency. Review/triage abnormal lab results.

(m) Supervise any training programs for physicians or residents such as the Ryan program for abortion training.

(n) Direct any research projects conducted at our facility.

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2.04. **Duties of Physician:** During the term of this Agreement, the Physician will render medical care and treatment consistent with the Physician's licensing and medical specialty on behalf of WWH pursuant to (i) agreements that WWH has with hospitals, institutions, third-party payors, or physicians; and (ii) referrals from other physicians. Furthermore, the Physician agrees to the following:

(a) The Physician will keep and maintain (or cause to be kept and maintained) in a timely fashion accurate and appropriate records relating to all professional services rendered by the Physician under this Agreement and timely prepare and attend to, in connection with such services, all reports, claims, and correspondence necessary and appropriate in the circumstances or as WWH may from time to time reasonably require;

(b) The Physician will review and follow the Clinical and Policy Guidelines of the National Abortion Federation;

(c) The Physician will in a timely fashion, record (or cause to be recorded), into each patient's medical chart, medical findings, test results, diagnosis, and prescribed treatment;

(d) The Physician will supervise training physicians, mid-level providers (such as Nurse Practitioners, Nurse Midwifes, and Physician's Assistants), and ancillary medical staff (such as nurses and medical assistants).

(e) The Physician is free to exercise the Physician's own professional judgment regarding any particular patient.

(f) The Physician will submit to and participate in quality assurance, peer review, risk management, and utilization review programs on behalf of WWH pursuant to agreements that WWH has with hospitals, institutions, third-party payors, or physicians.

(i) Review standing orders and all protocols. Recommend changes in writing to clinic management team.

2.03. **Licensure.** The Physician will be duly licensed or have certification at the beginning of this Agreement and maintain at all times during the term of this Agreement the following:

(a) Current license in the State of Illinois to practice medicine;

(b) Current unrestricted federal Drug Enforcement Agency certificate;

(c) Current Cardiac Pulmonary Resuscitation (CPR) Certificate or Advanced Cardiac Life Support (ACLS Certificate).

The Physician shall provide documentation of the above licenses and certifications prior to rendering services under this Agreement and will provide renewal licenses or certificates, as appropriate, during

the term of this Agreement. Physician will comply with and be governed by the ethics and standards of care of the medical profession.

ARTICLE III
COMPENSATION

3.01. Compensation as Medical Director: The LLC will cover all annual licensure expenses and will waive all malpractice fees for the Medical Director. The Doctor shall also be paid $5.00 for each abortion performed at the LLC for acting as Medical Director.

3.02. Compensation. As compensation for the Physician providing medical services hereunder, WWH will pay the Physician per procedure as follows:

$ 70.00 for medication abortion, including telemedicine;
$ 70.00 for surgical abortion to 12 weeks LMP
$ 100.00 for surgical abortion from 12.1 to 16.0 weeks LMP
$ 150.00 for surgical abortion from 16.1 to 18.0 weeks LMP

Gynecology visits will be paid as follows:

- IUD insertion: $35.00
- Nexplanon insertion: $45.00

3.03. Payment. The Physician will be paid bi-weekly via direct deposit on the clinic's payroll for medical care provided for the clinic sites. The physician will be reimbursed for mileage in travel to/from the clinic according to the current IRS rates. The Physician will receive from WWH an itemized statement from WWH reflecting the Physician's compensation under Section 3.01 of this Agreement.

3.04. No Other Benefits. The compensation described in Sections 3.01 hereof will be the Physician's sole compensation hereunder. The Physician expressly and irrevocably transfers, assigns, or otherwise conveys to WWH any and all rights, privileges, or other basis the Physician has or may not have to collect or account for fees, whether in cash, goods, or other items of value resulting from or incident to the Physician's performance of services on behalf of WWH pursuant to this Agreement. Since it is the intent of the parties for the Physician to be an independent contractor hereunder, the Physician is solely responsible for the costs and expenses related to any life, accident, disability, continuing medical education expenses, and benefits. The Physician is not entitled to participate in any pension plan, 4.01(k) plan, profit-sharing plan, or similar benefit plan, or other employee benefits available generally to employees of WWH. The WWH will have no responsibility for (i) withholding or payment of FICA taxes on behalf of the Physician; (ii) withholding or payment of federal income taxes on behalf of the Physician; or (iii) withholding or payment of any other state or federal taxes that WWH would otherwise be required to pay if the Physician were an employee of WWH. The Physician will be solely responsible for withholding amounts for, and payment of, (i) federal income taxes due on the compensation paid to the Physician hereunder, (ii) the Physician's self-employment taxes, and (iii) any other applicable state or federal taxes.

ARTICLE IV
INSURANCE

WWH shall provide professional liability insurance. The Physician must cooperate and provide the necessary information and documentation requested by WWH to obtain the necessary coverage for the Physician. WWH is responsible for the payment of the premiums. Those physicians carrying their own malpractice insurance that will cover them for work at WWH will be paid an additional $10.00 per abortion procedure.

ARTICLE V
PATIENTS, CASE RECORDS, AND HISTORIES

The Physician acknowledges that all patients seen by the Physician pursuant to, and during the term of, this Agreement are WWH's patients. All reports, x-ray films, or other imaging materials, slides, medical data, medical records, patient lists, fee books, patient records, files and other documents or copies thereof, and other confidential information of any kind pertaining to WWH's business, sales, financial conditions, products, or medical activities to which the Physician may have access, belong to and will remain the property of WWH. The Physician further agrees to keep confidential and not to use or to disclose to others, except as expressly required in writing from WWH or by law, any and all items described in this Article V.

ARTICLE VI
INDEMNITY

The Physician shall indemnify and save harmless WWH, its officers, agents, and employees from all suits, actions, losses, damages, claims, or liability of any character, type, or description, including without limiting the generality of the foregoing all expenses of litigation, court costs, and attorney's fees for injury or death to any person, or injury to any property, received or sustained by any person or persons or property, arising out of, or occasioned by, the acts of the Physician or its agents, subcontractors, or employees, in the execution or performance of this Agreement, and the failure of the Physician to perform any agreement or covenant required by this Agreement, including obtaining and maintaining the professional liability insurance required in Article IV of this Agreement.

ARTICLE VII
CONFIDENTIALITY

All information relating to WWH's operations, management, or financial status shall be treated as confidential by the Physician (the "Confidential Information"). The Confidential Information shall be and remain Confidential Information both during and after the termination of this Agreement, and shall not be released or disclosed by the Physician unless WWH has given its express prior written consent to such disclosure, which consent must specifically identify the Confidential Information to be disclosed by the Physician, and the nature of disclosure for which consent is given. In the event of a breach by the Physician of the provisions of this Article VII, WWH shall be entitled, at WWH's discretion, to exercise all available remedies at law or in equity

against the Physician, including without limitation, the right to terminate this Agreement and the right to an injunction restraining the Physician from disclosing, in whole or in part, any such information or from rendering services to any person, firm or corporation to whom any of such information may have been disclosed or is threatened to be disclosed. The provisions of this Article VII shall continue to be binding upon the Physician in accordance with its terms after termination of this Agreement for any reason.

ARTICLE VIII
CONDUCT AND EXPECTATIONS

Teamwork and respect are core values of the culture of WWH. The staff and owners of the WWH believe holistic healthcare requires a clinic team that respects and supports each other. The patients of WWH regularly comment on the remarkable care they received and how well the staff works together. Good communication and collaboration improve the patient experience. As a Physician working at WWH, you can count on us to:

- Represent you well and with pride to patients and their friends/families.
- Publicly support your decisions/judgments.
- Come to you privately and directly if we have a concern.
- Ask for clarification if we do not understand your orders.
- Chart patient requests or conditions clearly.
- Not ask you to perform procedures or see patients with whom you are uncomfortable.

In return, you are asked to treat patients, their friends/families, and the staff with the same high standard. WWH requires a Physician providing medical services to:

- Offer excellent medical care and be well-informed about medical innovation and practices in the field of healthcare.
- Have rapport with patients consistent with the core values of WWH – introduce yourself to each patient, make eye contact, ask her if she has questions, take time to listen to what she says.
- Communicate clearly with the WWH leadership about protocols, scheduling, and all other issues impacting your work here.
- Communicate clearly with nurses and staff about patients, treatment issues, and daily clinic flow.
- Provide feedback to the CEO if the clinic practices at the WWH are not up standards
- Generally, interact professionally and appropriately-- arrive on time, ready to see patients, able to make good decisions about patient care and communicate those decisions to staff.

Article IX.
COVENANT NOT TO COMPETE:

During the term of this Agreement and continuing for a period of one (1) year thereafter, the Physician shall not engage, directly or indirectly, as a consultant, principal, owner, agent, trustee or through the agency of any corporation, partnership, association or agent or agency, in any business ("Competitive Business") that provides similar

competing medical services to the Company within a one hundred (100) mile radius of any location where the Company regularly provides services in the State of Illinois. This Agreement shall not restrict or prevent the Physician from performing emergency abortions, as that term is commonly understood in the medical profession, as part of the Physicians practice at hospitals within the one hundred mile radius. Direct or indirect participation in a Competitive Business that is restricted hereby includes loaning funds for the purpose of establishing or operating any Competitive Business, or otherwise giving substantial advice to any Competitive Business, or lending or allowing his name or reputation to be used by any Competitive Business or otherwise allowing his skill, knowledge or experience to be so used.

In the event the Physician attempts to violate Article IX of this Agreement, in addition to all other legal, equitable or contractual remedies, WWH has the right to obtain injunctive relief against WWH to restrain and enjoin Physician from doing so, without the requirement of posting bond.

The parties agree that the restrictions set forth above are reasonable in light of all the facts and circumstances regarding this Agreement. If, however, any court of competent jurisdiction should determine that these restrictions are unreasonable, then the parties agree that the restrictions will, without further acts of the parties, be modified or amended to conform to the judgment of the court as to what would be reasonable; and thereafter the restrictions imposed by this paragraph shall be limited in accordance with the judgment of the court.

In the event of a breach of this Covenant Not to Compete by the parties agree that money damages alone would not be an adequate remedy and that the only adequate remedy would be permanent injunction requiring performance by the Physician of the covenants hereunder in addition to any monetary damages. Accordingly, the Physician agrees that in the event of a breach, WWH may apply to any court of competent jurisdiction for both temporary and permanent injunctions, together with any money damages suffered, together with reasonable costs and attorneys' fees.

ARTICLE X
MISCELLANEOUS

10.01. Malpractice Claims, Board Investigations, and Peer Review Notices. The Physician represents and warrants to WWH that, as of the date of this Agreement, the Physician has no knowledge of any pending or threatened malpractice claim or demand for payment made against the Physician, or incident that is likely to give rise thereto. The Physician will promptly notify WWH of any pending or threatened malpractice claim or demand for payment made against the Physician, or incident that is likely to give rise thereto, and will provide such related information as to such claim, demand, or incident as WWH may request. Furthermore, the Physician will promptly notify WWH of (i) any known or suspected act of fraud or abuse, (ii) any action or investigation taken against the Physician by any State or federal agency for fraud or abuse under Title XVIII or Title XIX of the Social Security Act or any State law or regulation; (iii) any action or investigation taken by any licensure board to restrict or revoke the Physician's license to practice medicine, (iv) of any notice taken by a hospital to investigate, restrict, or terminate the Physician's medical staff privileges, and

(v) any adverse notification or determination received by the Physician from a utilization, quality control, or peer review organization.

10.02. Governing Law. This Agreement will be interpreted, construed, and governed according to the laws of the State of Illinois.

10.03. Headings. The headings contained in this Agreement are for the convenience of the parties only and will not be deemed to affect the meaning of the provisions hereof.

10.04. Prior Agreements Superseded. This Agreement constitutes the sole and only agreement of the parties hereto and supersedes any prior understandings or written or oral agreements between the parties respecting the within subject matter.

10.05. Amendment. This Agreement may be amended or modified only by a written agreement signed by the party against whom enforcement of any waiver, change, or modification is sought.

