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

☐ ASTC ☐ HHA ☐ HMO ☐ HOSPICE x PREGNANCY TERMINATION CENTER

NAME AND ADDRESS
OF FACILITY
National Health Care, Inc., Peoria, IL

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE

DATE OF SURVEY 06/16/11

BY 26336 & 15162
(Surveyor)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

(Provider's Representative)

Section 205.220 Organizational Plan

An organizational plan shall be known to the staff and available for public information in the facility. The document shall clearly set forth the organization, duties, responsibility, accountability and relationships of professional staff and other personnel...

This requirement was not met as evidenced by:

A. Based on a review of Pregnancy Termination Center (PTC) organizational chart and staff interview, it was determined the PTC failed to ensure its lines of authority were clearly delineated.

Findings include:

1. The PTC organizational chart was reviewed. It indicated "National Health Care (NTC), Inc... Owner to Medical Director to Physicians." Then "Owner to Executive Director to... "It failed to clearly delineate the lines of authority between the physicians, Registered Nurses (RN), Licensed Practical Nurses (LPN), Surgical Technicians (ST), Laboratory staff, Sonogram staff, Counseling staff, or patient.
2. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above finding was confirmed.

A new organizational chart has been designed and a corresponding page with individual staff is listed. This has been reviewed with staff and implemented.

Completion Date: June 27, 2011

The Director will be responsible to keep it current.

See Exhibit #1

Section 205.230 Standards of Professional Work

(a)A qualified consulting committee shall be appointed in writing... The consulting committee shall meet not less than quarterly and shall document all meetings with written minutes...

This requirement was not met as evidenced by:

A. Based on a review of PTC policy and staff interview, it was determined the PTC failed to ensure the consulting committee met quarterly and minutes of the meetings were maintained.

Findings include:

1. The PTC policy titled "NTC Standards of Professional Work" was reviewed. It indicated "3. The consulting committee

RECEIVED

BY

The consulting committee will meet as documented in September, December, March and June. The minutes will be

	shall meet quarterly to review policy, formulate new procedures, and evaluate clinical problems as they arise. The meetings will be conducted in September, December, March and June. The minutes will be recorded." There was no documentation to indicate the consulting committee met in 2008, 2009, 2010, or 2011. 2. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above finding was confirmed.	recorded and keep in a notebook labeled Consulting committee and will be available for review as needed. We will have a recorded meeting on July 7th, 2011, this is first available date due to July 4th holiday. Completion Date: July 7th, 2011 The Director will be responsible to record and track the meeting and its outcome and suggestions. The Director will implement the policy or changes with the appropriate staff members in order to facilitate completion. The medical director will review with staff physicians any medical changes.
Section 205.230 Standards of Professional Work	(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. This requirement was not met as evidenced by: A. Based on a review of PTC policy manual and staff interview, it was determined the PTC failed to ensure a procedure for granting PTC privileges was established, implemented, and followed. Findings include: 1. The PTC policy manual was reviewed. It failed to include a procedure for granting privileges. 2. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above finding was confirmed.	We have been meeting but my notes were not put in a typed organized fashion, that has been corrected and the director is responsible. The Consulting Committee will initial all meetings. EX A1 Completion Date: July 7, 2011 EX. # 3.0 The Director will follow-up. The manual now includes a procedure for granting privileges, it will be reviewed by the consulting committee and approved Completion date: July 7, 2011 The director will be responsible to present new applicants and their documentation to the consulting committee as this situation presents itself
Section 205.230 Standards of Professional Work	(a)(3) Credentials shall be provided by those physicians seeking practice privileges. These credentials shall be reviewed by the credentials committee and specific practice privileges identified and recorded. Record of such accepted practice privileges shall be available for facility staff use and public information within the facility. This requirement was not met as evidenced by: A. Based on a review of PTC policy, a review of Medical Staff credential files, and staff interview, it was determined in 4 of 4	When a physician applies to the P T C for staff privilege the following will be noted and placed in the physician's file The information will be held by the Medical Director 1 Resume 2 Current Illinois License 3 Illinois hospital affiliation 4 Notarized letter stating privileges 5 Outstanding malpractice issues 6 ACLS Certified 7 Applicant's expectations 8 OR skills evaluated by Medical Director 9 Privileges granted Completion Date July 7, 2011 EX. # 2 The Medical Director will do the interview and review the information, it will be in the physician s file A yearly check will be initiated by the Medical Director The Administrator files the paper work and validates the information

Medical staff credential files reviewed, the PTC failed to ensure specific practice privileges were granted.

Findings include:

1. The PTC policy titled "NHC Standards of Professional Work" was reviewed. It indicated "4. When a staff position for a physician... All physicians at the center will have practice privileges available for staff use and public information within the facility.
2. Four out of four Medical staff credential files reviewed failed to include any documentation to indicate PTC specific privileges had been granted, or what the privileges were. There was no documentation to indicate the consulting committee met 2008, 2009, 2010, or 2011 to review medical staff credentials and privileges.
3. The credential file of P-1 was reviewed. P-1's application was dated 5/15/08. There was no documentation to indicate what privileges were being requested at that time or since. There was no documentation to indicate privileges had been reviewed and/or granted.
4. The credential file of P-2 was reviewed. P-2's application was dated 8/19/10. There was no documentation to indicate what privileges were being requested at that time or since. There was no documentation to indicate privileges had been reviewed and/or granted.
5. The credential file of P-3 was reviewed. P-3's application was dated 4/10/07. There was no documentation to indicate what privileges were being requested at that time or since. There was no documentation to indicate privileges had been reviewed and/or granted.
6. The credential file of P-4 was reviewed. There was no application for P-4. The filed indicated a letter from Aurora Health Care dated 9/30/03. There was no documentation to indicate what privileges were being requested at that time or since. There was no documentation to

We have always had the physician information available for staff and public information

We are changing credentialing policy and the Administrator will provide in each physician's file a short synopsis for any one's review at the facility

Completion Date: July 27, 2011 Ex 2

Administrator will follow-up with the individual physician input.

Asked and answered
Ex 2

Asked and answered
P1 is no longer here. If he is used, he will be re-certified.
Ex # 2

Asked and answered
Ex # 2

Asked and answered
Ex # 2

Asked and answered
Ex # 2

	indicate privileges had been reviewed and/or granted. 7. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above findings were confirmed.	
Section 205.230 Standards of Professional Work	(a)(4) Each member of the medical staff granted specific surgical practice privileges shall provide a notarized statement or documentation indicating the name of the Illinois' licensed hospital(s) where they have skilled- equivalent practice privileges. Such statements... As used in this subsection, "skilled- equivalent" means... This requirement was not met as evidenced by: A. Based on a review of Medical staff credential files and staff interview, it was determined in 4 of 4 Medical staff credential files reviewed, the PTC failed to ensure notarized documentation indicating the name of the Illinois' licensed hospital(s) where the physician had skilled- equivalent practice privileges was maintained in the credential file. Findings include: 1. Four out of four Medical staff credential files reviewed failed to include notarized documentation indicating the name of the Illinois' licensed hospital(s) where the physician had skilled- equivalent practice privileges. 2. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above findings were confirmed.	We have on file 2 hospital letters for Dr. Allen Palmer and Dr. Mandy Gittler. The doctors will provide notarized statements and a copy of the hospital face sheet. Completion Date: July 7, 2011 Dr. Smith is re-applying for staff privileges in Chicago. The Medical Director will follow and the Administrator will keep them current.
Section 205.230 Standards of Professional Work	(a)(5) The consulting committee shall act as a tissue committee and shall review at least quarterly pathological reports from procedures performed by each physician on the staff. Evidence of such review shall be recorded in the minutes. This requirement was not met as evidenced by: A. Based on a review of PTC policy and staff interview, it was determined the PTC failed to ensure tissue pathological reports	

	were reviewed, and documentation of the review, by the consulting committee quarterly. Findings include: 1. The PTC policy titled "NHC Standards of Professional Work" was reviewed. It indicated "6. The consulting committee shall review tissues quarterly and the review will be recorded in the minutes. All physicians performing procedures at the center will have their tissue reports evaluated." There was no documentation to indicate the consulting committee met in 2008, 2009, 2010, or 2011 or that tissue pathology reports were reviewed. 2. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above finding was confirmed.	The tissue reports are checked by the staff RN and signed off. All reports that are under 10gms are followed up by the Administrator and reviewed with the physician, he then initials the report. Any tissue reports that are inconsistent with the ultrasound and doctors findings are also reviewed. The tissue reports are then placed in the individual patient's chart. H.8 This is currently being done and has been done for the last 25 years Completion Date: July 7, 2011 Administrator will follow-up
Section 205.230 Standards of Professional Work	(b)(1) The Medical Director shall secure compliance with the policies and procedures pertaining to medical and surgical procedures, approved by the consulting committee. This requirement was not met as evidenced by: A. Based on a review of PTC policy manual and staff interview, it was determined the PTC failed to ensure compliance with the policies and procedures pertaining to medical and surgical procedures approved by the consulting committee. Findings include: 1. The PTC policy manual was reviewed. Policy and Procedure Review documentation indicated "Review of Policy and Procedure will be done on a semi-annual basis..." There was no documentation to indicate the policies and procedures had been approved by the consulting committee. The review sheet indicated review completed by the Administrator only. 2. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above finding was confirmed.	Approval sheet with Medical Director initials. Completed: July 7, 2011 I 9 Ex I 9 Administrator will follow-up Exhibit #3 Re-typed and resubmitted.
Section 205.230	(b)(2) The Medical Director shall be responsible for	

Standards of Professional Work	the implementation of 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... This requirement was not met as evidenced by: A. Based on observation, clinical record review, a review of Medical Practice Act of 1987, a review of Part 1300 Nurse Practice Act, a review of Staff Nurse job description, and staff interview, it was determined in 10 of 20 (Pts #2, #4, #5, #7, #10, #11, #14, #17, #19, #20) clinical records reviewed, in which the patient required Intravenous (IV) moderate sedation, the PTC Medical Director failed to ensure delegation of IV moderate sedation was to staff practicing within their scope of practice. Findings include: 1. During a tour of the PTC, conducted on 6/16/11 at 10:15 AM with the Administrator, it was verbalized by E-1 that Intravenous (IV) moderate sedation was performed by E-1, who is an LPN. It was further confirmed by the Administrator that LPNs administer IV moderate sedation. 2. Ten out of twenty clinical records reviewed (Pts #2, #4, #5, #7, #10, #11, #14, #17, #19, #20), in which the patient required IV moderate sedation, documentation indicated it was administered by an LPN. 3. The 225 ILCS 60/) Medical Practice Act of 1987 was reviewed. It indicated "Section 54.2. (b) In an office or practice setting and within a physician- patient relationship, a physician may delegate patient care tasks or duties to an unlicensed person who possesses appropriate training and experience provided a health care professional, who is practicing within the scope of such licensed professional's individual licensing Act, is on site to provide assistance."	Intravenous (IV) moderate sedation was done with the physician present in the operating suite. The L.P.N. has been IV certified, but after review from the department, that will no longer be done at this facility. Completed: June 23, 2011 Wanda Ball RN head nurse will follow-up. The Director will oversee head nurse. Policy changed. Completed June 23, 2011, Wanda Ball RN head nurse will follow-up. The Director will oversee head nurse. The Medical Practice Act of 1987 (225 ILCS 60) was reviewed by the staff physician and all duties that are delegated to unlicensed personnel will be initialed and kept in a log and signed off by the corresponding health care professional. The head nurse in the department will be responsible. Log book created. Completion date: June 30, 2011 Administrator will follow-up and do a random check.

	4. Part 1300 Nurse Practice Act was reviewed. It indicated "Section 1300.240 Standards for Pharmacology/ Administration of Medication Course for Practical Nurses... g) The curriculum shall not include the following procedures: .. 3) Administering medications via intravenous push or administering heparin in heparin locks." 5. The Staff Nurse job description was reviewed. There was no delineation between the requirements and duties of an RN or LPN. 6. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above findings were confirmed.	This has been corrected and the new curriculum will not include administering medications via intravenous push by an L.P.N.. Completed: June 30, 2011 Wanda Ball, RN will supervise. The Director will oversee head nurse. Staff nursing job description is currently being revised: delineation between the LPN and RN has been completed. Completion Date: June 30, 2011 Wanda Ball, RN will supervise. The director will oversee head nurse and do job description on a yearly basis.
Section 205.230 Standards of Professional Work	B. Based on observation, a review of Medical Practice Act of 1987, a review of personnel file, and staff interview, it was determined PTC Medical Director failed to ensure delegation of compounding of parenteral medications was to staff practicing within their scope of practice. Findings include: 1. During a tour of the PTC, conducted on 6/16/11 at 10:15 AM with the Administrator, E-4 was observed drawing up syringes of Lidocaine 5 ml with 0.2 ml Vasopressin. It was verbalized by E-4 and the Administrator that E-4 adds 5 ml 8.4% Sodium Bicarbonate just before use, due to instability of the medication. When E-4 was asked what her title was, E-4 stated "a certified nursing assistant (CNA) and one of the duties performed is the preparation of the above syringes for procedures. 2. The 225 ILCS 60/) Medical Practice Act of 1987 was reviewed. It indicated "Section 54.2. (b) In an office or practice setting and within a physician- patient relationship, a physician may delegate patient care tasks or duties to an unlicensed person who possesses appropriate training and experience provided a health care professional, who is practicing within the scope of such licensed professional's individual licensing	We now have two (2) people trained to assist the staff nurse in loading the Lidocaine Mix. This staff was trained by Wanda Ball, RN and is documented in the Lidocaine Log. A staff nurse is always present and they are the only people allowed to compound the medication. Each bottle is mixed, dated and initialed by the nurse. When the assistant draws up the mixture, the syringe is then labeled. J11 I have included the new daily log sheet to be signed off by the nurse who was compounding the mix and supervising the loading of the syringes. Completed and documented June 30, 2011 This will be monitored by the Administrator daily, by initialing the log sheet at the days end. These logs will be reviewed by the Q.I. committee ~~monthly~~ quarterly. K11

	Act, is on site to provide assistance." 3. The personnel file of E-4 was reviewed. There was no documentation to indicate E-4 had been instructed and/or demonstrated competency in the compounding of parenteral medications. 4. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above findings were confirmed.	Ms. Young and any other personnel that will be filling, the compounded Lido mixture will have technique training recorded in their employee charts and verified by the Head O.R. nurse Wanda Ball RN. Completed: June 30, 2011 Wanda Ball, RN will follow-up. The Director will oversee head nurse.
Section 205.230 Standards of Professional Work	C. Based on observation, a review of personnel files, a review of the Sonogram Technician job description, and staff interview, it was determined the PTC Medical Director failed to ensure sonogram procedures were performed by personnel with knowledge and demonstrated competency in performing the procedure. Findings include: 1. During a tour of the PTC, conducted on 6/16/11 at 10:30 AM, E-5 was observed assisting patients into and out of the sonogram room. It was verbalized by E-5 that she performs the sonograms to determine the age of the fetus prior to the procedure. When asked what training had been provided, E-5 verbalized that the Administrator had instructed her in performing sonograms. 2. The personnel file of E-5 was reviewed. There was no documentation to indicate E-5 had been instructed and/or demonstrated competency in performing sonograms. 3. The Sonogram Technician job description was reviewed. There was no documentation to indicate what education and/or qualifications were required for the position. It indicated "The Sonogram Technician is directly responsible to the Director of the Clinic and the physician." 4. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above findings were confirmed.	All sonographers have been under the direction since 1999 of Jolette Cole RT(ARDMS). She is an X-ray technologist that specializes in ultra sonography. We have her qualification and training records in the sonography binder. We will now add them to each employee verified to perform ultra sound. Completion Date: July 1, 2011 The Administrator and Ms. Cole will follow-up. Ex # 5 Ex. # 25 The Sonogram Technician job has been re-written to reflect what is required for the position. Completed July 1, 2011 Responsible physician of the day and the Administrator I did not confirm this; I was not asked or consulted.
Section 205.240 Policies and	The management/ owner of the ambulatory surgical treatment center shall formulate a written	

Procedures Manual	policies and procedures manual. This shall be done in cooperation with the medical and professional staff and shall be approved by the consulting committee. These procedures shall provide for the acceptance,... This requirement was not met as evidenced by: A. Based on a review of PTC policy manual and staff interview, it was determined the PTC failed to ensure its policies and procedures were approved by the consulting committee. Findings include: 1. The PTC policy manual was reviewed. There was no documentation to indicate the consulting committee had approved the manual. 2. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above finding was confirmed.	New form written and placed in PTC manual for Consulting Committee approval. #3 Completed: July 15, 2011 Administrator will follow-up
Section 205.310 Personnel Policies	Each ambulatory surgical treatment center shall have written personnel policies including... There shall be a documented procedure for orientation of new employees to the facility's policies and procedures as well as the personnel policies including a copy of the appropriate job description. This requirement was not met as evidenced by: A. Based on a review of PTC personnel policy manual, a review of personnel files, observation, and staff interview, it was determined the PTC failed to ensure it established, implemented, and maintained a staff orientation program to ensure demonstrated competency in the respective job description. Findings include: 1. The PTC personnel policy manual was reviewed. There was no documentation to indicate a program to ensure orientation of each staff member to their respective positions and ensure demonstrated competency in the provision of services for that position had been established,	We will re-do all orientation by July 23, 2011 and it will be noted and signed by the supervisor. Completion Date: July 7, 2011 Followed-up by immediate supervisor. The Director will oversee orientation.

	implemented, and/or maintained. 2. Nine of 12 personnel files (E-1 thru E-4, E-6 thru E-10) failed to include documentation of orientation and/or demonstrated competency in the provision of services for the position in which each served. 3 of 12 (E-5, E-11, E-12) failed to have a personnel file. 3. During a tour of the PTC, conducted on 6/16/11 at 10:30 AM, E-5 and E-11 were observed providing care to PTC patients. It was verbalized by the Administrator that E-12 was an employee who provided "respiratory" and laboratory services. 4. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above findings were confirmed.	We had a form that was in the employee chart. We are all redoing them and they will complete all training. Ex #6 Completed: June 30, 2011 The Administrator will follow-up This is completely incorrect. E-12 was not here on the day of the inspection. E-5 and E-11 were doing their correct jobs. The employee you are referring to as E-12 is a CNA who is currently studying respiratory therapy. She was walking patients and works as a receptionist while being a full time student in respiratory therapy.
Section 205.320 Presence of Qualified Physician	A qualified physician shall be present at the facility until all patients are medically discharged. The discharge criteria shall be defined by the qualified consulting committee. This requirement was not met as evidenced by: A. Based on a review of PTC policy manual and staff interview, it was determined the PTC failed to ensure discharge criteria were established and approved by the consulting committee. Findings include: 1. The PTC policy manual was reviewed. There was no documentation of discharge criteria. 2. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above finding was confirmed.	We are re-doing the patient recovery sheet to provide a more detailed discharge. This will need Consulting Committee approval and printing. Ex D' Completion Date: July 15, 2011 Follow-up by the Administrator.
Section 205.330 Nursing Personnel	(b) Nursing care may be provided by student nurses and LPNs who have been trained in observation and emergency techniques for preoperative and postoperative care of surgical patients and who are under the direct personal supervision of a RN at all times. This requirement was not met as evidenced by: A. Based on a review of personnel files and	Could be extended a few days due to the printing company.

	staff interview, it was determined the PTC failed to ensure LPNs were trained in observation and emergency techniques for preoperative and postoperative care of surgical patients. Findings include: 1. Three out of three LPN personnel files reviewed failed to include documentation of training in observation and emergency techniques for preoperative and postoperative care of surgical patients. 2. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above finding was confirmed.	All new employees will go through the emergency training and this will be documented in their file. The staff will go through this re-check every year. The Q.I. team will review this training and the Administrator will follow-up. The physicians will be available to discuss any new medical situation that may arise. The nursing staff will have an inservice about emergency techniques pre and post operative. The topics will be covered and Dr. Mandy Gittler will review the emergency situations. Completion Date: July 7, 2011 Follow-up and charted by Recovery Head Nurse. The director will oversee the head nurse.
Section 205.350 Laboratory Services	(b) Have a written agreement with a laboratory which possesses a valid CLIA certificate to perform any required laboratory procedures which are not performed in the center. This requirement was not met as evidenced by: A. Based on a review of PTC agreements and staff interview, it was determined the PTC failed to ensure it had a written agreement with a CLIA certified laboratory for procedures which are not performed in the center. Findings include: 1. The PTC agreements were reviewed. There was no agreement with a CLIA certified laboratory for procedures which are not performed in the center. 2. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above finding was confirmed. A form was presented with a Methodist Medical Center of Illinois laboratory sheet and a stamp of National Healthcare Services name on the top. It was verbalized that this form was what was utilized and no formal agreement was in place.	We have a current written agreement from Methodist Medical Center Laboratory. This has been a 30+ year agreement. I have included their CLIA certificate and the agreement Ex # 7 Completed June 17, 2011 Followed by the Administrator.
Section 205.410 Equipment	Equipment shall be in good working order... This requirement was not met as evidenced by: A. Based on observation, a review of PTC	

policy manual, a review of PTC sterilizer information book, and staff interview, it was determined the PTC failed to ensure it established, implemented, and maintained an ongoing preventative maintenance program for equipment utilized in the provision of patient care.