10.06. Assignment. Neither party, without the prior written consent of the other, will be permitted to assign this Agreement to any other party. Any attempted assignment in contravention of this Section 7.06 will be void and will constitute a material breach of this Agreement.

10.07. Confidentiality and Nondisparagement. The Physician agrees that the terms of this Agreement are confidential. The Physician will not disclose the terms of this Agreement to any third parties except as may be necessary to obtain advice and counseling from the Physician's attorney, accountants, or financial advisors, or as may otherwise be required by law. The Physician agrees not to make any comments or representations during and after the termination of this Agreement concerning WWH, its affiliates, directors, employees, or agents, or its relationship with the Physician, that may disparage or otherwise damage the reputation, good will, or other interests of WWH or its affiliates, directors, employees, or agents.

10.08. Notices. All notices under this Agreement must be in writing and are effective when hand-delivered, sent by mail, sent by facsimile transmission, or sent by email; to:

Whole Woman's Health of Peoria, LLC
Contact: Amy Hagstrom Miller
Address: 1812 Centre Creek Drive, Suite 205
Austin, TX 78754
Facsimile No: (512) 832-6568
Email: amy@wholewomanshealth.com

Physician: Contact Information follows Signature.

THE EFFECTIVE DATE OF THIS AGREEMENT SHALL BE JUNE 1, 2017.

WHOLE WOMAN'S HEALTH OF PEORIA, LLC

BY: [redacted]
AMY HAGSTROM MILLER, PRESIDENT

[redacted]
SIGNATURE OF THE PHYSICIAN

Yogendra Shah
PRINT THE NAME OF THE PHYSICIAN

ADDRESS: [redacted]

EMAIL: drshah@wholewomanshealth.com

Americans United for Life

Whole Woman's Health of Peoria
7405 N. University St., Peoria, IL 61614
(309) 691-9073

September 12, 2017

Dear Dr. L. Laursen,

This letter serves as notification that you have been granted active admitting privileges at Whole Woman's Health of Peoria. These admitting privileges will be due for review on September 12, 2018.

Thank you,

[redacted]

Amy Hagstrom Miller, CEO
Chairperson, Governing Board
Whole Woman's Health of Peoria

Americans United for Life

abortions, as that term is commonly understood in the medical profession, as part of the Physicians practice at hospitals within the one hundred mile radius. Direct or indirect participation in a Competitive Business that is restricted hereby includes loaning funds for the purpose of establishing or operating any Competitive Business, or otherwise giving substantial advice to any Competitive Business, or lending or allowing his name or reputation to be used by any Competitive Business or otherwise allowing his skill, knowledge or experience to be so used.

In the event the Physician attempts to violate Article IX of this Agreement, in addition to all other legal, equitable or contractual remedies, WWH has the right to obtain injunctive relief against WWH to restrain and enjoin Physician from doing so, without the requirement of posting bond.

The parties agree that the restrictions set forth above are reasonable in light of all the facts and circumstances regarding this Agreement. If, however, any court of competent jurisdiction should determine that these restrictions are unreasonable, then the parties agree that the restrictions will, without further acts of the parties, be modified or amended to conform to the judgment of the court as to what would be reasonable; and thereafter the restrictions imposed by this paragraph shall be limited in accordance with the judgment of the court.

In the event of a breach of this Covenant Not to Compete by the parties agree that money damages alone would not be an adequate remedy and that the only adequate remedy would be permanent injunction requiring performance by the Physician of the covenants hereunder in addition to any monetary damages. Accordingly, the Physician agrees that in the event of a breach, WWH may apply to any court of competent jurisdiction for both temporary and permanent injunctions, together with any money damages suffered, together with reasonable costs and attorneys' fees.

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10.02. Governing Law. This Agreement will be interpreted, construed, and governed according to the laws of the State of Illinios.

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10.07. Confidentiality and Nondisparagement. The Physician agrees that the terms of this Agreement are confidential. The Physician will not disclose the terms of this Agreement to any third parties except as may be necessary to obtain advice and counseling from the Physician's attorney, accountants, or financial advisors, or as may otherwise be required by law. The Physician agrees not to make any comments or representations during and after the termination of this Agreement concerning WWH, its affiliates, directors, employees, or agents, or its relationship with the Physician, that may disparage or otherwise damage the reputation, good will, or other interests of WWH or its affiliates, directors, employees, or agents.

Americans United for Life

Laura Laursen, MD

Business Address
Dept. of Obstetrics and Gynecology
University of Chicago
5841 South Maryland Avenue MC 2050
Chicago, IL 60637
773-834-9995

Home Address
[redacted]

Education

2008-2012	MD	Northwestern University Chicago, IL
2003-2007	BS	International Health Georgetown University Washington, DC

Graduate Medical Education

2012-2016	Residency Training in Obstetrics and Gynecology University of Illinois Hospital and Health Sciences System Chicago, IL
7/1/2016-Present	Fellowship in Family Planning The University of Chicago, Department of Obstetrics and Gynecology Chicago, IL

Academic Appointments

8/25/16-Present	Clinical Instructor The University of Chicago, Department of Obstetrics and Gynecology

Licensure and Board Certification

2017	Illinois	Licensed Physician and Surgeon
2016	ABOG	OBGYN Qualifying Exam Completed
2015	Illinois	Obstetrical Advanced Cardiac Life Support
2014	Illinois	Neonatal Resuscitation Certification for Providers
2015	Illinois	Basic Life Support
2010-2013	USMLE	Step 1, 2, 3 Completed

Academic Honors and Awards

2016	Outstanding Senior Resident Award, University of Illinois
2016	Chicago Gynecologic Society Resident Paper Competition 2nd place prize for "Contraceptive Choices after Medical and Surgical Abortion"
2015	Employee Poster Prize for "Perspectives on Long Acting Reversible Contraception In School Based Health Centers" at UIC Women's Health Research Day
2015	Mary Stephenson Residency Research Award, University of Illinois
2014	Medical Student Teaching Award, University of Illinois
2013, 2015	Resident Professionalism Award, University of Illinois
2012	Beatrice Tucker Award Recognizing Commitment to Women's Healthcare Northwestern University
2009	Summer Research Grant, Northwestern University
2007	Magna Cum Laude, Georgetown University

Publications

*Last name changed from Rosenbloom to Laursen in 2014

2017	**Laursen L**, Stumbras K, Lewnard I, Haider S. Contraceptive Choices after Medical and Surgical Abortion. *Womens Health Issues. Article in Press.*
2014	Doll K, Donnelly E, Helenowski I, **Rosenbloom L**, Schink J, Small W, Lurain J. Radical Hysterectomy Compared to Primary Radiation in Stage IB1 Cervical Cancer. American Journal of Clinical Oncology. 2014. 37(1): 30-4.
2012	**Rosenbloom L**, Buchert E, Vasiloff R, Feinglass J, Dong X, Simon M. Preventing Excessive Weight Gain among Publicly Insured Pregnant Women. Journal of Community Health. 2012. 37(5) 1066-1070.
2011	Kennedy S, Osgood R, **Rosenbloom L**, Feinglass J, Simon M. Knowledge of Human Papillomavirus among Publicly and Privately Insured Women. Journal of Midwifery and Women's Health. 2011. 56(5) 481-487.

Presentations

November 2015	**Laursen L**, Stumbras K, Lewnard I, Haider S. Post-abortal Contraception: Are Medical Abortion Patients getting Short-changed? North American Forum on Family Planning. Chicago Illinois Poster Presentation.
November 2015	**Laursen L**, Stumbras K, Stoffel C, Haider S. Perspectives on Long Acting Reversible Contraception in School Based Health Centers. North American Forum on Family Planning. Chicago, Illinois. Online Poster Presentation.
April 2015	**Laursen L**, Stumbras K, Lewnard I, Haider S. Post-abortal Contraception: Are Medical Abortion Patients getting Short-changed? University of Illinois at Chicago Women's Health Research Day. Chicago, IL. Poster Presentation.
April 2015	**Laursen L**, Stumbras K, Stoffel C, Haider S. Perspectives on Long Acting Reversible Contraception in School Based Health Centers. University of Illinois at Chicago Women's Health Research Day, Chicago, IL. Poster Presentation. *Employee Poster Prize Winner.*
June 2011	Doll K, Donnelly E, Helenowski I, **Rosenbloom L**, Schink J, Small W, Lurain J. Radical hysterectomy compared to primary radiation in stage IB1 cervical cancer. Western Association of Gynecologic Oncologists Annual Meeting, Park City, UT. Poster Presentation.
October 2009	Kennedy S, Osgood R, **Rosenbloom L**, Feinglass J, Simon M. Knowledge of Human Papillomavirus among Publicly and Privately Insured Women. Feinberg School of Medicine Medical Student Summer Research Program Conference. Chicago, IL. Poster Presentation.

Professional Positions

2015-2016	Chief Resident

Professional Memberships

2016-Present	Society of Family Planning
2016-Present	European Society of Contraception and Reproductive Health
2016-Present	Association of Reproductive Health Professionals
2014-Present	Physicians for Reproductive Health
2012-Present	American College of Obstetrics and Gynecology
2008-2012	Medical Students for Choice

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Research

2016-Present — **Community Violence Exposure and Sexual Risking Taking Among Adolescent Girls**
I am currently preforming a mixed methods study evaluating community violence exposure and its impact on sexual risk taking among 15-19-year-old girls in Chicago. I have started focus groups and plan for a quantitative survey in fall 2017. *Research Mentor: Melissa Gilliam MD, MPH*

20014-2016 — **Contraception after Medical and Surgical Abortion**
I preformed a retrospective chart review analyzing contraception use after medical versus surgical abortion. Women who had surgical abortions were 2.36 (CI 1.71-3.29) times more likely to receive long acting reversible contraception (LARC) than those who had medical abortions. Surgical abortion patients were also more likely to receive contraception overall. *Research Mentor: Sadia Haider MD, MPH*

2012-2016 — **Long Acting Reversible Contraception in School Based Health Centers**
I administered a survey to health care providers and administrators in Illinois school based health centers. Respondents were generally supportive of and knowledgeable about LARC use by adolescents, but in practice there is little LARC provision. Lack of training, cost of the devices, and lack of devices were the most commonly sited barriers. *Research Mentor: Sadia Haider MD, MPH*

2011 — **Treatment of Stage IB1 Cervical Cancer**
I assisted with chart reviews in a retrospective study analyzing treatment options for stage IB1 cervical cancer. We found that treatment of stage IB1 cervix cancer with radical hysterectomy ± adjuvant radiation resulted in a significantly lower rate of recurrence, improved overall survival and fewer complications compared with radiotherapy alone. *Research Mentor: John Lurain, MD*

2010- 2012 — **Preventing Excessive Weight Gain in Pregnancy**
I worked with the Northwestern University obstetrics resident clinic to develop a framework to reduce excessive weight gain in pregnancy. Through directed counseling and feedback checklists patients in the intervention group were 34% (P=.009) less likely to gain weight exceeding the Institute of Medicine guidelines.
Research Mentor: Melissa Simon MD, MPH

2009-2011 — **Knowledge of the Human Papillomavirus**
I administered surveys and helped with data analysis as part of a study looking at knowledge of HPV among women presenting for HPV vaccination. We found that there was overall low knowledge about viral etiology of cervical cancer, the clinical presentation of HPV infection and the lack of complete protection against cervical cancer with the HPV vaccine. *Research Mentor: Melissa Simon MD, MPH*

Relevant Work and Volunteer Experience

2016-Present — **Family Planning Fellow and Clinical Instructor of Obstetrics and Gynecology**
University of Chicago, Chicago, Illinois
I currently provide abortion and contraception care in both an academic setting and at Planned Parenthood. I also am an attending physician and supervise residents on labor and delivery and on the gynecology service in a high-volume, tertiary care hospital.