Findings include:

1. During a tour of the PTC, conducted with the Administrator on 6/16/11 at 10:45 AM, the following items were observed with no documentation to indicate when preventative maintenance had been performed: In Room #3, one Berkly Model VC-II, one Gleamer Light, and one Welch-Allyn Blood pressure machine; in the sterilization area, one Pelton-Crane and two Tuttrauer Sterilizers; in the Sonogram room, the sonogram machine; and in the laboratory room, the centrifuge; in the hallway next to the crash cart, one portable oxygen tank with a sticker which indicated last check was 10/16/2000 and when the tank was turned on it indicated "Need refill line". It was verbalized by the Administrator and E-5 that equipment did not undergo preventative maintenance. Both verbalized that "If we have a problem, we just call the company and they come repair whatever it is."
2. The PTC sterilizer information book was reviewed. It indicated one Pelton-Crane and two Tuttrauer Sterilizers. The Pelton-Crane requisition type form was dated 1994 and the Tuttrauer requisition type form was dated 1995. It was verbalized by the Administrator that this was the last time the sterilizers were maintained, as "we call if we have any problems."
3. The PTC policy manual was reviewed. There was no policy to address the preventative maintenance of patient care equipment.
4. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above findings were confirmed.

A preventative maintenance log has been established for all equipment. This will include Sterilizers Welch Allyn Blood Pressure, Berkley VCII, SONO and the centrifuge. E+ 015

Kirk Medical Equipment Medical Repair Service
705 E Lincoln #114
Normal, IL 61761

He has the above equipment in his possession at this time. They will all be checked and returned before clinic on June 30, 2011.

Completed: June 28, 2011

The Gleamer Lights: if the bulb burns out it is replaced, if it does not function correctly we call the company.

The Welch Allyn is self testing and routinely checked and when Richmark is here. They will be checked and signed off.

Completed June 28, 2011

The machine manual will be checked and signed yearly and is added to the crash cart list.

The Oxygen Tank was refilled and checked.

Completed: June 28, 2011

E< 8

Oxygen tank will be added to crash cart list. Followed by head OR nurse. The Administrator will oversee the head nurse.

New policy will be written on machine maintenance.

H 8

Completion Date: June 30, 2011

The Administrator will oversee this and sign off yearly

The Q.I. team will review quarterly. E+ 15

Section 205.410 (d) The facility shall have written procedures to

Equipment	assure the safety in storage and use of all narcotics and medications in accordance with state and federal law. This requirement was not met as evidenced by: A. Based on observation, a review of PTC policy manual, and staff interview, it was determined the PTC failed to ensure drugs were stored in a locked cabinet, as per PTC policy. Findings include: 1. During a tour of the PTC, conducted with the Administrator on 6/16/11 at 10:45 AM, the following medications were observed unsecured, and/or unlabeled: a) In the Handicap counseling room: 10 stacked unlabeled medication cups with 2 tablets of Aleve sitting on the lamp stand. b) In the Recovery Room: 1 unopen and 1 open bottle of 100 tablets of Misoprostol 200 micrograms per tablet in an unlocked drawer. All open vials, in each area, failed to indicate when they were opened. c) In Procedure Room #1: 1 unopen and 1 open vial of Fentanyl 50 micrograms per ml; 1 open vial of Midazolam 5mg per 10 ml, and 1 unopen vial of Atropine 0.4 mg per ml on the procedure stand inside the door. d) In Procedure Room #2: 1 open vial of Fentanyl, 1 unopen and 1 open vial of Midazolam, and 1 unopen vial of Atropine on the procedure stand inside the door. e) In Procedure Room #3: 1 open vial of each Fentanyl and Midazolam and 1 unopen vial of Atropine on the procedure stand inside the door. 2. The PTC policy titled "Medication Handling Protocol" was reviewed. It indicated "All medications are to be stored in a locked cabinet in the Recovery Room and will... All narcotics are stored under lock and key.." 3. During a staff interview, conducted with	Aleve will no longer be left in cups, they will be directly given by the counselor Completed: June 30, 2011 Recovery Nurse will implement and follow-up. The Administrator will oversee. The med drawer in Pre-Op was left unlocked, the staff nurse has been reprimanded. We have had a staff in service, all bottles will be labeled when opened, and drawer will be locked at all times. Completed: June 30, 2011 Recovery Nurse will follow-up. The Administrator will oversee. All Procedure Room drugs will be locked in individual boxes, the nurse in the operating room will sign in and out in recovery Completed June 23, 2011 Recovery Head Nurse responsible and will follow-up. Reviewed on clinic days by the Administrator and signed off as checked as correct after the head nurses. The narcotics are now totally secured and locked. Completed: June 23, 2011 Head Recovery Nurse is accountable for signing drugs out and checking them back in. Each nurse will count with the head nurse. Checked end of procedure days as complete by the Administrator.

	the Administrator on 6/16/11 at 2:30 PM, the above findings were confirmed.	
Section 205.410 Sanitary Facility	(a)The Ambulatory surgical treatment center shall insure maintenance of a sanitary facility with all equipment in good working order. Written procedures shall include provision for... This requirement was not met as evidenced by: A. Based on observation, a review of PTC Sterilizer Monitoring log, and staff interview, it was determined the PTC failed to ensure sterilizers were cleaned monthly, as per its monitoring log requirement. Findings include: 1. During a tour of the PTC, conducted on 6/16/11 at 10:45 AM, 1 Pelton Crane and 2 Tuttnauer sterilizers were observed in the sterilizer area. On the Sterilizer Monitoring log, it indicated all 3 sterilizers were to be cleaned on 6/7/11. There was no documentation to indicate 3 out of 3 sterilizers had been cleaned on that day or since. 2. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above findings were confirmed.	The sterilizers are at Kirk Repair. they are being cleaned and maintenance performed. 4 8 Completed: June 28, 2011 Lead surgical technician is responsible and cleaning of the sterilizers will be documented. They are cleaned monthly. A log is already established and current. 4 9 Completed: Current to June 28, 2011 Lead surgical technician is responsible. Followed and checked by the Administrator.
Section 205.410 Sanitary Facility	B. Based on Policy review, observation, and staff interview, it was determined the PTC failed to ensure infection control processes were maintained to prevent the potential for cross-contamination of patient care items. Findings include: 1. The Facility policy indicated "all laundry is processed on site and requires no special labeling of contaminated linen provided that Universal precautions are adhered to when handling." There was no documentation to indicate the linens were laundered and water temperatures were monitored, as necessary to prevent the potential for cross contamination of	Laundry is processed on site All linen used is out in a yellow contaminated laundry bag as was explained. There was a laundry handling procedure in the OSHA Policy Book. Meister Plumbing is coming to see about a higher temperature setting. Laundry Precautions will be reinforced by the Administrator As of June 30, 2011, we will be using paper gowns until this issue is resolved. Completion Date July 18, 2011 Administrator will follow-up

	contagions. 2. During a tour of the PTC, conducted on 6/16/11 at 10:45 AM with the Administrator, the following items were observed: On the crash cart, 2 cups of snack nuts and packages of prepackaged cookies. In 3 out of 3 procedure rooms, emesis basins with open packages of bandaids and open 2x2 gauze squares. In the Medication Closet, 4 or more boxes of various birth control medications and patient care items were stored on the floor. It was verbalized by the Administrator that these were to be picked up by a disposal company today. These boxes were open and there was nothing to indicate that these were not available for patient use. 3. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above findings were confirmed.	(a) There are no snacks on the crash cart shelf (b) Band-Aids will not be opened before they are to be applied. (c) Boxes of pills were taken by Medical Waste as I stated. All patient supplies have been elevated off the floor (d) No open 2x2 in emesis basins Completed: June 22, 2011 Administrative Assistant along with Head OR nurse will follow-up. The Administrator will oversee Administrative Assistant.
Section 205.510 Emergency Care a) b)	a)Each facility shall have a written plan of procedure to be followed in case of fire, explosion, or non-patient medical emergency... b)Each facility shall be prepared to manage those emergencies which may be associated with procedures performed there. These requirements were not met as evidenced by: A. Based on a review of the policy and procedural manuals, a review of personnel files and staff interview, it was determined the Facility failed to ensure staff training for emergency or non-emergency situations were conducted. Findings include: 1. The PTC policy and procedural manual was reviewed. Policies related to emergency preparedness and/or non-medical emergencies were present; however, 12 of 12 personnel files failed to indicate staff was trained in handling emergencies of any type. The Administrator indicated training had taken place, but training was not	On June 29-30, 2011, we will repeat emergency preparedness, Pathogens, P.P.E. TB and will be recorded and available for inspection. The Administrator and Head OR nurse are both OSHA certified trainers and our re-certificate is in Bloomington in August. Completed: June 29-30, 2011 The Administrator is responsible The Q.I. team will review monthly.

EX 16

recorded.

2. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM.

Section 205.520 b) Pre-operative care

b) A complete medical history shall be obtained and the physical examination shall be complete. A pre-anesthetic evaluation shall be completed specifically identifying any patient sensitivity or contraindications to anesthesia.

This requirement was not met as evidenced by:

Findings include:

A. Based on a review of twenty clinical records and staff interview, it was determined the Facility failed to ensure medical histories and complete physical examinations were reviewed by the physician prior to the procedure.

1. Twenty clinical records were reviewed on survey date 06/16/11. None of the records contained documentation to indicate the histories (completed by the patient), nor the physical examinations (laboratory work, pelvic, and sonogram completed by the nurse, laboratory, and/or sonographer) were reviewed by the physician prior to the procedure. There was no documentation to indicate a pre-anesthetic evaluation was conducted, prior to the administration of IV moderate sedation, on any patients records reviewed.

2. An interview was conducted with the Administrator on 06/16/11. It was verbalized that the patients fill out their own histories. There was no documentation to indicate the physician or nurses administering IV sedation reviewed the medical histories The Administrator indicated the

We are re-writing the chart to include an area for the documentation to indicate physician review of all the pertinent information and pre-sedation evaluation. Spacing will be provided for nurse evaluation also. During our Consulting Committee meeting, we will discuss how to implement more of a physical exam.

Completion Date: July 20, 2011.

The Administrator and Medical Director will be responsible

The Q.I. team will review on a quarterly. basis. This will be done the last clinic day of the month. If any problems are discovered the issue involved will be discussed with the appropriate staff and how to correct the situation.

Completion date: August 31, 2011

E+1

	only examination completed was a pelvic exam, a sonogram and laboratory work-up. 3. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above findings were confirmed.	
Section 205.530 a) b) 2) E) i) ii) iii) Operative Care	a)Surgical procedures shall be performed only by a qualified physician within the limits of the defined specific practice privileges that have been granted..... b)Administration of Anesthesia 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. E) A registered nurse. If the ASTC policy allows the registered nurse to deliver moderate sedation ordered by a physician licensed to practice medicine in all its branches the following are required: i) The registered nurse must be under the supervision of physician.... ii) The registered nurse must attain ACLS certification.... iii) The supervising physician licensed to practice medicine in all its branches,...must have training and experience in delivering and monitoring moderate sedation and possess clinical privileges at the ASTC to administer moderate sedation or analgesia..... These requirements were not met as evidenced by: A. Based on policy review and a review of physician credentials and files, it was determined the Facility failed to ensure any physician had defined specific privileges granted.....	Asked and answered Completed
	Findings include: 1. The Facility policy titled "Standards of Professional Work," indicated: #4. When a staff position for a physician becomes available, all applications will be reviewed by the committee. All physicians at the	Asked and answered Ex # 2

center will have practice privileges available for staff use and public information within the Facility.