2016-Present — **Member of Personal PAC Future Voices Campaign**
Chicago, Illinois
Personal PAC is non-partisan political action campaign focused on electing pro-choice candidates to state and local offices in Illinois. I am responsible for outreach and recruitment of young professionals to Personal PAC events. I am also hosting a fundraiser with state representative Sara Feigenholtz at my house this spring.

2012-2016 — **Obstetrics and Gynecology Residency**
University of Illinois, Chicago, Illinois
I trained with a diverse, complex, underserved patient population. I became confident with high-risk medical and surgical OBGYN care. I also worked with a

large midwife group and learned how to co laborate on labor and delivery. Dur ng residency, I was the chief resident and I received both the outstanding senior resident award, professionalism awards, and a medical student teaching award.

2013-2105

Resident Volunteer
CoimmunityHealth Clinic, Chicago, Illinois
The Community Health Clinic is Chicago's largest free clinic. As a resident volunteer, I supervised medical students and provide gynecologic care to uninsured patients.

2012

Women's Global Health Rotation
Mulago and Arua Hospitals, Kampala, Uganda
I spent my forth year medical school elective rotating at an urban and a rural hospital in Uganda. I focused my time on the gynecology wards where I saw the devastating complications of unsafe abortion. I rounded with the medical team, assisted with procedures and participated in manual vacuum aspiration training.

2012

MSFC Reproductive Health Externship
Midwest Access Project, Chicago, IL
I participated in the reproductive health externship sponsored by Medical Students for Choice. I spent two weeks working at All Women's Health and Planned Parenthood assisting with pregnancy termination procedures and providing contraceptive counseling.

2010- 2011

President of Northwestern University Medical Students for Choice
Feinberg School of Medicine, Chicago, IL
I planned educational events for the medical school including hands-on contraception workshops, provider panels and ethics round tables. I also Organized the 2010 Medical Students for Choice Midwest Regional Conference "From West Africa to the Midwest: International and Domestic Perspectives on Reproductive Choice," which had 100 students in attendance.

2007-2008

Clinical Research Study Assistant
Memorial Sloan Kettering Cancer Center, New York, NY
I spent one year working in the genitourinary cancers clinical trials division. Responsibilities included data management, study tool administration and abstract writing for one industry sponsored and two institutional pharmaceutical trials.

2006

Strategic Information Intern
President's Emergency Plan for AIDS Relief (PEPFAR), Washington, DC
To supplement my international health undergraduate degree, I did a yearlong internship at PEPFAR. I learned the inner workings of a large governmental organization while helping to prepare the office for external audit by the Institute of Medicine. My senior thesis, Analyzing Post-Conflict Health Sectors: Sierra Leone, Rwanda, and Angola, was presented at organization's weekly staff meeting.

2004-2007

Director of Recruiting and Training
Learning Enterprises, Washington, DC
I developed and coordinated recruiting and branding efforts in the U.S. and abroad. While managing a $50,000 budget I oversaw fund-raising activities, developed a new training curriculum for 90 volunteers and supervised campus directors.

2003-2007

Member of H*yas for Choice
Georgetown University, Washington, DC
I negotiated with the catholic administration to allow condom distribution at designated areas on campus. We organized reproductive health speakers and provided students with resources to obtain contraception and abortion services off-campus. We also volunteered with Emily's List and NARAL to organize the March for Women's Lives.

Conferences

April 2017	**National Abortion Federation,** *Montreal, Canada* I attended sessions that broadened by understanding of abortion provision. I met providers from independent clinics and learned about the important abortion work that is being done outside of the academic setting. This conference solidified by desire to provide care in low-access areas in the Midwest.
March 2015	**CREOG Leadership Workshop for Residents,** *Chicago, Illinois* I attended a leadership workshop for administrative chief residents sponsored by CREOG. The workshop focused on the critical teaching and leadership skills in residency training. Through lectures and small group discussions I learned skills that will better equip me for my clinical, educational, and administrative roles.
October 2014 November 2015 November 2016	**North American Form on Family Planning** I attended the Society of Family Planning's annual meeting. The lectures and presentations provided me with new clinical knowledge relevant to my own practice. The sessions also provoked me to think deeper about issues surrounding reproductive rights and reproductive justice. I reviewed current research in the field and was motivated by the supportive and inspirational family planning community.
2009, 2010	**Medical Students for Choice (MSFC) National Conference,** *Salt Lake City, Utah and Chicago, Illinois* During my 2nd and 3rd years of medical school I attended the MSFC national conference. There I learned about abortion techniques and contraception issues that supplemented my medical school education. These events have influenced my career and were part of my motivation to become an abortion provider.

Personal Interests

Associate Board Member of Farm.Butcher.Table, a food oriented charity
Yoga
World travel

INDEPENDENT CONTRACTOR AGREEMENT

The Independent Contractor Agreement (the "Agreement") is entered into by and between Whole Woman's Health of the Peoria, LLC ("WWH") and the physician who executes this Agreement (the "Physician").

RECITALS:

A. WWH is a Illinois limited liability company that operates a woman's medical clinic.

B. The Physician is presently licensed by the Illinois State Board of Medical Practice to practice medicine in the State of Illinois.

C. WWH desires to obtain the services of the Physician, and the Physician desires to perform certain services as an independent contractor for WWH according to the terms, conditions, and provisions set out in this Agreement.

NOW, THEREFORE, in consideration of the mutual promises set forth herein, the parties agree as follows:

ARTICLE I
TERM AND TERMINATION

The term of this Agreement shall be for one (1) year commencing on the Effective Date of this Agreement. This Agreement may be terminated by either party upon thirty (30) days' written notice to the other party. This Agreement shall be automatically renewed for additional one year terms, unless either party provides the other party written notice of termination thirty (30) days before the end of the then applicable term.

ARTICLE II
STATUS AND DUTIES

2.01. Independent Contactor: The parties agree that the relationship between them is that of independent contractors. It is hereby understood and agreed that WWH may not and will not supervise, manage, operate, control, or direct the activities of the Physician, nor can WWH control the means by which the Physician performs his obligations under the terms of this Agreement.

2.02. Part-time Contractor: WWH hereby agrees to contract with the Physician on an as-needed basis, and the Physician hereby agrees to perform services and duties under this Agreement on an as-needed basis as an independent contractor and not as a common law employee, an agent, or a partner of WWH. The Physician agrees to provide WWH with thirty (30) days notice if the Physician will have to miss a day that the Physician has previously agreed to work in order to enable WWH to find a substitute.

2.04. Duties of Physician: During the term of this Agreement, the Physician will render medical care and treatment consistent with the Physician's licensing and medical specialty on behalf of WWH pursuant to (i) agreements that WWH has with hospitals, institutions, third-party payors,

or physicians; and (ii) referrals from other physicians. Furthermore, the Physician agrees to the following:

(a) The Physician will keep and maintain (or cause to be kept and maintained) in a timely fashion accurate and appropriate records relating to all professional services rendered by the Physician under this Agreement and timely prepare and attend to, in connection with such services, all reports, claims, and correspondence necessary and appropriate in the circumstances or as WWH may from time to time reasonably require;

(b) The Physician will review and follow the Clinical and Policy Guidelines of the National Abortion Federation;

(c) The Physician will in a timely fashion, record (or cause to be recorded), into each patient's medical chart, medical findings, test results, diagnosis, and prescribed treatment;

(d) The Physician will supervise training physicians, mid-level providers (such as Nurse Practitioners, Nurse Midwifes, and Physician's Assistants), and ancillary medical staff (such as nurses and medical assistants).

(e) The Physician is free to exercise the Physician's own professional judgment regarding any particular patient.

(f) The Physician will submit to and participate in quality assurance, peer review, risk management, and utilization review programs on behalf of WWH pursuant to agreements that WWH has with hospitals, institutions, third-party payors, or physicians.

(i) Review standing orders and all protocols. Recommend changes in writing to clinic management team.

2.03. Licensure. The Physician will be duly licensed or have certification at the beginning of this Agreement and maintain at all times during the term of this Agreement the following:

(a) Current license in the State of Illinois to practice medicine;

(b) Current unrestricted federal Drug Enforcement Agency certificate;

(c) Current Cardiac Pulmonary Resuscitation (CPR) Certificate or Advanced Cardiac Life Support (ACLS Certificate).

The Physician shall provide documentation of the above licenses and certifications prior to rendering services under this Agreement and will provide renewal licenses or certificates as

appropriate, during the term of this Agreement. Physician will comply with and be governed by the ethics and standards of care of the medical profession.

ARTICLE III
COMPENSATION

3.01. Compensation. As compensation for the Physician providing medical services hereunder, WWH will pay the Physician per procedure as follows:

$ 50.00 for medication abortion, including telemedicine;
$ 25.00 for post-medication abortion suction procedures;
$ 70.00 for surgical abortion to 14 weeks LMP (12 gestation);
$ 125.00 for surgical abortion from 14.1 to 16.0 weeks LMP (12.1-14.0 gestation);
$ 150.00 for surgical abortion from 16.1 to 18.0 weeks LMP (14.1-16.0 gestation);

Gynecology visits will be paid as follows:

- IUD insertion: $35.00
- Implanon insertion: $45.00

3.02. Payment. The Physician will be paid bi-weekly via direct deposit on the clinic's payroll for medical care provided for the clinic sites. The physician will be reimbursed for mileage in travel to/from the clinic according to the current IRS rates. The Physician will receive from WWH an itemized statement from WWH reflecting the Physician's compensation under Section 3.01 of this Agreement.

3.03. No Other Benefits. The compensation described in Sections 3.01 hereof will be the Physician's sole compensation hereunder. The Physician expressly and irrevocably transfers, assigns, or otherwise conveys to WWH any and all rights, privileges, or other basis the Physician has or may not have to collect or account for fees, whether in cash, goods, or other items of value resulting from or incident to the Physician's performance of services on behalf of WWH pursuant to this Agreement. Since it is the intent of the parties for the Physician to be an independent contractor hereunder, the Physician is solely responsible for the costs and expenses related to any life, accident, disability, continuing medical education expenses, and benefits. The Physician is not entitled to participate in any pension plan, 4.01(k) plan, profit-sharing plan, or similar benefit plan, or other employee benefits available generally to employees of WWH. The WWH will have no responsibility for (i) withholding or payment of FICA taxes on behalf of the Physician; (ii) withholding or payment of federal income taxes on behalf of the Physician; or (iii) withholding or payment of any other state or federal taxes that WWH would otherwise be required to pay if the Physician were an employee of WWH. The Physician will be solely responsible for withholding amounts for, and payment of, (i) federal income taxes due on the compensation paid to the Physician hereunder, (ii) the Physician's self-employment taxes, and (iii) any other applicable state or federal taxes.

ARTICLE IV
INSURANCE

WWH shall provide professional liability insurance. The Physician must cooperate and provide the necessary information and documentation requested by WWH to obtain the necessary coverage for the Physician. WWH is responsible for the payment of the premiums, but the Physician shares a small portion of the premium expense. Those physicians carrying their own malpractice insurance that will cover them for work at WWH-TC will be paid an additional $10.00 per abortion procedure.

ARTICLE V
PATIENTS, CASE RECORDS, AND HISTORIES

The Physician acknowledges that all patients seen by the Physician pursuant to, and during the term of, this Agreement are WWH's patients. All reports, x-ray films, or other imaging materials, slides, medical data, medical records, patient lists, fee books, patient records, files and other documents or copies thereof, and other confidential information of any kind pertaining to WWH's business, sales, financial conditions, products, or medical activities to which the Physician may have access, belong to and will remain the property of WWH. The Physician further agrees to keep confidential and not to use or to disclose to others, except as expressly required in writing from WWH or by law, any and all items described in this Article V.

ARTICLE VI
INDEMNITY

The Physician shall indemnify and save harmless WWH, its officers, agents, and employees from all suits, actions, losses, damages, claims, or liability of any character, type, or description, including without limiting the generality of the foregoing all expenses of litigation, court costs, and attorney's fees for injury or death to any person, or injury to any property, received or sustained by any person or persons or property, arising out of, or occasioned by, the acts of the Physician or its agents, subcontractors, or employees, in the execution or performance of this Agreement, and the failure of the Physician to perform any agreement or covenant required by this Agreement, including obtaining and maintaining the professional liability insurance required in Article IV of this Agreement.

ARTICLE VII
CONFIDENTIALITY

All information relating to WWH's operations, management, or financial status shall be treated as confidential by the Physician (the "Confidential Information"). The Confidential Information shall be and remain Confidential Information both during and after the termination of this Agreement, and shall not be released or disclosed by the Physician unless WWH has given its express prior written consent to such disclosure, which consent must specifically identify the Confidential Information to be disclosed by the Physician, and the nature of disclosure for which consent is given. In the event of a breach by the Physician of the provisions of this Article VII, WWH shall be entitled, at WWH's discretion, to exercise all available remedies at law or in equity against the Physician, including without limitation, the right to terminate this Agreement and the right to an injunction restraining the Physician from disclosing, in whole or in part, any such information or from rendering services to any person, firm or

corporation to whom any of such information may have been disclosed or is threatened to be disclosed. The provisions of this Article VII shall continue to be binding upon the Physician in accordance with its terms after termination of this Agreement for any reason.

ARTICLE VIII
CONDUCT AND EXPECTATIONS

Teamwork and respect are core values of the culture of WWH. The staff and owners of the WWH believe holistic healthcare requires a clinic team that respects and supports each other. The patients of WWH regularly comment on the remarkable care they received and how well the staff works together. Good communication and collaboration improve the patient experience. As a Physician working at WWH, you can count on us to:

- Represent you well and with pride to patients and their friends/families.
- Publicly support your decisions/judgments.
- Come to you privately and directly if we have a concern.
- Ask for clarification if we do not understand your orders.
- Chart patient requests or conditions clearly.
- Not ask you to perform procedures or see patients with whom you are uncomfortable.

In return, you are asked to treat patients, their friends/families, and the staff with the same high standard. WWH requires a Physician providing medical services to:

- Offer excellent medical care and be well-informed about medical innovation and practices in the field of healthcare.
- Have rapport with patients consistent with the core values of WWH -- introduce yourself to each patient, make eye contact, ask her if she has questions, take time to listen to what she says.
- Communicate clearly with the WWH leadership about protocols, scheduling, and all other issues impacting your work here.
- Communicate clearly with nurses and staff about patients, treatment issues, and daily clinic flow.
- Provide feed back to the CEO if the clinic practices at the WWH are not up standards
- Generally, interact professionally and appropriately-- arrive on time, ready to see patients, able to make good decisions about patient care and communicate those decisions to staff.

Article IX.
COVENANT NOT TO COMPETE:

During the term of this Agreement and continuing for a period of one (1) year thereafter, the Physician shall not engage, directly or indirectly, as a consultant, principal, owner, agent, trustee or through the agency of any corporation, partnership, association or agent or agency, in any business ("Competitive Business") that provides similar and competing medical services to the Company within a one hundred (100) mile radius of any location where the Company regularly provides services in the State of Illinois. This Agreement shall not restrict or prevent the Physician from performing emergency

10.08. Notices. All notices under this Agreement must be in writing and are effective when hand-delivered, sent by mail, sent by facsimile transmission, or sent by email; to:

Whole Woman's Health of Peoria, LLC
Contact: **Amy Hagstrom Miller**
Address: **1812 Centre Creek Dr. Ste 205**
Austin, TX 78754
Facsimile No: (512) 832-6568
Email: **amy@wholewomanshealth.com**

Physician: Contact Information follows Signature.

THE EFFECTIVE DATE OF THIS AGREEMENT SHALL BE SEPTEMBER 20TH, 2017.

WHOLE WOMAN'S HEALTH OF PEORIA, LLC

[redacted]

BY: _____
AMY HAGSTROM MILLER, PRESIDENT

[redacted]

_____
SIGNATURE OF THE PHYSICIAN

_____
PRINT THE NAME OF THE PHYSICIAN
ADDRESS: [redacted]

EMAIL:

Americans United for Life

From: "Ward, Cathy [ORT]" <cward@bsd.uchicago.edu>
Date: Tuesday, June 20, 2017 at 9:29 AM
To: "Laursen, Laura [UCH]" <Laura.Laursen@uchospitals.edu>
Cc: "Lengyel, Ernst [OBG]" <elengyel@bsd.uchicago.edu>, "Richardson, Douglas [OBG]" <drichard@bsd.uchicago.edu>, "Nunes, Ken [OBG]" <knunes@bsd.uchicago.edu>, "Anderson, Brie [OBG]" <banderson@bsd.uchicago.edu>
Subject: Academic Reappointment

Hi Laura,

Congratulations! We requested and received Dean/Provost for your reappointment as a Clinical Instructor for one year effective July 1, 2017.

Best,

Cathy
Catherine Ward, PHR, SHRM-CP
Academic Affairs Manager
Department of Orthopaedic Surgery and Rehabilitation Medicine Department of Obstetrics and Gynecology Department of Ophthalmology and Visual Science University of Chicago Medicine & Biological Sciences
5841 S. Maryland Ave. | Rm. S362, MC3079 | Chicago, IL 60637
Office: 773-702-8715

THE UNIVERSITY OF
CHICAGO
MEDICINE

DATE: September 9, 2016

TO: Laura E. Laursen, MD
Department of Ob/Gyn
University of Chicago Hospitals
5841 S. Maryland Avenue
M/C 2050
Chicago, IL 60637-1470

FROM: Sandra Culbertson, MD
President, Medical Staff Organization

RE: APPOINTMENT TO THE MEDICAL STAFF

This is to inform you that your application for Medical Staff privileges at the University of Chicago Medical Center has been approved effective **09/09/2016**.

Please be advised that in accordance with the Medical Staff Bylaws, your privileges will be on Focused Professional Practice Evaluation (FPPE) for 6-months. This process is implemented for all initially requested privileges.

I ask you to pay close attention to the Patient Care Policy and Procedures regarding patient care activities and the Medical Staff Bylaws, Rules and Regulations, regarding activities such as timely completion of medical records and not removing them from the property, informed consent, telephone orders, Papanicolaou tests and professional liability action notification. **Both the Policies and Procedures and the Medical Staff Bylaws are now located on the Medical Center's Intranet at (http://home.uchospitals.edu) under the clinical tab.** In accepting privileges, you must agree to accept the professional obligations reflected in the granting of privileges and to provide for or assure that provisions are made for the continuous care of all patients for whom you are responsible.

Thank you for your cooperation, and welcome to the medical staff.

Whole Woman's Health of Peoria
7405 N. University St., Peoria, IL 61614
(309) 691-9073

January 23,2018

Dear Dr. B. Brown

This letter serves as notification that you have been granted active admitting privileges at Whole Woman's Health of Peoria. These admitting privileges will be due for review on January 23, 2019.

Thank you,

[redacted]

Amy Hagstrom Miller, CEO
Chairperson, Governing Board
Whole Woman's Health of Peoria

Americans United for Life

Benjamin P. Brown, M.D.

University of Chicago
Department of Obstetrics and Gynecology
5841 S. Maryland Ave. – MC2050
Chicago, IL 60637

Phone: [redacted]
Email: benjamin.brown@uchospitals.edu

ACADEMIC TRAINING

2004-2008	A.B., Portuguese and Brazilian Studies, Brown University, Providence, RI
2008-2012	M.D., Alpert Medical School of Brown University, Providence, RI
2012-2016	Resident, Department of Obstetrics and Gynecology, University of Chicago Medical Center, Chicago, IL
2015-2016	Academic Chief Resident, Department of Obstetrics and Gynecology, University of Chicago Medical Center, Chicago, IL
2016-present	Fellow in Family Planning, Section of Family Planning and Contraceptive Research, Department of Obstetrics and Gynecology, University of Chicago Medical Center, Chicago, IL
2016-present	Candidate for M.S. in Public Health Sciences, Department of Public Health Sciences, University of Chicago, Chicago, IL
2017-present	Fellow in Clinical Medical Ethics, MacLean Center for Clinical Medical Ethics, University of Chicago, Chicago, IL

ACADEMIC APPOINTMENTS AND HOSPITAL PRIVILEGES

2016-present	Clinical Instructor, Section of General Obstetrics and Gynecology, Department of Obstetrics and Gynecology, University of Chicago, Chicago, IL

SCHOLARSHIP

(a) Peer-reviewed publications:

1. Brown, Benjamin P. "Teaching and Learning Moments: Tying Square Knots." Academic Medicine. May 2013;88(5):580. Essay.
2. Brown, Benjamin P. "Labour." Medical Humanities. Dec 2013;39(2):90. Poem.
3. Brown, Benjamin P. and Julie Chor. "Adding Injury to Injury: Ethical Implications of the Medicaid Sterilization Consent Regulations." Obstetrics and Gynecology. June 2014;123(6):1348-1351.
4. Brown, Benjamin P. "Interpreting Medicine: Lessons from a Spanish-Language Clinic." Annals of Family Medicine. Sept/Oct 2014;12(5):473-474. Essay.
5. Brown, Benjamin P. "Country drive, 11 weeks." Medical Humanities. Dec 2014;40:116. Poem.
6. Brown, Benjamin P., Lee Hasselbacher and Julie Chor. "Whose Choice?: Developing a Unifying Ethical Framework for Conscience Laws in Health Care." Obstetrics and Gynecology. Aug 2016;128(2):391-395.
7. Brown, Benjamin P. and Julie Chor. "What Are the Risks and Benefits of (Not) Incorporating Information about Population Growth and its Impact on Climate Change into Reproductive Care?" AMA Journal of Ethics. Dec 2017;19(12):1157-1163.

(b) Non-peer-reviewed original articles:

1. Brown, Benjamin P. "O Povo de Deus na Terra do Sol: Ecclesiological Innovation, Liberationist Catholicism and Citizenship in Brazil." Brown University. 13 May 2008. Honors thesis.

2. Brown, Benjamin P. "Necessary, not Evil: Abortion and the Stewardship Testimony." Friends Journal: Quaker Thought and Life Today. Feb 2013;59(2):10-12. <http://www.friendsjournal.org/necessary-not-evil-abortion-and-the-stewardship-testimony/>
3. Wellisch, Lawren D. and Benjamin P. Brown. "HPV Vaccination: It's Time for More Public Schools to Join the Fight Against Cervical Cancer." Infectious Diseases in Children. May 2014. <http://www.healio.com/pediatrics/vaccine-preventable-diseases/news/print/infectious-diseases-in-children/%7Bb0bf3e92-f441-4c27-9abc-dcef84488a2c%7D/its-time-for-more-public-schools-to-join-the-fight-against-cervical-cancer> Editorial.

(c) Book chapters:

Brown, Benjamin P. and Meaghan Tenney. "Cervical Malignancy." The 5-Minute Clinical Consult 2016. Ed. Frank J. Domino. Philadelphia, PA: Lippencott Williams & Wilkins, 2015. Prior editions published yearly from 2012-2014.