2. Four of four physician files were reviewed on survey date 06/16/11. There was no documentation to indicate surgical and/or anesthesia privileges had been applied for and/or granted to any physician by a consulting or designated committee.
3. The above findings were verified with the Facility Administrator on 06/16/11 at 10:00 am

All physicians will be renewing credentials at the Consulting Committee meeting. The meeting will be on July 7th, depending on the ability to get everyone together. This meeting will include practice privilege and sedation privileges.

Completion Date: July 7, 2011

Ex #2

Administrator will follow-up

Section 205.530
Operative Care
b) 2) E)
i) ii) iii)

B. Based on a review of the IL Nurse Practice Act, a review of clinical records, a review of personnel files, and staff interview, it was determined that the Facility failed to ensure personnel administering intravenous sedation were qualified in the State of IL to administer anesthesia.

Findings include:

1. The Illinois Nurse Practice Act, part 1300.240 "Standards for pharmacology/administration of medication course for practical nurses," indicates: f) This (LPN) curriculum shall prepare the LPN to start peripheral intravenous therapy that consists of a short catheter inserted through the skin into a peripheral vein. g) The curriculum shall not include: #3) Administering medications via intravenous push or administering heparin in heparin locks.
2. Ten (Pt. #'s 2, 4, 5, 7, 10, 11, 14, 17, 19, &20) of twenty clinical records contained documentation that an LPN had administered the IV sedation prior to the pregnancy termination procedure. All patients received the standard ordered Fentanyl, 50mcg and Midazolam (Versed) 2.5mg, intravenous push, (IVP).
3. There was no documentation in three of three LPN files reviewed to indicate any LPN had been "IV certified." There was no documented evidence in the LPN credential files to indicate the LPNs possessed IV certification certificates. The

The L.P.N, who is IV certified and the certificate was in her folders, is not longer doing IV sedation. The physician was present in the room at the time. There will be an R.N. in the room; I am placing an Ad for a new RN in room 2. At this time we will not use the 3rd OR room.

Completed: June 30, 2011

The Head OR nurse will follow this and no L.P.N. will give IV medication.

This will be checked by the Administrator on a random basis.

	LPN files contained current licensure, applications, as well as, confidentiality statements. 4. During an interview with the Facility Administrator conducted on 06/16/11 at 3:00 pm, the above findings were verified.	
Section 205.530 E) i) ii)iii)&v)	A registered nurse. If the ASTC policy allows the registered nurse to deliver moderate sedation ordered by a physician licensed to practice medicine in all its branches the following are required: i)The registered nurse must be under the supervision of a physician licensed to practice....and have no other responsibilities during the procedure. ii)The registered nurse must maintain current Advanced Cardiac Life Support (ACLS) certification.... iii)The supervising physician licensed to practice...must have training and experience in delivering and monitoring moderate sedation and possess clinical privileges at the ASTC to administer moderate sedation or analgesia. v)The supervising physician licensed to practice medicine in all its branches... must maintain current ACLS certification as appropriate to the age of the patient. These requirements were not met as evidenced by: A. Based on observation, a review of personnel credential files and staff interview, it was determined the RNs administering moderate sedation had multiple clinical responsibilities, were not ACLS certified and the physicians were not privileged to administer moderate sedation. Findings include: 1. During a tour of the PTC it was observed that the RNs were performing many tasks other than continual observation of the patients receiving IV sedation. The duties included but were not limited to, laboratory/ phlebotomy, counseling,	I have no nursing personnel that have ever done laboratory or phlebotomy procedures They do counseling pre-op, operating room and recovery as needed and within their scope of training. Completed: June 23, 2011 Administrator will follow-up

prepping other patients, preparing medications and post recovery.

2. The credential files of all RNs, (3), and physicians, (4), were reviewed on survey date 06/16/11. There was no indication any of the RNs were ACLS certified. There was no documentation to indicate 3 of 4 physicians (P-1, P-2, P-4) were ACLS certified.
3. The above findings were verified with the Facility Administrator on 06/16/11 at 3:00pm.

The patient is never alone and the physicians are giving all IV medications. The physician does not leave the room until the procedure is over. They are all ACLS certified. The R.N.s are taking the exams as this is written. We have received one back and the R.N. passed.

R18
S19

The patient is taken to recovery by the R.N. Since the physician is giving the IV sedation the R.N. is there and will monitor the patient completely.

Completion Date: July 20, 2011

Checked by the Medical Director and filed in chart by Administrator

Section 205.530 e) e) A registered nurse, qualified by training and experience in operating room nursing, shall be present in the operating room and function as the circulating nurse during all invasive or operative procedures....

The charts are reviewed by the Administrator and the Q.I. team. The chart is the record for the R.N. that was in the operating room.

This requirement was not met as evidenced by:

A. Based on observation and staff interview, it was determined the Facility failed to ensure all RNs were present in the procedural area at all times during the termination of the pregnancy.

Findings include:

1. During a tour of the Facility conducted on survey date 06/16/11, it was observed that RN performed multiple tasks, or was not present at all during the invasive procedures performed. Documentation indicated LPNs were, at times, solely, the only nursing staff in the patient procedural rooms. All staff members performed multiple tasks and the 2 different, non - current, personnel sheets indicated all staff were performing multiple tasks daily from clerical work, performing sonography, patient preparations, recovery, counseling, drawing pre-filled medications, assisting the physician, etc.
2. During an interview with the Facility Administrator conducted on survey date, 06/16/11 at 2:00 pm, the Administrator indicated she was not aware of the new regulations and that they "had always

All staff have multiple tasks, the RN will always be present in the operating room. No LPN will be in the operating room without an RN during an invasive procedure.

As to multiple tasks you implied that just anyone is doing anything. I have validated all positions you questioned.

Followed by OR head nurse and the Administrator will oversee.

I have no answer; everyone is trained to perform multiple tasks.

Completed June 30, 2011

Administrator will follow along with the appropriate supervisor, this will be documented if necessary

performed this way."

205.620 Statistical Data (a) 3), 4), 5)	a)Each ambulatory surgical treatment center shall collect, compile and maintain the following clinical statistical data..... 3) the number and type of complications reported, including specific procedure associated with each complication; 4) the number of patients requiring transfer to a licensed hospital for treatment....list the procedure performed... 5) the number of deaths, including the specific procedure that was performed. These requirements were not met as evidenced by: A. Based on a review of the comprehensive data sheets presented and staff interview, it was determined the Facility failed to ensure all administrative statistical data including report entries and error reports were conducted as required, quarterly. Findings include: 1. There was no actual data presented or reviewed for the center. The documentation presented included reported numerical counts of procedures performed per month. The last counted statistics was dated March of 2011. The statistical data report failed to include the specific procedures conducted, any or no complications, specific procedures utilized, medical or surgical abortions, the number of transferred patients, or the number of adverse reactions or deaths. 2. The Administrator indicated in an interview on 06/16/11 at 10:00 am that "we've had no problems in the last 36 yrs." It was indicated that there had never been an adverse event, a transfer out or a death. The above findings were verified with the Administrator on 06/16/11 at 2:30 pm.	We have made a new form to accommodate the regulation. It is included and the information is available for inspection. This form will include all the information required. Ex: 11 SAME AS Ex 11 Ex T#20 Completed: June 28, 2011 Followed by Head Receptionist. Reviewed by Administrative Assistant. This clinic has never had a death or serious life threatening issue as a result of any procedure done. We have had transfer out on a couple of occasions but they were not surgical incidence related. Completed: June 30, 2011 Followed-up by the head receptionist and Administrator.

National Health Care, Inc.

7405 N. University Street, Suite D
Peoria, Illinois 61614
309-691-9073
(Illinois) 800-322-1622
(Iowa) 800-322-5442
www.abortionaccessnhc.com

June 30, 2011

Jo Dee Havens, RN, BA
Illinois Department of Health
525-535 West Jefferson Street
Springfield, Illinois 62761-0001

Dear Ms. Havens,

I am returning the Plan of Correction to the department. Some of the chart reconstruction will take a couple of weeks, due to printing and correction checks. After printing the drafts, the Consulting Committee will review them for approval.

We are having a Consulting Committee meeting around July 7th. I will be glad to send this and any other material the department requests.

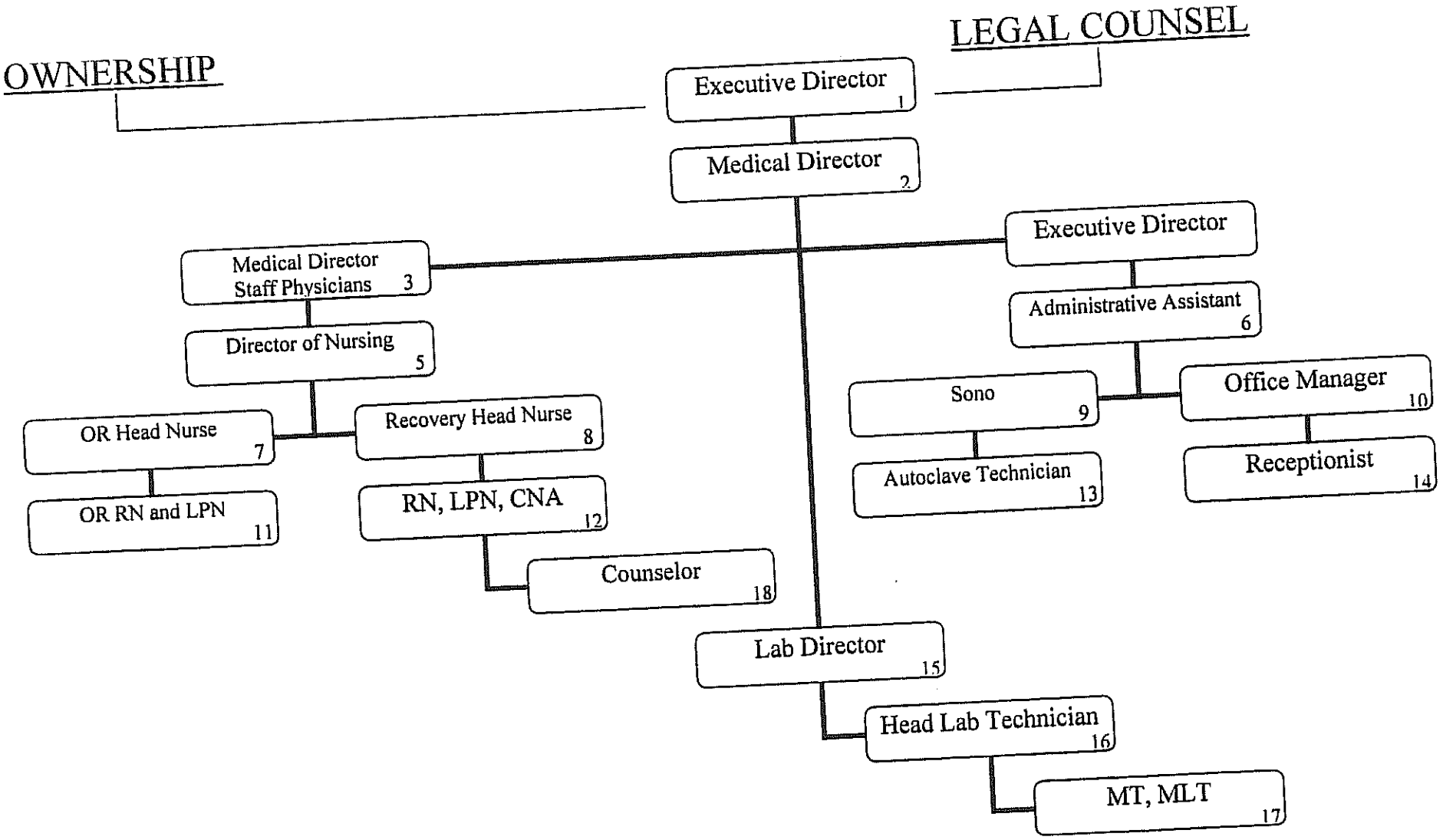
Thank you to both you and Ms. Singer for your assistance. If you have any further questions, please let me know. I can be reached at 309-691-9073.

Respectfully,

Margaret A. Van Duyn
Administrator
National Health Care, Inc.

Ex # 1

DEPARTMENT ORGANIZATIONAL CHART



Ex-2

205.230
a(2)

A.

1. When a physician applies to the P.T.C. for staff privilege the following will be noted and placed in the physician's file. The information will be held by the Medical Director.

1. Resume
2. Current Illinois License
3. Illinois hospital affiliation
4. Notarized letter stating privileges
5. Outstanding malpractice issues
6. ACLS Certified
7. Applicant's expectations
8. OR skills evaluated by Medical Director
9. Privileges granted

Completion Date: July 7, 2011

The Medical Director will do the interview and review the information, it will be in the physician's file. A yearly check will be initiated by the Medical Director. The Administrator files the paper work and validates the information.

Ex. 3

Policy and Procedure Review

Review of Policy and Procedure will be done on a semi-annual basis. Anytime a procedure is changed it will be noted in the comment section and dated.

Director	Dr. Palmer	Dr. Smith	Dr. Gittler	
_____	_____	_____	_____	January 2011
_____	_____	_____	_____	June 2011
_____	_____	_____	_____	January 2012
_____	_____	_____	_____	June 2012
_____	_____	_____	_____	January 2013
_____	_____	_____	_____	June 2013
_____	_____	_____	_____	January 2014
_____	_____	_____	_____	June 2014

Comments: _____

National Health Care, Inc. Ex 4

Title: Staff RN

Reports To: Nurse Supervisor, Staff Physician, Clinic Director

Education Requirements:

- Graduate from an accredited school of nursing
- Possess a current Illinois Nursing License
- Possess current CPR certification
- Able to take ACLS if necessary
- Experienced in Surgical Nursing or Post Partum

Position Summary:

1. Ability to perform all nursing duties within the scope of the Nursing Practice Act
2. Able to assess a situation and act accordingly
3. Follow direction of the supervising nurse
4. Ability to function as a team member
5. Work with and support ancillary staff

Duties:

1. Perform all duties within the scope of the held nursing license
2. Demonstrate proper care of patients
3. Comfort and support patients while withholding judgment
4. Assist physicians in the procedure room
5. Provide emotional and physical support to patients
6. Perform physical assessments
7. Demonstrate skill in completing patient charts
8. Perform venapuncture
9. Give medications as needed
10. Operate basic emergency medical equipment and utilize medications on the crash cart (as directed by the staff physician)
11. Be accountable at the end of the day for any narcotics used
12. Dismantle and re-stock the OR

Physical and Emotional Requirements:

- Be in good health
- Able to lift and transfer patient if needed
- Able to handle an emotionally demanding atmosphere

Ex 4

National Health Care, Inc.

Title: Staff LPN

Reports To: Nurse Supervisor, Staff Physician, Clinic Director

Education Requirements:

- Graduate of an accredited school of nursing
- Possess a current Illinois Nursing License
- Possess current CPR certification

Position Summary:

1. Ability to perform all nursing duties within the scope of the Nursing Practice Act
2. Ability to assess a situation and act accordingly
3. Take directions from Nurse Supervisor
4. Ability to function as a team member

Duties:

1. Talk with women in regards to their expectations about the procedure, pain relief, recovery, etc.
2. Ensure proper care of patients in a pre-surgical, surgical, or recovery phase (according to the policy and procedures of the clinic)
3. Comfort and support patients while withholding judgment
4. Demonstrate effective communication skills
5. Demonstrate excellent patient assessment skills
6. Demonstrate skill in completing patient charts
7. Exhibit basic nursing and aseptic techniques
8. Operate and understand basic emergency equipment use under a physicians direction

Physical and Emotional Requirements:

- Be in good health
- Able to lift and transfer patient if needed
- Able to handle an emotionally demanding atmosphere

Ex # 5

701 Platt Way, Hudson, IL 61748•309-208-6301•joette21@gmail.com

Joette Cole

Objective

Registered Diagnostic Medical Sonographer, RDMS (ARDMS Certified)

Experience

July 1992 – August 1994 — Carle Clinic Association — Urbana, IL

Diagnostic Medical Sonographer

- OB/GYN

August 1994 – March 2000 — Dr. Carolyn Garcia — Bloomington, IL

Diagnostic Medical Sonographer

- OB/GYN
- Abdomen

March 2000 - Present — Sonultra — Bloomington, IL

Diagnostic Medical Sonographer

- Application Specialist
- Quality Assurance
- Sonography Consulting

March 2000 - Present — Downstate Diagnostics — Bloomington, IL

Diagnostic Medical Sonographer

- OB/GYN
- Abdomen
- Urology

Education

July 1991-July 1992 — University of Iowa — Iowa City, IA

Diagnostic Medical Sonographer

- ARDMS Certified – National Boards Taken August 1992
- Certified in Abdomen, OB, Physics

References

References are available on request.

Ex # 5

ARDMS

The globally recognized standard of excellence in sonography 2011

ARDMS® HAS AWARDED CREDENTIALS TO

JOETTE L. COLE

CREDENTIALS

RDMS(AB OB/GYN)

ARDMS #	REGISTERED SINCE	STATUS	EXPIRES ON
29933	1992	ACTIVE	12/31/2011

Check for up-to-date status at www.ARDMS.org/MYARDMS.

ET #6

New Employee &
Employee Yearly Check

This will be done in June of each year.

Current Year _____

_____ 1. Privacy Statement

_____ 2. W-4 with birthday

_____ 3. Yearly Evaluation

_____ 4. Fire Drill, Disaster Training, OSHA

_____ 5. License, CPR, or certification

_____ Date _____ Employee

Comments on orientation and job competency: _____

_____

_____

_____

_____

_____

_____ Supervisor

_____ Administrator

Ex #7

Methodist

June 20, 2011

To Whom It May Concern:

National Health Care Inc. has a long standing agreement with Methodist Medical Center Laboratory that lab testing not performed on site at National Health Care is performed at MMCI lab as indicated. Invoicing is sent to National Health Care Inc. Methodist Medical Center Laboratory is a CLIA certified lab (see attached certificate).

Deb Deeb

DDeeb

Coordinator, Client Services
Methodist Medical Center Laboratory

CENTERS FOR MEDICARE & MEDICAID SERVICES

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF ACCREDITATION

LABORATORY NAME AND ADDRESS

METHODIST MEDICAL CENTER OF ILLINOIS
221 NE GLEN OAK
PEORIA, IL 61636

CLIA ID NUMBER
14D0431854

EFFECTIVE DATE
02/28/2011

EXPIRATION DATE
02/27/2013

LABORATORY DIRECTOR
DEVENDRA TRIVEDI MD

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.

Judith A. Yost, Director
Division of Laboratory Services
Survey and Certification Group
Center for Medicaid and State Operations

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

964 certs2_012911A

If you currently hold a Certificate of Compliance or Certificate of Accreditation, below is a list of the laboratory specialties/subspecialties you are certified to perform and their effective date:

LAB CERTIFICATION (CODE)	EFFECTIVE DATE
BACTERIOLOGY (110)	07/14/1995
MYCOLOGY (120)	07/14/1995
PARASITOLOGY (130)	07/14/1995
VIROLOGY (140)	06/14/2000
SYPHILIS SEROLOGY (210)	07/14/1995
GENERAL IMMUNOLOGY (220)	07/14/1995
ROUTINE CHEMISTRY (310)	07/14/1995
URINALYSIS (320)	07/14/1995
ENDOCRINOLOGY (330)	07/14/1995
TOXICOLOGY (340)	07/14/1995
HEMATOLOGY (400)	07/14/1995
ABO & RH GROUP (510)	07/14/1995
ANTIBODY TRANSFUSION (520)	07/14/1995
ANTIBODY NON-TRANSFUSION (530)	07/14/1995
ANTIBODY IDENTIFICATION (540)	07/14/1995
COMPATIBILITY TESTING (550)	07/14/1995
HISTOPATHOLOGY (610)	01/07/1999
ORAL PATHOLOGY (620)	06/13/2003
CYTOLOGY (630)	

FOR MORE INFORMATION ABOUT CLIA, VISIT OUR WEBSITE AT WWW.CMS.HHS.GOV/CLIA
OR CONTACT YOUR LOCAL STATE AGENCY. PLEASE SEE THE REVERSE FOR
YOUR STATE AGENCY'S ADDRESS AND PHONE NUMBER.
PLEASE CONTACT YOUR STATE AGENCY FOR ANY CHANGES TO YOUR CURRENT CERTIFICATE.

Ex #7

EXECUTION

TRANSFER AGREEMENT
between
NATIONAL HEALTHCARE - PEORIA
and
THE METHODIST MEDICAL CENTER OF ILLINOIS

THIS TRANSFER AGREEMENT ("**Agreement**") is made and executed on the last date written below, to be effective on June 27, 2011 ("**Effective Date**"), by and between **NATIONAL HEALTHCARE - PEORIA**, an Illinois corporation ("**Facility**") and **THE METHODIST MEDICAL CENTER OF ILLINOIS**, an Illinois not-for-profit Corporation, located and doing business in Peoria, Illinois (hereinafter referred to as "**Hospital**") (individually a "**Party**", collectively the "**Parties**").