(d) Abstracts and presentations:

1. Brown, Benjamin P., Vrishali Lopes and Trevor Tejada-Berges. "Identifying Strategies to Improve Care of Limited English Proficiency Patients at Women and Infants' Hospital of Rhode Island." National Hispanic Medical Association Annual Conference, Washington, DC, 17-20 Mar 2011. Poster.
2. Brown, Benjamin P., Lawren D. Wellisch, Chelsea Cress and Michelle Forcier. "Reframing Messages for Teens to Increase Interest in Long-acting Reversible Contraceptives." Contraception. Aug 2013;88(2):305. Presented at Reproductive Health 2013 (The Association of Reproductive Health Professionals' Annual Clinical Meeting), Denver, CO, 19-21 Sept 2013. Oral presentation / roundtable.
3. Brown, Benjamin P., Catherine Hagbom Ma, Summer Martins and Amy K. Whitaker. "Shared Negative Experiences with Long-acting Reversible Contraceptives and their Impact on Contraception Counseling: A Mixed Methods Study." Contraception. Sept 2014;90(3):320. Presented at the North American Forum on Family Planning, Miami, FL, 12-13 Oct 2014. Poster.
4. Holmquist, Sabrina A., Amber Truehart and Benjamin P. Brown. "Feedback: The Breakfast (Club) of Champions: Empowering Residents to Identify and Manage Challenging Learners." Presented at the Association of Professors of Gynecology and Obstetrics' Martin L. Stone, MD Faculty Development Seminar, Bonita Springs, FL, 9-12 Jan 2016. Workshop.
5. Carlos, Christine, Benjamin P. Brown, Bree Andrews and Dalia Feltman. "Parental Decision-making for Delivery Room Care of Periviable Infants." Presented at the Pediatric Academic Societies Meeting, 6-9 May 2017. Poster.
6. Wellisch, Lawren, Benjamin P. Brown and Amber Truehart. "Utility of an Open-access Database for Comparing Adverse Events Associated with Etonogestrel Implants in Pediatric and Adult Populations." Accepted for presentation at the North American Forum on Family Planning, Atlanta, GA, 14-16 Oct 2017. Poster.

(e) Other works that are publically available:

1. Brown, Benjamin P. "Medical Training." This I Believe Rhode Island. Rhode Island Public Radio, Providence, RI. 10 Dec 2008. Radio Essay.
2. Rodriguez, Pablo and Benjamin P. Brown. "El Cáncer Cervical y el Virus de la Papiloma Humana. [tr: Cervical Cancer and the Human Papilloma Virus]" El Aprendiz Médico. WELH, Providence, RI, 8 Dec 2010. Radio Interview.

3. Brown, Benjamin P. "HB 40 Allows Doctors to Serve All Patients." State Journal-Register [Springfield, IL]. 30 Sept 2017. Letter to the editor.

FUNDING

1. Project Grant, Northern Rhode Island Area Health Education Center, Woonsocket, RI. PI: Trevor Tejada-Berges. My role: Mentee. Title: "Assessing Interpreter Utilization at Women and Infants' Hospital." Total direct costs: $6,230. Project period: 6/8/08-8/31/09.
2. Trainee Research Grant, Society of Family Planning, Philadelphia, PA. PI: Amy K. Whitaker. My role: Mentee. Title: "Prevalence of Shared Negative Contraception Experiences and their Impact on Counseling about Long-acting Reversible Contraceptives." Total direct costs: $5,000. Project period: 7/1/13-7/14/14.
3. Fellowship Research Grant, Society of Family Planning, Philadelphia, PA. Mentors: Melissa Gilliam and Robert Kaestner. My role: PI. Title: "Impact of Distance to a Provider and State-level Abortion Restrictions on Abortion Rate." Total direct costs: $69,997. Project period: 3/1/2017-6/30/2018.

HONORS, PRIZES AND AWARDS

2008	Departmental Honors, Department of Portuguese and Brazilian Studies, Brown University
2008	Karina Palmira Lago Award, Department of Portuguese and Brazilian Studies, Brown University
2008	Magna cum laude, Brown University
2009	Leadership Award, Area Health Education Center Network of Rhode Island, Providence, RI
2011	Gold Humanism Honor Society, Alpert Medical School of Brown University
2012	Alpha Omega Alpha Honor Society, Alpert Medical School of Brown University
2012	Jack and Edna Saphier Prize for Outstanding Contributions by a Student to Obstetrics and Gynecology, Alpert Medical School of Brown University
2013, 2016	Arnold P. Gold Foundation Humanism and Excellence in Teaching Award, Pritzker School of Medicine, University of Chicago
2014-2016	Golden Apple Teaching Award, Department of Obstetrics and Gynecology, University of Chicago Medical Center
2015	Ryan Program Resident Award for Excellence in Family Planning, Department of Obstetrics and Gynecology, University of Chicago Medical Center

PROFESSIONAL SOCIETIES

2009-present	American College of Obstetricians and Gynecologists
2016-present	National Abortion Federation
2016-present	Society of Family Planning

TEACHING EXPERIENCE

Alpert Medical School of Brown University:

2009-2010	Teaching Fellow, Doctoring I and II (Responsibilities: Teaching basic clinical exam skills)
2010-2012	Guest Lecturer, Doctoring IV (Lecture: Working with Limited-English Proficiency Patients)
2011-2012	Breast and Pelvic Exam Teaching Assistant, Doctoring IV (Responsibilities: Teaching advanced clinical exam skills)

2012 Senior Teaching Assistant, Clinical Skills Clerkship (Responsibilities: Teaching rising third-year medical students about participation in clinical teams)

University of Chicago Medical Center:

2015-2016 Academic Chief Resident, Department of Obstetrics and Gynecology (Responsibilities: Coordinating journal club and resident didactics, developing a residents-as-teachers curriculum)

2016-present Clinical Instructor, Obstetrics and Gynecology Medical Student Clerkship (Lectures: Intrapartum Care, Abortion, Contraception; Additional Responsibilities: OSCE faculty, Pelvic exam clinical skills session preceptor)

2016-present Clinical Instructor, General Obstetrics and Gynecology, Obstetrics and Gynecology Residency (Lectures: Evaluation and Care of Women and Girls Post-Sexual Assault; Additional Responsibilities: Attending physician for labor and delivery unit and for gynecology consults, Evidence-Based Medicine Day statistics mentor for second-year residents, Intern Boot Camp faculty for sessions on diversity and informed consent)

Loyola University Medical Center:

2016-2017 Lecturer, Teaching Everything About Contraception (TEACH) Program for Residents, Department of Obstetrics and Gynecology (Lectures: Intrauterine Contraception, Female Tubal Sterilization)

University of Illinois Hospital and Health Sciences System:

2017 Lecturer and OSCE Faculty, Ob/Gyn Preparation for Residency Boot Camp (Responsibilities: Running obstetric and gynecologic simulation sessions for Chicago-area students matched into ob/gyn)

Hospital Materno-Infantil Inguarán, Mexico City, Mexico:

2017 Lecturer and Course Leader, The Importance of Reproductive Health (Lecture: Maternal Sepsis; Additional Responsibilities: Running simulation sessions on second trimester abortion skills, maternal sepsis, thromboembolic disease and ACLS)

SERVICE

University of Chicago Medical Center

Quality improvement:

2012-2013 Member, Breastfeeding Task Force

2016-present Cascade Peer Support Counselor, Department of Obstetrics and Gynecology

2017 Author, Policy on Second Trimester Induction of Labor, Department of Obstetrics and Gynecology

2017-present Member, Fetal Demise Workflow Group

Extramural

Leadership roles:

2003 Health Educator, Amigos de las Américas, Huehuete, Nicaragua

2006 Project Supervisor, Amigos das Américas, Caruaru, Brazil

2008-2012 Reproductive Health Outreach and Advocacy Coordinator, Medical Students for Choice, Alpert Medical School of Brown University

Americans United for Life

Ad hoc manuscript reviewer:
Family Medicine
Journal of Health Disparities Research and Practice
Obstetrics and Gynecology

Other:
2004-2005 Spanish Interpreter, Interpreter's Aide Program, Rhode Island Hospital, Providence, RI

ADVOCACY TRAINING
2017-present Fellow, Leadership Training Academy, Physicians for Reproductive Health, New York, NY

LANGUAGES SPOKEN

French	Basic
Portuguese	Fluent
Spanish	Fluent, qualified as a medical interpreter

Americans United for Life

INDEPENDENT CONTRACTOR AGREEMENT

The Independent Contractor Agreement (the "Agreement") is entered into by and between Whole Woman's Health of the Peoria, LLC ("WWH") and the physician who executes this Agreement (the "Physician").

RECITALS:

A. WWH is a Illinois limited liability company that operates a woman's medical clinic.

B. The Physician is presently licensed by the Illinois State Board of Medical Practice to practice medicine in the State of Illinois.

C. WWH desires to obtain the services of the Physician, and the Physician desires to perform certain services as an independent contractor for WWH according to the terms, conditions, and provisions set out in this Agreement.

NOW, THEREFORE, in consideration of the mutual promises set forth herein, the parties agree as follows:

ARTICLE I
TERM AND TERMINATION

The term of this Agreement shall be for one (1) year commencing on the Effective Date of this Agreement. This Agreement may be terminated by either party upon thirty (30) days' written notice to the other party. This Agreement shall be automatically renewed for additional one year terms, unless either party provides the other party written notice of termination thirty (30) days before the end of the then applicable term.

ARTICLE II
STATUS AND DUTIES

2.01. Independent Contactor: The parties agree that the relationship between them is that of independent contractors. It is hereby understood and agreed that WWH may not and will not supervise, manage, operate, control, or direct the activities of the Physician, nor can WWH control the means by which the Physician performs his obligations under the terms of this Agreement.

2.02. Part-time Contractor: WWH hereby agrees to contract with the Physician on an as-needed basis, and the Physician hereby agrees to perform services and duties under this Agreement on an as-needed basis as an independent contractor and not as a common law employee, an agent, or a partner of WWH. The Physician agrees to provide WWH with thirty (30) days notice if the Physician will have to miss a day that the Physician has previously agreed to work in order to enable WWH to find a substitute.

2.04. Duties of Physician: During the term of this Agreement, the Physician will render medical care and treatment consistent with the Physician's licensing and medical specialty on behalf of WWH pursuant to (i) agreements that WWH has with hospitals, institutions, third-party payors, or physicians; and (ii) referrals from other physicians. Furthermore, the Physician agrees to the following:

(a) The Physician will keep and maintain (or cause to be kept and maintained) in a timely fashion accurate and appropriate records relating to all professional services rendered by the Physician under this Agreement and timely prepare and attend to, in connection with such services, all reports, claims, and correspondence necessary and appropriate in the circumstances or as WWH may from time to time reasonably require;

(b) The Physician will review and follow the Clinical and Policy Guidelines of the National Abortion Federation;

(c) The Physician will in a timely fashion, record (or cause to be recorded), into each patient's medical chart, medical findings, test results, diagnosis, and prescribed treatment;

(d) The Physician will supervise training physicians, mid-level providers (such as Nurse Practitioners, Nurse Midwifes, and Physician's Assistants), and ancillary medical staff (such as nurses and medical assistants).

(e) The Physician is free to exercise the Physician's own professional judgment regarding any particular patient.

(f) The Physician will submit to and participate in quality assurance, peer review, risk management, and utilization review programs on behalf of WWH pursuant to agreements that WWH has with hospitals, institutions, third-party payors, or physicians.

(i) Review standing orders and all protocols. Recommend changes in writing to clinic management team.

2.03. Licensure. The Physician will be duly licensed or have certification at the beginning of this Agreement and maintain at all times during the term of this Agreement the following:

(a) Current license in the State of Illinois to practice medicine;

(b) Current unrestricted federal Drug Enforcement Agency certificate;

(c) Current Cardiac Pulmonary Resuscitation (CPR) Certificate or Advanced Cardiac Life Support (ACLS Certificate).

The Physician shall provide documentation of the above licenses and certifications prior to rendering services under this Agreement and will provide renewal licenses or certificates, as appropriate, during

the term of this Agreement. Physician will comply with and be governed by the ethics and standards of care of the medical profession.

ARTICLE III
COMPENSATION

3.01. Compensation. As compensation for the Physician providing medical services hereunder, WWH will pay the Physician per procedure as follows:

$ 50.00 for medication abortion, including telemedicine;
$ 25.00 for post-medication abortion suction procedures;
$ 70.00 for surgical abortion to 14 weeks LMP (12 gestation);
$ 125.00 for surgical abortion from 14.1 to 16.0 weeks LMP (12.1-14.0 gestation);
$ 150.00 for surgical abortion from 16.1 to 18.0 weeks LMP (14.1-16.0 gestation);

Gynecology visits will be paid as follows:

- IUD insertion: $35.00
- Implanon insertion: $45.00

3.02. Payment. The Physician will be paid bi-weekly via direct deposit on the clinic's payroll for medical care provided for the clinic sites. The physician will be reimbursed for mileage in travel to/from the clinic according to the current IRS rates. The Physician will receive from WWH an itemized statement from WWH reflecting the Physician's compensation under Section 3.01 of this Agreement.