RECITALS

WHEREAS, both parties desire to formalize an agreement whereby patients, regardless of payor sources, are transferred to the appropriate institution for various levels of medical or surgical care according to the dictates of the patients' medical conditions as judged by attending and consultant physicians;

WHEREAS, the Parties hereto specifically wish to facilitate: (a) the timely transfer of patients and the medical records and other information necessary or useful for the care and treatment of patients transferred to and from each Party; (b) the determination as to whether such patients can be adequately cared for other than by either of the Parties hereto; (c) the continuity of care and treatment appropriate to the needs of the transferred patient; and (d) the utilization of knowledge and other resources of both healthcare entities in a coordinated and cooperative manner to improve the professional healthcare of patients; and

NOW, THEREFORE, in consideration of the mutual covenants contained herein, and in reliance upon the recitals, set forth above and incorporated by reference herein, the Parties hereto agree as follows:

I. DUTIES AND RESPONSIBILITIES

1.1. Joint Responsibilities. In accordance with the policies and procedures of the Hospital and upon the recommendation of the patient's attending physician that such a transfer is medically appropriate, such patient shall be transferred from the Hospital to the Facility as long as the Facility has bed availability, staff availability, is able to provide the services requested by the Hospital, including on-call specialty physician availability, and pursuant to any other necessary criteria established by the Facility. In such cases, the Facility and the Hospital agree to exercise best efforts to provide for prompt admission of the patient. If applicable, the Parties shall comply with all EMTALA requirements with respect to such transfers.

1.2. Facility. The Facility shall accept patients in need of transfer from the Hospital pursuant to the criteria set forth in Section 1.1. Further, Facility shall designate a

Peoria, IL 61614
Ottawa IL 61350
Attention: Margaret Van Duyn
Fax: _____
Telephone: 309.691.9073

Peoria, IL 61636
Attention: Deborah R. Simon
Fax: 309.680.2543
Telephone: 309.672.5928

Or to other such address, and to the attention of such other person(s) or officer(s) as a Party may designate by written notice.

4.8 Governing Law. This Agreement shall be construed and interpreted in accordance with the laws in Illinois.

4.9 Nonexclusive. Nothing in this Agreement will be construed as limiting the right of either party to affiliate or contract with any other party.

4.10 It is understood and agreed that neither Party to this Agreement shall be legally liable for any negligent nor wrongful act, either by commission or omission, chargeable to the other, unless such liability is imposed by law and that this Agreement shall not be construed as seeking to either enlarge or diminish any obligations or duty owed by one Party against the other or against a third party.

IN WITNESS WHEREOF, the Parties have hereto executed this Agreement as of the last date written below.

Facility:
NATIONAL HEALTHCARE - PEORIA

By: Margaret Van Duyn
Margaret Van Duyn, Clinical Director
for National Healthcare
Date: June 20th 2011

Hospital:
THE METHODIST MEDICAL CENTER OF ILLINOIS

By: Deborah Simon
Deborah R. Simon, Sr VP & COO
Date: 6/21/11

REVIEWED FOR
LEGAL SUFFICIENCY
6/20/2011
MHSC CORPORATE COMPLIANCE

Ex # 8

Machines Needing a Yearly Check
2011

Machine	Brand	Model #	Checked Date (M/D)	Initials
Vacuum Curettage (OR 3)	Berkeley	VCII	June 24-28	MV
Vacuum Curettage (OR 2)	Berkeley	VCII	" "	MV
Vacuum Curettage (OR 1)	Berkeley	SVII	" "	MV
Gleamer Light (OR 3)	Gleamer	GL13106	" "	MV
Gleamer Light (OR 2)	Gleamer	GL13106	" "	MV
Gleamer Light (OR 1)	Gleamer	GL13106	" "	MV
Centrafuge (Lab)	Dade	569	" "	MV
Oxygen Tank	E-tank	n/a	" "	MV
Autoclave	Pelton-Crane	OCR	" "	MV
Autoclave	Tuttanauer	2340M	" "	MV
Autoclave	Tuttanauer	2340M	" "	MV

Machines Needing a Yearly Check
2011

Machine	Brand	Model #	Checked Date (M/D)	Initials
Vacuum Curettage (OR 3)	Berkeley	VCII	June 24-28	MV
Vacuum Curettage (OR 2)	Berkeley	VCII	" "	MV
Vacuum Curettage (OR 1)	Berkeley	SVII	" "	MV
Gleamer Light (OR 3)	Gleamer	GL13106	" "	MV
Gleamer Light (OR 2)	Gleamer	GL13106	" "	MV
Gleamer Light (OR 1)	Gleamer	GL13106	" "	MV
Centrafuge (Lab)	Dade	569	" "	MV
Oxygen Tank	E-tank	n/a	" "	MV
Autoclave	Pelton-Crane	OCR	" "	MV
Autoclave	Tuttanauer	2340M	" "	MV
Autoclave	Tuttanauer	2340M	" "	MV

Ex 48

O_2 Tank

LOT NUMBER
EQ 04 Y 172 C
LITERS 679
EXP DATE 06-21-2016

Ex # 8

No 4675

KIRK RELIABLE REPAIR SERVICE

705 E. Lincoln, Ste. 114
Normal, IL 61761

Telephone: (309) 452-5248

Customer's Order No.

Date June 27, 1996

Name National Health Care

Address 7405 N. University

City Peoria State Ill.

SOLD BY	CASH	C. O. D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT
	✓		✓			

QUAN.	DESCRIPTION	PRICE	AMOUNT
1	Sterilizer Model 2340M Ser# 980 3470		75 00
1	Door Gasket		45 95
1	Safety Valve		120 95
	TAX		10 58
			131 53
	Service 1.5 hr	80.00	120 00
			251 53
	Travel 1.5 hr	80.00	120 00
			371 53
		TOTAL	

THANK YOU Please keep this copy for reference

ALL claims and returned goods MUST be accompanied by this bill.

Rec'd By

There are several of these tickets on file for the department.

Ex # 9

Sterilizer Monitoring

	Pelton Crane A4-36746		Tuttnauer 9811946		Tuttnauer 9803470	
Date	Spore	Clean	Spore	Clean	Spore	Clean
10/25/2010	PK	PK	PK	PK	PK	PK
11/04/2010	PK	PK	PK	PK	PK	PK
12/05/2010	PK	PK	PK	PK	PK	PK
01/17/2011	PK	PK	PK	PK	PK	PK
02/08/2011	PK	PK	PK	PK	PK	PK
03/22/2011	PK	PK	PK	PK	PK	PK
04/01/2011	PK	PK	PK	PK	PK	PK
05/03/2011	PK	PK	PK	PK	PK	PK
06/07/2011	PK	PK	PK	PK	PK	PK
07/01/2011	PK	PK	PK	PK	PK	PK

Ex #10 - yearly + new

New Employee &
Employee Yearly Check

This will be done in June of each year.

Current Year _____

_____ 1. Privacy Statement

_____ 2. W-4 with birthday

_____ 3. Yearly Evaluation

_____ 4. Fire Drill, Disaster Training, OSHA

_____ 5. License, CPR, or certification

_____ Date _____ Employee

Comments on orientation and job competency: _____

_____

_____

_____

_____

_____

_____ Supervisor

_____ Administrator

Ex 11

National Health Care Inc.
Quarterly Abortion Report

Quarter:_____ Year: _____

	Jan	Feb	Mar	Qtr1	Apr	May	Jun	Qtr2	Jul	Aug	Sep	Qtr3	Oct	Nov	Dec	Qtr4	Year Totals
Total Number of Patients																	
12 Weeks or Less (LMP)																	
13 to 16 weeks (LMP)																	
Medical AB < 9 wks																	
No. of Follow-up																	

ABORTION INCIDENTS

No. of Incomplete Abs																	
No. of Failed Abortions																	
No. of Perforations																	
No. of Infections																	
No. of Hemorrhages																	
No. of Ectopic Pregnancy																	
No. of Deaths*																	
Other (Specifiy_____)																	

INCIDENT MANAGEMENT

No. of Resuctions																	
No. of Hospitalizations																	
No. of Transfusions																	
No. of Laparotomies																	
No. of Laparoscopies																	

*Submit immediately an Abortion Incident Report

Outline of Corrections
National Health Care, Inc.

1. Copy of Consulting Committee
    a. **Exhibit #20**

2. Responsible for Tissues
    a. **Exhibit #20**

3. Director of Policy Review, Procedure Change Review
    a. **Exhibit #20**

4. Lidocaine Physician Review
    a. **Exhibit #24**

5. Sonogram Technician Job Description, Resume
    a. **Exhibit #25**
    b. Medical Director will review staff credentialing on July 27, 2011 (**Exhibit #21**)

6. MT/MLT and Surgical Technician Job Description
    a. **Exhibit #26**

7. Staff Orientation – Copy of form and who will sign off
    a. **Exhibit #27**

8. Discharge Criteria will be reviewed and sent on July 27, 2001

9. Emergency Training – completed and on file
    a. Blank form sent
    b. **Exhibit #29**

10. Chart Equipment Maintenance
    a. **Exhibit #8**

11. Laundry
    a. Laundry checks
    b. Laundry procedures
    c. Follow-up
    d. **Exhibit #22**

12. Crash Cart Revised, check list enclosed
    a. **Exhibit #23**

13. Medical Chart
    a. Review of history
    b. Sign off
    c. **Exhibit #28**

14. Laboratory Phlebotomy
    a. **Exhibit #30**

Exhibit #20

July 7, 2011
Consulting Committee

Attending:

1. Bernard Smith, M.D.—Medical Director
2. Allen Palmer, D.O.—Senior Staff OB-Gyn
3. Mandy Gittler, M.D.
4. Margaret Van Duyn, Administrator

The meeting commenced at 1:00pm. We will be reviewing policy, procedures and a review of pathology reports.

The committee will meet quarterly: September, December, March, and June.

On June 16, 2011, the Illinois Department of Public Health surveyed our P.T.T. A Plan of Correction was submitted to us.

We have instituted a procedure for granting privileges at the P.T.C. for a new staff physician:

1. Resume
2. Current Illinois License
3. Illinois Hospital Affiliation
4. Notarized letter stating privileges
5. Outstanding malpractice issues
6. ACLS certified
7. Applicant's expectation
8. OR skills evaluated by the Medical Director
9. Type of privilege granted

Should any concerns arise they will be discussed and reviewed by the Medical Director. All staff physicians are being reviewed and brought up to current requirements. Dr. Stewart Kernes is not on staff at this time. If he needs to be reinstated, his credentials will be reviewed and privileges applied for will be evaluated.

Discussion was held about a circulating nurse. The requirement is that an R.N must be in the OR during invasive procedures. We will drop down to 2 procedure rooms. We only have 3 R.N.s on staff, so we will have to try some other options.

The physician will now give all intravenous sedation.

All medication will be secured in a locked box in the individual operating rooms. The R.N. will be responsible for checking the medications in and out with the recovery room nurse. The count shall be done before and after surgery.

Discussion was held in depth about ACLS certification and how that will be accomplished. The physicians are looking into dates and courses. Certification will be documented as the course.

Chart pages were reviewed and changes are being discussed as how to validate that the physician and nurse have reviewed the chart. The physicians will review the chart as changes are made and printed. The Consulting Committee will review the final chart pages in question.

We now have a document that requires the staff physicians to sign off semi-annually after the Policy and Procedure Manual has been reviewed.

The new transfer agreement, and laboratory acceptance from Methodist Medical Hospital was reviewed and accepted.

20 Path reports and charts were reviewed.

5 Path reports—Dr. Bernard Smith
8 Path reports—Dr. Allen Palmer
7 Path reports—Dr. Mandy Gittler

All charts were accepted.

Meeting adjournment: 3:05

Respectfully Submitted,

Margaret A. Van Duyn
Administrator

Bernard Smith, M.D.

Allen Palmer, D.O.

Mandy Gittler, M.D.

Physician Tissue Review

Month _____ **Year**_____

Surgery Date: _____ Charts Review Date _____ Physician_____

Comments: _____

_____

Surgery Date: _____ Charts Review Date _____ Physician_____

Comments: _____

_____

Surgery Date: _____ Charts Review Date _____ Physician_____

Comments: _____

_____

Surgery Date: _____ Charts Review Date _____ Physician_____

Comments: _____

_____

Surgery Date: _____ Charts Review Date _____ Physician_____

Comments: _____

_____

Surgery Date: _____ Charts Review Date _____ Physician_____

Comments: _____

_____

Surgery Date: _____ Charts Review Date _____ Physician_____

Comments: _____

_____

End of Month Review

_____
Benard Smith, M.D
Medical Director

_____
Margaret Van Duyn
Administrator

Revised July 12, 20111

#20 cont

Policy Procedure and Procedural Change

The Policy and Procedure Manual will be reviewed yearly. A comment section will be provided.

Incorporated in this section is also a procedural change. Whenever a change is made in the clinic, it will always be discussed by the Consulting Committee but in addition will be reviewed and signed off by the Medical Director. This will also be noted in the Q.I.

The Administrator will check this for completion yearly and whenever there is a procedural change.

Revised July 12, 2011

Procedure Policy Review
Yearly Review

January 2011

Date: _____ _____ Medical Director

Comments: _____

_____

_____

_____

_____

January 2012

Date: _____ _____ Medical Director

Comments: _____

_____

_____

_____

_____

January 2013

Date: _____ _____ Medical Director

Comments: _____

_____

_____

_____

_____

Revised July 12, 2011

Procedure Change

Date: _____

Describe Change: _____

_____

_____

_____

_____

_____
Medical Director

_____
Administrator

Revised July 13, 2011

Exhibit "2"

Lidocaine Medication Log

All bottles will be labeled and initialed by the compounding nurse.

The compounding nurse will oversee the drawing up of the medication and she will initial the following log.

This log will be verified by the physician of the day. The Administrator will be responsible to follow.

Date	# Drawn	# Discarded	RN/LPN	Physician

Revised 7-13-11

Exhibit #25

2011

National Health Care, Inc.

Title: Sonogram Technician

Reports To: Staff Physician, Nursing Staff, Clinic Director

Education Requirements:

- RT, RN, LPN or Sonogram Trained
- Trained in Sonogram Techniques for gestational dating
- Able to be evaluated by our consulting RT for competency
- Possess current CPR certification (if requested)

Position Summary:

1. Perform ultrasounds, be aware that a vaginal probe can be stressful
2. Able to chart and record sonogram findings accurately
3. Respectfully acknowledge the need for patient privacy
4. Can demonstrate knowledge and understanding of NHC policy and procedures

Duties:

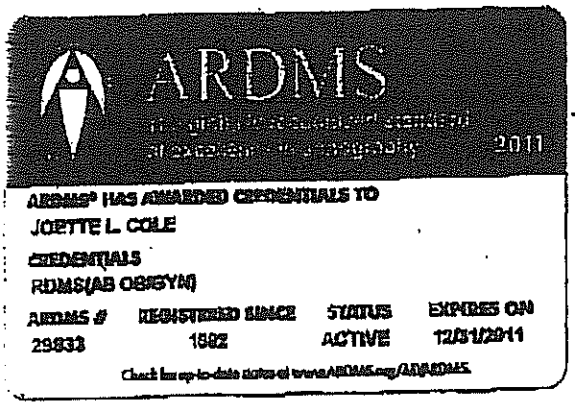
1. Determine positive pregnancy
2. Determine gestational age
3. Rule out ectopic pregnancy
4. Inform the proper staff person or staff physician of any abnormalities noted

Physical and Emotional Requirements:

- Be in good health
- Able to lift and transfer patient if needed
- Able to handle an emotionally demanding atmosphere

Revised July 13, 2011

Ex #25 cont...



ARDMS

2011

ARDMS® HAS AWARDED CREDENTIALS TO

JOETTE L. COLE

CREDENTIALS

RDMS(AB OB/GYN)

ARDMS #	REGISTERED SINCE	STATUS	EXPIRES ON
29833	1992	ACTIVE	12/31/2011

Check for up-to-date status at www.ARDMS.org/AR/ARDMS.

Exhibit #21

Re-Credentialing Review
July 27, 2011

, M.D., our current Medical Director today, will review M.D., our staff physician for compliance in regards to staff privileges.

reviewed:

1. Resume
2. Current Illinois License
3. Illinois Hospital Affiliation, Illinois Masonic current and on active staff
4. Notarized letter stating privileges
5. No outstanding malpractice issues
6. ACLS certification will be completed August 5, 2011. Will follow-up for completion.
7. Dr. Gittler had her operating skills reviewed previously and again today.
8. Privileges granted for pregnancy termination and intravenous sedation.

I found the above requirements satisfied and current.

_____ _____

Date

_____

Margaret Van Duyn, Administrator

National Health Care, Inc.

Title: Laboratory Technician

Reports To: Lab Supervisor, Lab Director, Clinic Director

Education Requirements:

- Graduate of a certified laboratory program or Military Field Service School and possess a certificate of completion
- Possess current CPR certification
- Have experience in Blood Bank

Position Summary:

1. Ability to perform laboratory testing
2. Ability to pass CAP proficiency test with a 100%
3. Be self-motivated
4. Ability to be respectful of patients

Duties:

1. Respect patient individuality
2. Follow accepted laboratory procedures
3. Perform and record daily controls
4. Chart and record laboratory results
5. Provide support if needed in the clinic
6. Recognize that if the patient is not tolerating the procedure well, provide support and call for help

Physical and Emotional Requirements:

- Be in good health
- Able to lift and transfer patient if needed
- Able to handle an emotionally demanding atmosphere

Revised July 13, 2011

#7Le cont...

National Health Care, Inc.

Title: Surgical Technician

Reports To: Staff Physician, Clinic Director

Education Requirements:

- High School Diploma or GED
- A person that has the ability to work within the guidelines of the clinic

Position Summary:

1. Ability to function as a team member
2. Be self-motivated
3. Able to assess a situation and act accordingly
4. Follow medical guidelines
5. Follow directions from professional staff in case of an emergency

Duties:

1. Check all supplies before procedure days so that anything needed can be made before procedures start
2. Set up each OR room
    a. Place bottles in the machine and hook up hoses
    b. Unwrap instruments and place a sterile towel over them
3. Ensure that RN has compounded Lidocaine mixture and drawn up syringes for patient procedures
4. During procedures:
    a. Remove dirty instrument packs and POC
    b. Check POC
    c. Wash and rewrap instrument packs, wrapping should be snug against contents
    d. Soak MVA's in OPA for 9-12 minutes, rinse, dry and put back in OR room (if used)
    e. Set up OR room for next patient procedure
    f. Sterilize instruments
5. End of day:
    a. Remove and wash all instrument packs, bottles, and hoses from OR
    b. Wrap and sterilize all instruments
        i. Date packs with month and day
    c. Place hoses back in OR rooms after cleaning
    d. Spray all surfaces with Cavicide and wipe down
    e. Pack products of conception for pick up and shipping

Physical and Emotional Requirements:

- Be in good health
- Able to lift and transfer a patient if needed
- Able to handle an emotionally demanding atmosphere

Revised July 13, 2011

Exhibit # 21

Job Orientation and Certification

Filed in Employee Chart

Employee: _____

Position: _____

Training Start Date: _____

Facilitator: _____

Comments: _____

_____

_____

_____

_____

_____

Training Completion Date: _____

_____ Employee Signature

_____ Facilitator

_____ Date

_____ Administrator

This will be filed in the employee record. Every task the employee is assigned will be evaluated in this manner.

Revised 7-13-11

New Employee Orientation

_____ Initial interview and discussion of clinic policy, salary, workdays and time off.

_____ Privacy statement

_____ W-4 with birthday

_____ I-9

_____ Personnel Policy, Job Description

_____ Fire Drill, Disaster Training

_____ OSHA Testing

_____ Walk Through _____ Date Completed

_____ Hep. Vac.

_____ Lic. _____ Date Completed

_____ _____

Date Employee

Comments: _____

_____

_____

_____

_____

_____

_____

Director

Exhibit #27

OSHA, Fire Drill, Disaster, and Emergency Training

DATE: OSHA TRAINER:

PATIENT EMERGENCY TRAINER: POLICY/PROCEDURE TRAINER:

(Name)	_____ (date)	_____ (date)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

_____ Administrator

_____ Staff Physician

FIRE/BOMB/TORNADO EMERGENCY PROCEDURES

FIRE

Every Employee is familiar with the following locations:

Pull station locations:

1. Front waiting room
2. Under Front Desk (Silent Police Alarm)
3. Back Door
4. OR Hallway
5. Hallway to front door

Fire Extinguishers:

1. Front waiting room
2. Receptionist Area
3. By Doctor's Room
4. Back Door
5. By Counseling Room #4
6. By Pre-op
7. Front Door
8. Hallway by Recovery
9. Recovery

In the event of a fire, R.A.C.E. and P.A.S.S. procedures will be followed.

R.A.C.E

R = **RESCUE** anyone in immediate danger from the fire while avoiding endangerment of one's own life.

A = **ALARM** the director and staff physician and ensure activation of pull station alarm box. Silent police notification alarm is located under the front receptionist desk.

C = **CONFINE** the fire by closing all doors and windows

E = **EXTINGUISH** the fire by using P.A.S.S. with correct type of extinguisher for the fire or **EVACUATE** the area if the fire is too large for a fire extinguisher.

Each employee will evacuate the patients and patient's support persons under the discretion of the Director and staff physician. Employees will evacuate according to the evacuation routes posted in every hallway of the clinic, always using the closest route to safety. All staff and patients will meet at tree line of the back parking lot. Front receptionist responsible to bring daily patient roster so that all patients can be accounted for.

P.A.S.S

P = **PULL** the pin on the fire extinguisher

A = **AIM** the extinguisher nozzle at the base of the fire

S = **SQUEEZE** or press the handle

S = **SWEEP** from side to side until the fire is extinguished.