3.03. No Other Benefits. The compensation described in Sections 3.01 hereof will be the Physician's sole compensation hereunder. The Physician expressly and irrevocably transfers, assigns, or otherwise conveys to WWH any and all rights, privileges, or other basis the Physician has or may not have to collect or account for fees, whether in cash, goods, or other items of value resulting from or incident to the Physician's performance of services on behalf of WWH pursuant to this Agreement. Since it is the intent of the parties for the Physician to be an independent contractor hereunder, the Physician is solely responsible for the costs and expenses related to any life, accident, disability, continuing medical education expenses, and benefits. The Physician is not entitled to participate in any pension plan, 4.01(k) plan, profit-sharing plan, or similar benefit plan, or other employee benefits available generally to employees of WWH. The WWH will have no responsibility for (i) withholding or payment of FICA taxes on behalf of the Physician; (ii) withholding or payment of federal income taxes on behalf of the Physician; or (iii) withholding or payment of any other state or federal taxes that WWH would otherwise be required to pay if the Physician were an employee of WWH. The Physician will be solely responsible for withholding amounts for, and payment of, (i) federal income taxes due on the compensation paid to the Physician hereunder, (ii) the Physician's self-employment taxes, and (iii) any other applicable state or federal taxes.

ARTICLE IV
INSURANCE

WWH shall provide professional liability insurance. The Physician must cooperate and provide the necessary information and documentation requested by WWH to obtain the necessary coverage for the Physician. WWH is responsible for the payment of the premiums, but the Physician shares a small portion of the premium expense. Those physicians carrying their own malpractice insurance that will cover them for work at WWH-FC will be paid an additional $10.00 per abortion procedure.

(N) Peoria

ARTICLE V
PATIENTS, CASE RECORDS, AND HISTORIES

The Physician acknowledges that all patients seen by the Physician pursuant to, and during the term of, this Agreement are WWH's patients. All reports, x-ray films, or other imaging materials, slides, medical data, medical records, patient lists, fee books, patient records, files and other documents or copies thereof, and other confidential information of any kind pertaining to WWH's business, sales, financial conditions, products, or medical activities to which the Physician may have access, belong to and will remain the property of WWH. The Physician further agrees to keep confidential and not to use or to disclose to others, except as expressly required in writing from WWH or by law, any and all items described in this Article V.

ARTICLE VI
INDEMNITY

The Physician shall indemnify and save harmless WWH, its officers, agents, and employees from all suits, actions, losses, damages, claims, or liability of any character, type, or description, including without limiting the generality of the foregoing all expenses of litigation, court costs, and attorney's fees for injury or death to any person, or injury to any property, received or sustained by any person or persons or property, arising out of, or occasioned by, the acts of the Physician or its agents, subcontractors, or employees, in the execution or performance of this Agreement, and the failure of the Physician to perform any agreement or covenant required by this Agreement, including obtaining and maintaining the professional liability insurance required in Article IV of this Agreement.

ARTICLE VII
CONFIDENTIALITY

All information relating to WWH's operations, management, or financial status shall be treated as confidential by the Physician (the "Confidential Information"). The Confidential Information shall be and remain Confidential Information both during and after the termination of this Agreement, and shall not be released or disclosed by the Physician unless WWH has given its express prior written consent to such disclosure, which consent must specifically identify the Confidential Information to be disclosed by the Physician, and the nature of disclosure for which consent is given. In the event of a breach by the Physician of the provisions of this Article VII, WWH shall be entitled, at WWH's discretion, to exercise all available remedies at law or in equity.

against the Physician, including without limitation, the right to terminate this Agreement and the right to an injunction restraining the Physician from disclosing, in whole or in part, any such information or from rendering services to any person, firm or corporation to whom any of such information may have been disclosed or is threatened to be disclosed. The provisions of this Article VII shall continue to be binding upon the Physician in accordance with its terms after termination of this Agreement for any reason.

ARTICLE VIII
CONDUCT AND EXPECTATIONS

Teamwork and respect are core values of the culture of WWH. The staff and owners of the WWH believe holistic healthcare requires a clinic team that respects and supports each other. The patients of WWH regularly comment on the remarkable care they received and how well the staff works together. Good communication and collaboration improve the patient experience. As a Physician working at WWH, you can count on us to:

- Represent you well and with pride to patients and their friends/families.
- Publicly support your decisions/judgments.
- Come to you privately and directly if we have a concern.
- Ask for clarification if we do not understand your orders.
- Chart patient requests or conditions clearly.
- Not ask you to perform procedures or see patients with whom you are uncomfortable.

In return, you are asked to treat patients, their friends/families, and the staff with the same high standard. WWH requires a Physician providing medical services to:

- Offer excellent medical care and be well-informed about medical innovation and practices in the field of healthcare.
- Have rapport with patients consistent with the core values of WWH -- introduce yourself to each patient, make eye contact, ask her if she has questions, take time to listen to what she says.
- Communicate clearly with the WWH leadership about protocols, scheduling, and all other issues impacting your work here.
- Communicate clearly with nurses and staff about patients, treatment issues, and daily clinic flow.
- Provide feed back to the CEO if the clinic practices at the WWH are not up standards
- Generally, interact professionally and appropriately-- arrive on time, ready to see patients able to make good decisions about patient care and communicate those decisions to staff.

Article IX.
COVENANT NOT TO COMPETE:

During the term of this Agreement and continuing for a period of one (1) year thereafter, the Physician shall not engage, directly or indirectly, as a consultant, principal, owner, agent, trustee or through the agency of any corporation, partnership, association or agent or agency, in any business ("Competitive Business") that provides similar and

competing medical services to the Company within a one hundred (100) mile radius of any location where the Company regularly provides services in the State of Illinois. This Agreement shall not restrict or prevent the Physician from performing emergency abortions, as that term is commonly understood in the medical profession, as part of the Physicians practice at hospitals within the one hundred mile radius. Direct or indirect participation in a Competitive Business that is restricted hereby includes loaning funds for the purpose of establishing or operating any Competitive Business, or otherwise giving substantial advice to any Competitive Business, or lending or allowing his name or reputation to be used by any Competitive Business or otherwise allowing his skill, knowledge or experience to be so used.

In the event the Physician attempts to violate Article IX of this Agreement, in addition to all other legal, equitable or contractual remedies, WWH has the right to obtain injunctive relief against WWH to restrain and enjoin Physician from doing so, without the requirement of posting bond.

The parties agree that the restrictions set forth above are reasonable in light of all the facts and circumstances regarding this Agreement. If, however, any court of competent jurisdiction should determine that these restrictions are unreasonable, then the parties agree that the restrictions will, without further acts of the parties, be modified or amended to conform to the judgment of the court as to what would be reasonable; and thereafter the restrictions imposed by this paragraph shall be limited in accordance with the judgment of the court.

In the event of a breach of this Covenant Not to Compete by the parties agree that money damages alone would not be an adequate remedy and that the only adequate remedy would be permanent injunction requiring performance by the Physician of the covenants hereunder in addition to any monetary damages. Accordingly, the Physician agrees that in the event of a breach, WWH may apply to any court of competent jurisdiction for both temporary and permanent injunctions, together with any money damages suffered, together with reasonable costs and attorneys' fees.

ARTICLE X
MISCELLANEOUS

10.01. Malpractice Claims, Board Investigations, and Peer Review Notices. The Physician represents and warrants to WWH that, as of the date of this Agreement, the Physician has no knowledge of any pending or threatened malpractice claim or demand for payment made against the Physician, or incident that is likely to give rise thereto. The Physician will promptly notify WWH of any pending or threatened malpractice claim or demand for payment made against the Physician, or incident that is likely to give rise thereto, and will provide such related information as to such claim, demand, or incident as WWH may request. Furthermore, the Physician will promptly notify WWH of (i) any known or suspected act of fraud or abuse, (ii) any action or investigation taken against the Physician by any State or federal agency for fraud or abuse under Title XVIII or Title XIX of the Social Security Act or any State law or regulation; (iii) any action or investigation taken by any licensure board to restrict or revoke the Physician's license to practice medicine, (iv) of any action taken by a hospital to investigate, restrict, or terminate the Physician's medical staff privileges, and

(v) any adverse notification or determination received by the Physician from a utilization, quality control, or peer review organization.

10.02. Governing Law. This Agreement will be interpreted, construed, and governed according to the laws of the State of Illinios.

10.03. Headings. The headings contained in this Agreement are for the convenience of the parties only and will not be deemed to affect the meaning of the provisions hereof.

10.04. Prior Agreements Superseded. This Agreement constitutes the sole and only agreement of the parties hereto and supersedes any prior understandings or written or oral agreements between the parties respecting the within subject matter.

10.05. Amendment. This Agreement may be amended or modified only by a written agreement signed by the party against whom enforcement of any waiver, change, or modification is sought.

10.06. Assignment. Neither party, without the prior written consent of the other, will be permitted to assign this Agreement to any other party. Any attempted assignment in contravention of this Section 7.06 will be void and will constitute a material breach of this Agreement.

10.07. Confidentiality and Nondisparagement. The Physician agrees that the terms of this Agreement are confidential. The Physician will not disclose the terms of this Agreement to any third parties except as may be necessary to obtain advice and counseling from the Physician's attorney, accountants, or financial advisors, or as may otherwise be required by law. The Physician agrees not to make any comments or representations during and after the termination of this Agreement concerning WWH, its affiliates, directors, employees, or agents, or its relationship with the Physician, that may disparage or otherwise damage the reputation, good will, or other interests of WWH or its affiliates, directors, employees, or agents.

Americans United for Life

10.08. Notices. All notices under this Agreement must be in writing and are effective when hand-delivered, sent by mail, sent by facsimile transmission, or sent by email; to:

Whole Woman's Health of Peoria, LLC
Contact: **Amy Hagstrom Miller**
Address: **1812 Centre Creek Dr. Ste 205**
Austin, TX 78754
Facsimile No: (512) 832-6568
Email: **amy@wholewomanshealth.com**

Physician: Contact Information follows Signature.

THE EFFECTIVE DATE OF THIS AGREEMENT SHALL BE ~~JULY 1, 2017.~~ Jan 19, 2018

WHOLE WOMAN'S HEALTH OF PEORIA, LLC

[redacted]

BY: _____
AMY HAGSTROM MILLER, PRESIDENT

[redacted]

_____
SIGNATURE OF THE PHYSICIAN

By Tamio P. Brown 1/19/18
_____
PRINT THE NAME OF THE PHYSICIAN
ADDRESS: [redacted]

EMAIL:

Americans United for Life

CONFIDENTIALITY AND SECURITY AGREEMENT

As an invitee (the "Invitee") for Whole Woman's Health ("WWH") with access to the premises you must sign and agree to the terms of this Confidentiality and Security Agreement (the "Agreement").

PURPOSE:

Security and confidentiality in a medical office that provides abortion services is of paramount importance. Many individuals and groups will attempt to obtain any and all information about WWH, the physical premises, and the staff and employees of WWH. Any information obtained by such groups and individuals will be widely disseminated and may be used by individuals and groups that want to cause harm to WWH, its employees and premises.

1. CONFIDENTIALITY AND PRIVACY

The Invitee agrees not to disclose or disseminate in any way any information relating to WWH, including, but not limited to, the names, descriptions or any other information about the staff and employees of WWH; a description or drawings about the physical layout of WWH's premises, including, but not limited to the location of security cameras or other security devices; and any information about patients or other people that may be present at WWH (the "Confidential Information").

2. RETURN OF CONFIDENTIAL INFORMATION

The Invitee shall take all the appropriate measures to protect the secrecy of and avoid disclosure or improper use of Confidential Information that Invitee may have in its possession to prevent it from falling into the possession of third persons. Invitee agrees to return any and all Confidential Information in its possession to WWH or destroy any and all such Confidential Information after Invitee completes its services to WWH or its contractual relationship with WWH is terminated.

3. EQUITABLE RELIEF

Invitee agrees that its obligations as set forth by this Agreement are necessary and reasonable in order to protect WWH, its employees and business and the Invitee expressly agrees that monetary damages may be inadequate to fully compensate the WWH for any breach by the Recipient of its covenants, obligations and agreements set forth in the Agreement. Accordingly, Invitee agrees and acknowledges that any such violation or threatened violation may cause irreparable injury to WWH and that, in addition to any other remedies that may be available, in law, equity or otherwise, WWH shall be entitled to seek equitable relief, including, but not limited to temporary and permanent injunctive relief against any threatened or continuing breach of this Agreement, without the necessity of proving actual damages.

NAME OF INVITEE:

[redacted]

BENJAMIN A. [redacted]

SIGNATURE AND TITLE OF PERSON SIGNING ON BEHALF OF INVITEE

CONTACT INFORMATION FOR INVITEE:
ADDRESS:

[redacted]

TELEPHONE NUMBER: [redacted]

EMAIL: [redacted]

Americans United for Life

AT THE FOREFRONT
UChicago Medicine

DATE: 11/24/2017

TO: Benjamin P. Brown, MD
Department of Ob/Gyn
University of Chicago Hospitals
5841 S. Maryland Ave.
M/C 2050
Chicago, IL 60637

FROM: Edward T, Naureckas, MD
President, Medical Staff Organization

RE: Medical Staff Privileges

We are pleased to inform you that the Medical Staff Executive Committee, on the recommendation of the Physician Credentials and Privileges Committee, has approved your reappointment application to University of Chicago Medical Center.

Privileges approved from: 12/31/2017 - 12/31/2018.

As a member of the Medical Staff you are expected to fulfill all requirements set forth in the Bylaws, Rules and Regulations of the Medical Staff.

I thank you for your continued success and contributions to this institution.

Americans United for Life

Whole Woman's Health

In-Service Training
Documentation for Training Binder

In-Service Title: Daily AED Log

Date: 03/28/2018

In-Service Trainer: Holly Worsfold

Summary of Contents. Attach agenda and/or handouts.

All staff trained on changing the batteries on the AED properly. Also reviewed manufacture instructions.

Staff instructed on the Daily AED log book implemented. And that its to be checked upon opening of office daily.

Attendance

Print name

Dawn Franklin RN
JAMES LOPER
Sherry Cisa
Debbie L. Bailey
KATHY COBLE
Wendy Quinn
Bonnie B. Bottenberg

[redacted]

Americans United for Life

Whole Woman's Health of Peoria, LLC
7405 N. University St. Suite D, Peoria, IL 61614
P: 309-691-9073 / F: 309-691-4528

In-Service Training
Documentation for Personnel File

Staff Member: All staff

Title: AED daily log

Date: 03-28-2018

Trainer: Holly Worsfold

In-Service Title: Daily AED log instituted.

Describe what you learned. Attach agenda and/or handouts:

All staff trained on changing the batteries. And how to check the active Status Indicator. Green flashing light means batteries are functioning properly. Red flashing light indicates AED needs attention.

All staff made aware of new "daily AED log" and to be done as part of opening office daily.

Debora L Bailey

Staff Signature: [signature]

Trainer Signature: [signature]

Reviewed 9/15

[redacted]

Americans United for Life

AED Battery Check

Date	Mon	Tue	Wed	Thu	Fri	Sat		
3-28-18			BAY					
3 29 - 18				BAY				
3.30.18					HW			
4-2-18	BAY					3-31 18 BAY		
4-3-18		BAY						
4-4-18			BAY					
4-5-18				BAY				
4-6-18					HW			
4-9-18	BAY							
4-10-18		BAY						
4-11-18			BAY					
4-12-18				BAY	~~HW~~			
4-13-18					HW			
4-16 18	BAY							
4-17-18		BAY						
4-18 18			BAY					
4-19-18				BAY				
4-20-18					HW			
4-23-18	BAY							
4-24-18		BAY						
4-25-18			BAY					
4-26-18				BAY				
4-27-18					HW			
4-28-18						BAY		
4-30-18	BAY							
5-1-18		BAY						
5-2-18			BAY					
5-3-18				BAY				
5-4-18					HW	~~BAY~~		
5-7-18	BAY							
5-8-18		BAY						
5-9-18			BAY					
5-10-18				BAY				
5-11-18					HW			
5-14-18	BAY							
5-15-18		BAY						
5-16-18			BAY					
5-17-18				BAY				
5-18-18					HW			

Americans United for Life

AED Battery Check

Date	Mon	Tue	Wed	Thu	Fri	Sat		
5-21-18	BAW							
5-22-18		BAW						
5-23-18			RAW					
5-24-18				RAW				
5-25-18					HW			
5-29-18	BAW							
5-30-18								
5-31-18								
4-1-18								

Americans United for Life

Whole Woman's Health

In-Service Training
Documentation for Training Binder

In-Service Title: Reviewed policy for Decontamination, Disinfection, Sterilization, and Storage of Sterile Supplies.

Date: 05/10/2018

In-Service Trainer: Holly Worsfold & Kathy Coble

Summary of Contents. Attach agenda and/or handouts.

Implemented Mckesson spore testing. Kathy demonstrated how to properly run a sample. Also went over manufacture manual.

Holly reviewed the policy and how to properly document.

Attendance

Print name	Signature
Dawn Franklin RN	[redacted]
LITHENA LOVER	
Sherry Crisp	
DeDora L. Bailey	
KATHY COBLE	
Wendy Quinn	
Bonnie F. Kimbley	

Americans United for Life

Biological Record Sheet

Test Date	Sterilizer	Load No.	Initials	COMMENTS
5-10-18	PC	1	KC	LOT 262 EXP 09/01/20
Incubation Date IN: 5-10-18 OUT: 5-11-18		Test Results (-) +	Control Results (-) +	LOT 6742 EXP 02/28/20
Test Date 5-10-18	Sterilizer TUTT	Load No. 1	Initials KC	COMMENTS LOT 262 EXP 09/01/20
Incubation Date IN: 5-10-18 OUT: 5-11-18		Test Results (-) +	Control Results (-) +	LOT 6742 EXP 02/28/20
Test Date 5-14-18	Sterilizer PC	Load No. 1	Initials KC	COMMENTS LOT 262 EXP 09/01/20
Incubation Date IN: 5-14-18 OUT: 5-15-18		Test Results (-) +	Control Results (-) +	LOT 6742 EXP 02/28/20
Test Date 5-17-18	Sterilizer PC	Load No. 1	Initials KC	COMMENTS LOT 262 EXP 09/01/20
Incubation Date IN: 5-17-18 OUT: 5-18-18		Test Results (-) +	Control Results (-) +	LOT 6742 EXP 02/28/20
Test Date 5-17-18	Sterilizer TUTT	Load No. 1	Initials KC	COMMENTS LOT 262 EXP 09/01/20
Incubation Date IN: 5-17-18 OUT: 5-18-18		Test Results (-) +	Control Results (-) +	LOT 6742 EXP 02/28/20

Biological Results: - No color change in media (sterile) + Media changes to yellow (non-sterile)

Biological Record Sheet

Test Date	Sterilizer	Load No.	Initials	COMMENTS
Incubation Date IN: OUT:		Test Results - +	Control Results - +	
Test Date	Sterilizer	Load No.	Initials	COMMENTS
Incubation Date IN: OUT:		Test Results - +	Control Results - +	
Test Date	Sterilizer	Load No.	Initials	COMMENTS
Incubation Date IN: OUT:		Test Results - +	Control Results - +	
Test Date	Sterilizer	Load No.	Initials	COMMENTS
Incubation Date IN: OUT:		Test Results - +	Control Results - +	
Test Date	Sterilizer	Load No.	Initials	COMMENTS
Incubation Date IN: OUT:		Test Results - +	Control Results - +	

Biological Results: - No color change in media (sterile) + Media changes to yellow (non-sterile)

MAYFIELD
MEDICAL SERVICES

200 W Central St
Bethalto, IL 62010

INVOICE

DATE	INVOICE #	CUST #
5/24/2017	0000047162	0008566

BILL TO:
Whole Womans Health
7405 N University St
Suite D
Peoria IL 61614

SHIP TO:
Whole Womans Health
7405 N University St
Suite D
Peoria IL 61614

P.O. NUMBER	TERMS	DUE DATE	REP
	2% 10 NET 30	6/23/2017	0023

QUAN	PART #	DESCRIPTION	PRICE	AMOUNT
1.00		Labor For Stanley Chytil date of service 5-23-17 on a Pelton & Crane Sterilizer Model Omni-Clave, S/N A4-36746. The sterilizer is heating only to 118C and then stops. Checked the unit and the temperature knob is turn all the way down. Set temperature button all the way Up and start cycle. Unit reached 272F at 30psi in 15 minutes and start sterilizing. Vented chamber and start dry cycle. Unit finished without any problems and is in good working condition.	149.00	149.00
		TOTAL		$149.00

Mayfield Medical Services, Inc. appreciates your business!!

Phone: 800-667-3570 *Fax: 877-598-1976*

PLEASE REMIT PAYMENT TO 200 W CENTRAL ST BETHALTO IL 62019

DISCOVER MasterCard VISA

Received
6-2-17 HW
7501 $149.00

Whole Woman's Health of Peoria, LLC
7405 N. University St. Suite D, Peoria, IL 61614
P: 309-691-9073 / F: 309-691-4528

In-Service Training
Documentation for Personnel File

Staff Member: All Staff

Title: Spore testing

Date: 05-10-2018

Trainer: Holly Worsfold + Kathy Coble

In-Service Title: Reviewed Policy for Decontamination, Disinfection, Sterilization and Storage of Sterile Supplies

Describe what you learned. Attach agenda and/or handouts:

Implemented McKesson Spore testing. Kathy demonstrated how they work. Also went over factory manual

Reviewed policy and documentation in "Autoclave load log" binder

Staff Signature: [redacted]

Trainer Signature: _____

Reviewed 9/15

Whole Woman's Health

In-Service Training
Documentation for Training Binder

In-Service Title: Medication Therapy Practices Policy Review

Date: 05/16/2018

In-Service Trainer: Holly Worsfold

Summary of Contents. Attach agenda and/or handouts.

Reviewed Medication Therapy Practices policy. Reiterated documentation on opening medications and discarding them after 28 days properly.

Reviewed IV medication guidelines and following sterile technique.

Attendance

Print name

Dawn Franklin, RN
Bonnie F. Bottinberg RN
[redacted]

Americans United for Life

Whole Woman's Health
Medication Abortion Consent

I certify the following to be true (please initial each line):

_____ I take responsibility for making the decision to have an abortion and nobody is forcing me to have a medication abortion.
_____ I am sure of my decision and understand that once I take mifepristone (Mifeprex™), I have started the abortion process and I can NOT change my mind.
_____ I understand that I must place 4 tablets of misoprostol (Cytotec™) 200 mcg buccally (between cheeks and gums) 24 to 48 hrs after taking the mifepristone (Mifeprex™).
_____ I understand and agree to the medication abortion process using mifepristone (Mifeprex™) and misoprostol (Cytotec™). I understand these medications usually interrupt the growth of a pregnancy and cause an abortion.
_____ I understand that mifepristone (Mifeprex™) is an FDA approved drug for abortion and that misoprostol (Cytotec™) has FDA approval for preventing stomach ulcers.
_____ I realize that there are possible side effects of the drugs mifepristone (Mifeprex™) and misoprostol (Cytotec™). Mifepristone (Mifeprex™) may cause nausea, diarrhea, and bleeding. Possible side effects of misoprostol include but are not limited to nausea, vomiting, diarrhea, fever, abdominal pain, and cramping. Undergoing a medication abortion includes risk of infection and sepsis.
_____ There is also a 0.1% risk of hemorrhage, a 0.2% risk of infection, a 0.07% risk of hospitalization, and 0.1% chance of needing a blood transfusion.
_____ I understand that the use of misoprostol (Cytotec™) usually results in moderate to severe cramping that can last several hours, and that pain medication may not provide complete relief.
_____ I understand that the intended result of using mifepristone (Mifeprex™) and misoprostol (Cytotec™) is to abort the pregnancy and has about a 95-97% success rate. I understand I may or may not be able to see the egg sac, embryo or fetus, placenta, and pregnancy-related material, and that it is not exactly predictable when the pregnancy will pass.
_____ I understand that for my safety, in case of an emergency, I should have a support person with me or "on-call" that can drive and has an available car the day I use the misoprostol.
_____ I have been advised to be within one hour's drive from an emergency room, and to have a phone with me, at the time that I ingest the misoprostol (Cytotec™).
_____ I consent to all medications, shots, blood and urine tests, and ultrasounds performed at Whole Woman's Health in the course of my treatment.
_____ I have been advised to contact Whole Woman's Health's emergency number if I have signs of hemorrhage, fever, infection, or severe diarrhea and vomiting.
_____ I understand that there is a possibility of a co-existing pregnancy located outside of my uterus and not visualized on today's ultrasound. I understand that mifepristone may not abort a pregnancy located outside the uterus. These pregnancies are called ectopic pregnancies and can pose serious health risks including rupture and internal hemorrhage, which may be life threatening. I understand the symptoms of a concurrent ectopic pregnancy and when to call.
_____ I understand that more than one visit to Whole Woman's Health is necessary to make sure that the abortion has occurred and that I am no longer pregnant. I agree to return to Whole Woman's Health for my follow-up appointment 7 to 14 days after I have taken the mifepristone (Mifeprex™).
_____ I realize that medication abortion has about a 3-5% failure rate and that the drugs may cause serious fetal deformities, such as deformed arms and legs, paralyzed face, and nerve damage.
_____ I agree to have a surgical abortion if the medication abortion fails. I understand that there is a slight risk of the following possible complications with a surgical abortion:

- ☐ infection
- ☐ hemorrhage
- ☐ incomplete abortion
- ☐ anesthetic reaction
- ☐ scar tissue in the uterus
- ☐ tear or puncture of the uterus, cervix, bowel, or bladder
- ☐ death

_____ I understand that when possible, I shall be treated for any resulting complications by Whole Woman's Health in the clinic at no extra charge to me. However, should hospitalization or treatment at another facility be necessary, I understand that I will be responsible for any charges accrued.
_____ I understand that the risk of death (mortality) is much greater for childbirth than for a first trimester surgical or medication abortion, but that a mortality risk exists for any outcome of pregnancy.
_____ I understand the patient consent for medication abortion.

To the best of my knowledge, I do NOT have any of the following (please initial each line to certify that these conditions do NOT apply to you):

_____ Sickle cell anemia, leukemia, or thalassemia
_____ Heart disease that is AHA class 3 or higher
_____ Adrenal insufficiency
_____ An IUD in place
_____ Blood clotting disorders
_____ Liver or kidney disease
_____ Seizure disorder or epilepsy that is not controlled by medication
_____ Inflammatory bowel disease (such as colitis, Crohn's, irritable bowel syndrome)
_____ Allergy to mifepristone (Mifeprex™) or misoprostol (Cytotec™)
_____ Any medical condition that requires me to take "blood thinners" such as aspirin (ASA), warfarin (Coumadin™),or heparin
_____ High blood pressure not controlled by medication
_____ Long term use of corticosteroids
_____ Respiratory disease
_____ Known or suspected ectopic pregnancy
_____ Immune Deficiency Disorder
_____ Alcohol or drug addiction
_____ Take any of the following medications on an everyday basis (If so, please circle)
□ Aspirin □Coumadin □Ibuprofen □Heparin □Rifampin □Dexamethasone □Phenytoin
□Phenobarbital □Carbamazepine □Ketoconazole □Itraconazole □Erythromycin

Using Mifepristone "Off-Label"

The "off-label" or evidence-based alternative dispensing of a medication involves giving instructions for use of a prescription medication that differ from the written instructions that the pharmaceutical company and the FDA agreed upon when the drug was released. The "off-label" use of medications is perfectly acceptable and legal. Physicians commonly dispense and prescribe medications for "off-label" use when they have knowledge and experience in the use of a particular drug in a manner different than the written labeling, and when they understand that the "off-label" use will have an effective and efficient result with no significant increase in risks or side effects. The "off-label" use of mifepristone (Mifeprex™) (RU486) and misoprostol (Cytotec™) is based on studies by Schaff and Winikoff, showing that vaginal insertion of misoprostol (Cytotec™) is just as effective as buccal ingestion with less side effects. Furthermore, a study by Mitch Creinin shows taking misoprostol (Cytotec™) 6 to 72 hrs after the mifepristone (Mifeprex™) to be just as effective as taking it 24-48 hrs after mifepristone (Mifeprex™).

By my signature below, I confirm that I have read and understood this information on the "off-label" use of mifepristone (Mifeprex™) and misoprostol (Cytotec™), and have had an opportunity to ask any questions I might have regarding the use of these medications.

Patient's Signature _____ Date _____

Patient name (printed) _____

Counselor's Signature _____ Date _____

Physician Signature _____

Americans United for Life

Whole Woman's Health

In-Service Training
Documentation for Training Binder

In-Service Title: Counseling and Documentation

Date: 05/16/2018

In-Service Trainer: Holly Worsfold

Summary of Contents. Attach agenda and/or handouts.

Reviewed Medical Abortion procedure, aftercare instructions, and importance of follow up. Also possible complications.

Reviewed the importance of proper documentation. Went over chart audit reviews before discharging the patient.

Attendance

Print name	Signature
Dawn Franklin, RN	[redacted]
LIMENA LOPEZ	
Sherri Crist	
Debra L. Bailey	
KATHY COBLE	
Wendy Quinn	
Bonnie F. Bottenberg	

Americans United for Life

7016 3010 0000 4671 2989

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

August 27, 2018

Holly Worsfold, Administrator
Whole Woman's Health of Peoria, LLC
7405 North University Ste D
Peoria, IL 61614

Re: Voluntary Non-Renewal of License #7003195

Dear Ms. Worsfold:

This letter confirms the Illinois Department of Public Health's receipt of correspondence submitted by Whole Woman's Health of Peoria ("facility"), license #7003195, indicating its intent to voluntarily not renew its license as a Pregnancy Termination Specialty Center ("PTSC") issued under the Ambulatory Surgical Treatment Act ("Act") [210 ILCS 5] and the Ambulatory Surgical Treatment Center Licensing Requirements Code ("Code") [77 Ill. Adm. Code 205]. The facility's most recent license was effective June 3, 2017, and expired on June 3, 2018.

The Department conducted an onsite survey of the facility on March 23, 2018. During the survey the Department collected statistical data addressing the number and types of medical and surgical procedures performed by the facility during 2017 and 2018. On June 27, 2018, and August 7, 2018, in response to the Department's request, the facility provided additional data for 2018 and clarification of the data for 2017 and 2018.

Section 205.110 of the Code defines an Ambulatory Surgical Treatment Center as "[a]*ny institution or building devoted primarily to the maintenance and operation of facilities for the performance of surgical procedures*, and *any place that meets and complies with the definition of an ambulatory surgical treatment center under the* Act and this Part, as evidenced by use of the facilities by physicians, podiatrists or dentists in the performance of surgical procedures that constitutes more than 50 percent of the activities at that location." 77 Ill. Adm. Code 205.110 (emphasis original)

The Department's review of the data your facility furnished substantiates that surgical procedures have not constituted more than 50 percent of the overall activities at that location during 2017 and the first six (6) months of 2018.

In accordance with the decision to voluntarily not renew its license, Whole Woman's Health of Peoria is hereby prohibited from operating as a PTSC under the authority of the Act or Code. Whole Woman's Health may wish to consult its legal counsel to determine if any State license or

registration, including but not limited to registration under the Medical Corporation Act [805 ILCS 15], is required for its continued operations.

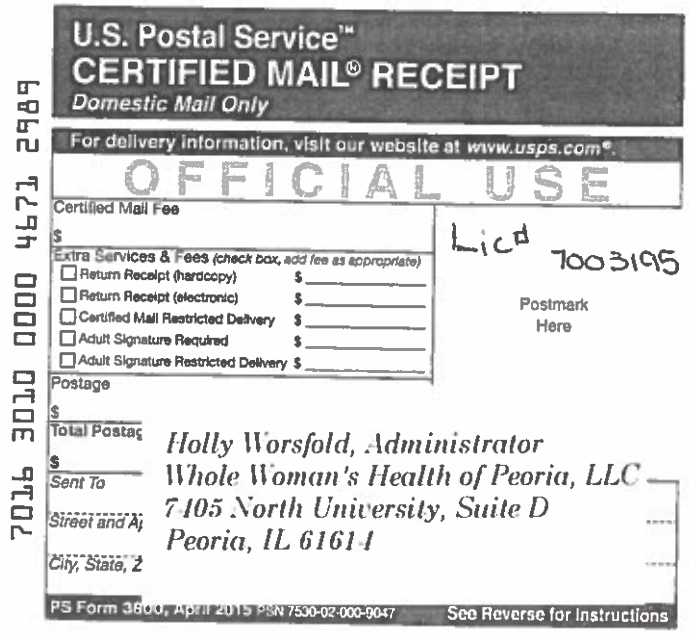
If you have any questions, please contact me at (217) 782-7412, or in writing at the Illinois Department of Public Health, Division of Health Care Facilities and Programs, Central Office Operations Section, 525 West Jefferson St. 4th Floor, Springfield, IL 62761-0001. The Division's fax number is (217) 782-0382. The Department's TTY number for the hearing impaired is (800) 547-0466. My email address is karen.senger@illinois.gov

Sincerely,

[redacted]

Karen Senger, RN, BSN
Division Chief
Division of Health Care Facilities and Programs

Cc: Nirav D. Shah, Director



Whole Woman's Health, LLC
Transforming Healthcare, One Woman at a Time

Karen Senger, RN, BSN
Division Chief
Health Care Facilities and Programs
Illinois Department of Public Health
525 W. Jefferson St., 4th Floor
Springfield, IL 62761

June 27, 2018

Dear Ms. Senger:

As we discussed during our conference call on May 15, 2018, Whole Woman's Health of Peoria (WWH) does not meet the definition of an ambulatory surgical treatment center under Illinois law, as it is not "devoted primarily to the maintenance and operation of facilities for the performance of surgical procedures." WWH therefore seeks to terminate its license (license #7003195) under the Ambulatory Surgical Treatment Center Act.

We conducted a review of unique patients seen and determined that in both 2017 and the first quarter of 2018 surgical abortions accounted for less than 50% of services provided by WWH of Peoria. Given the slight decrease in surgical abortions in 2018 compared to 2017, we do not anticipate that surgical procedures will exceed the 50% threshold requiring an ambulatory surgical center license and request your assistance in terminating our license.

In 2017, WWH of Peoria saw 1,294 unique patients for abortion care and birth control counseling. Of those patients, 572 (44%) were seen for surgical abortion services, 582 (45%) were seen for medication abortions, 104 (8%) were seen for pregnancy ultrasounds, and 36 (3%) were seen for birth control consultations.

In the first quarter of 2018, WWH of Peoria saw 416 unique patients for abortion care and birth control counseling. Of those patients, 171 (41%) of patients were seen for surgical abortion services. The remaining 245 patients were seen for medication abortions (48%), pregnancy ultrasounds (8%) or birth control consultations (2%). In total, WWH of Peoria completed 382 abortions, both surgical and medication, in the first quarter of 2018.

Thank you for your attention to this matter. We are, of course, happy to answer any questions you may have.

Sincerely,

Samantha Speaks
Chief Operating Officer
Whole Woman's Health

Americans United for Life

Making fabulous abortion care a reality.
Be Courageous. Be Innovative. Be Passionate. Be Genuine. Be Yourself.