BOMB THREAT

1. Activate the police call button at the front reception desk.
2. Notify the director and/or physician
3. Help route the patients through the appropriate exits
4. Follow directions from the police as deemed appropriate.

TORNADO

1. Designated tornado safe spot is the O.R. hallway. All persons in the building shall immediately go the O.R. hallway in the event of a tornado warning.
2. All patients must be accounted for by the nursing staff. Nursing supervisor will report any missing persons to director.
3. All staff must be accounted for by their immediate supervisor. Supervisors will report any missing staff to the director.
4. All persons will stay in the tornado safe spot until the ALL CLEAR is issued by the National Weather Service.

EMERGENCY PATIENT CARE WILL BE FOLLOWED BY THE PROTOCOL LISTED AS Emergency Transfer and Reporting and Emergency Evacuation Plan will be followed.

Revised July 12, 2011

Exhibit # 22

Laundry Washing

At this facility blood is considered potentially hazardous and infectious and it shall be handled as such.

1. In the recovery room, gowns are placed in a fluid proof container. The linen bag is yellow and labeled as infectious linens. The bags are not handled in the patient area.

2. In the laundry room, staff puts on the proper P.P.E. (gloves, apron) and removes gowns from the infectious linen bags. The gowns are placed directly into the washer with ½ cup of bleach and laundry detergent, the water temperature use is hot. They are washed at a full cycle then dried.

3. Visibly contaminated laundry will be handled differently. The laundry will be soaked in Haemo-Sal Enzyme Active Protein Dissolvent (½ cup) for 40 minutes in water in washing machine. The cycle is finished, then on full cycle with hot water and ½ cup bleach is completed. The bleach will be precisely measured at ½ cup.

4. Gowns are dried and folded and returned to the patient counseling rooms.

5. A chart will be signed off for the addition of bleach and Haemo-Sal as needed.

6. This will be checked monthly by the Administrative Assistant.

Revised July 12, 2011

HANDLING OF LAUNDRY

Contaminated laundry defined as "any laundry that may contain blood or other potentially infectious materials" shall be handled utilizing Universal Precautions to prevent occupational exposure. All used gowns and other laundry will be in yellow infectious bags. All laundry is processed on site and requires no special labeling of contaminated linen provided that Universal Precautions are adhered to when handling.

Bags or containers used to collect contaminated laundry must be able to prevent soak through or leakage of fluids to the exterior of the bag. Cloth bags should be used for the majority of laundry with the bags designed with greater ability to resist leakage for contaminated or wet linen.

Contaminated laundry shall:

1. not be sorted or rinsed in patient care areas
2. not be thrown on the floor
3. not be hugged against uniform
4. be bagged in room where linen is used
5. Be handled using appropriate personal protective equipment i.e. Gloves and other appropriate PPE when necessary

Procedure for linen processing is as follows:

1 Patient shall be instructed to remove gown and place in laundry bag.
2. At the end of each working day, contaminated linen shall be transferred from linen bag to washer using appropriate personal protective equipment.
3. Normal washing cycle shall follow.

REGULATED WASTE
THE FOLLOWING BODY SECRETIONS SHALL BE CONSIDERED AS POTENTIALLY INFECTIOUS AND SHALL BE HANDLED AND DISPOSED OF AS SUCH

BLOOD
VAGINAL SECRETIONS
SEMEN
AMNIOTIC FLUID

Laundry Washing Chart

Month__________ Year___________

Date: __________ #Loads__________ ½ cup bleach__________ Int.________
#Loads__________ Haemo-sal Soak ½ cup ½ bleach full cycle Int.________

Date: __________ #Loads__________ ½ cup bleach__________ Int.________
#Loads__________ Haemo-sal Soak ½ cup ½ bleach full cycle Int.________

Date: __________ #Loads__________ ½ cup bleach__________ Int.________
#Loads__________ Haemo-sal Soak ½ cup ½ bleach full cycle Int.________

Date: __________ #Loads__________ ½ cup bleach__________ Int.________
#Loads__________ Haemo-sal Soak ½ cup ½ bleach full cycle Int.________

Date: __________ #Loads__________ ½ cup bleach__________ Int.________
#Loads__________ Haemo-sal Soak ½ cup ½ bleach full cycle Int.________

Date: __________ #Loads__________ ½ cup bleach__________ Int.________
#Loads__________ Haemo-sal Soak ½ cup ½ bleach full cycle Int.________

Date: __________ #Loads__________ ½ cup bleach__________ Int.________
#Loads__________ Haemo-sal Soak ½ cup ½ bleach full cycle Int.________

Date: __________ #Loads__________ ½ cup bleach__________ Int.________
#Loads__________ Haemo-sal Soak ½ cup ½ bleach full cycle Int.________

Monthly Review__________________ Date:______________

Revised July 12, 2011

Exhibit #23

Monthly Crash Cart Check

All listed Medications and Emergency Drugs have been checked and verified as current and up to date.

O2 tank has been checked being in proper working order and the tank it filled.

The Head OR nurse will sign off monthly and the Recovery Room nurse will verify.

2011

January	_____ Checked	_____ Verified	February	_____ Checked	_____ Verified
March	_____ Checked	_____ Verified	April	_____ Checked	_____ Verified
May	_____ Checked	_____ Verified	June	_____ Checked	_____ Verified
July	_____ Checked	_____ Verified	August	_____ Checked	_____ Verified
September	_____ Checked	_____ Verified	October	_____ Checked	_____ Verified
November	_____ Checked	_____ Verified	December	_____ Checked	_____ Verified

Pt # _____ Pt. Name _____ Date ____/____/____

SONO

1. LMP _____ Calc WK _____ Gravida ____ Para ____ SONO WEEKS _____

Sac Seen _____ Yolk Sac _____ Fetal Pole _____ CRL _____ B.P.D. _____

Other _____ _____ Int

LAB

2. Preg Test Sens: _____ Hgb _____ Rh _____

Rho-Gam _____ Tech _____

PRE-OP

3. Time _____ B.P. _____ Pulse _____

Misoprostol info: ☐ _____ Pt. Int. Misoprostol 200 mcg#2 ☐ _____ Int.

P.E.

4. Gest _____ Ant _____ Mid _____ Post _____ Adnexa _____

Abnormalities were noted in the following areas: Heart _____ Lungs _____ Abd _____ Pelvis _____

OR NOTES

Admit Time _____ B.P. _____ Pulse _____ O_2 Sat _____

A. Paracervical block. Lidocaine HCL 1% 15 ml 20 ml Additives in block: 5cc 8.4% Sodium Bicarbonate 0.2 ml Vasopressin per 45cc Lidocaine

☐ Fentanyl 50 mcg given I.V. Midazolam HCL 2.5 mg ☐ 2.0 mg ☐ Time _____ _____ M.D./RN

B. Cervix dilated to _____ Uterine Depth _____ Cannula _____ mm Blood Loss: _____ mL Tissue to P.L.S.

Rho - GAM: Cervical ☐ IM ☐ Mini 50ug ☐ Full 300ug ☐ Methergine 0.2 mg/cervical ☐ Pitocin 10 units / cervical ☐

C. L.O.C. Alert & Responsive ☐ Easily Arousable ☐ Other: _____

_____

_____

_____

I have reviewed the patient's medical history, performed a physical exam and found them to be within the clinic's guidelines.

_____ RN

_____ M.D.

Discharge: Satisfactory ☐ Walked to RR c assist. ☐

Exhibit #30

Lab Supervision

All procedures in the laboratory are done by an MT/MLT. The testing is done by fingerstick routing. The laboratory technician is present at all times, and patients are seen individually. The MT/MLT will provide continual observation.

On a rare occasion we need to draw a BHCG that will be sent to the hospital. The MT/MLT will do that, and they do not leave the patient alone.

The laboratory supervisor will follow-up.

Revised 7-13-11

National Health Care, Inc.

7405 N. University Street, Suite D
Peoria, Illinois 61614
309-691-9073
(Illinois) 800-322-1622
(Iowa) 800-322-5442
www.abortionaccessnhc.com

#700167C

August 2, 2011

JoDee Havens, R.N., B.A., Supervisor
Division of Health Care Facilities and Programs
Illinois Department of Public Health
525 West Jefferson Street, 4th Floor
Springfield, IL 62761-0001

Dear Ms. Havens:

I am sending what I hope will be our final submission for our Plan of Correction.

I am also sending the list you sent me that are now numbered with the exhibit numbers in the margin where they are needed.

We have assigned a number to our staff members and our physicians to keep their identity private. This list is on file at the office or I can drive them down to Springfield for review.

I am not able to answer the question regarding Dr. Smith's privileges as they are not complete.

If he is unable to get anything other than Courtesy Privileges, he will be leaving this facility after 26 years of caring for women with not one (1) major complication.

Respectfully Submitted,

Margaret Van Duyn
Administrator

Ms. Van Duyn,

Here is a list of the requested documents and additional information that is needed in the plan of correction. If you have any questions please feel free to contact me at 217-782-0497. Thank you, JoDee Havens

Documents still needed:

A. 1. Meeting minutes from July 27, 2011
B 2. Credentialing of > NOT DONE
C 3. Privileges for Dr. Smith
D 4. Copy of discharge criteria along with patient recovery sheet
E 5. Copy of who attended staff inservice for emergency techniques pre and post operative
F 6. Policy on machine maintenance
G 7. Need copies of ACLS of RN's and physicians

Additional information needed in the Plan of Correction

H 8. 205.230(a)(5) – Who does the written tissue review report go to?
I 9. 205.230(b)(1) – (Part A) Need more detail about the approval sheet for policies and procedures, need to incorporate into Quality Assurance and Performance Improvement program.
J 10. 205.230(b)(1) – (Part B) Need to correct Plan of Correction, it indicates that Ms. Young will still be loading syringes I did see in your documentation the RN will be doing this, but the Plan of Correction needs to reflect this as well.
K 11. 205.310 – Needs to be incorporated into Quality Assurance and Performance Improvement, how are you going to monitor?
L 12. 205.320 – Incorporate the detailed discharge/discharge criteria into Quality Assurance and Performance Improvement.
M 13. 205.330(b) – How frequently you will be having inservices for emergency techniques for pre and post operative care, who is responsible for ensuring this is done.
N 14. 204.410(a) – (Part A) Incorporate into Quality Assurance and Performance Improvement, is there any monitoring being done?
O 15. 205.410 (a)- (Part B) Incorporate into Quality Assurance and Performance Improvement.
P 16. 205.510 (a) – Incorporate into Quality Assurance and Performance Improvement, how are you going to ensure staff training for emergency/non-emergency situations is completed annually?
Q 17. 205.520 (b) - Incorporate into Quality Assurance and Performance Improvement, how are you going to monitor to ensure medical histories physical exams are done prior to the procedure?
R 18. 205.530 E)i)ii)iii&v) – Plan of correction does not make any reference to the deficient practice of not providing continuous observation of patients that receive IV sedation, incorporate into Quality Assurance and Performance Improvement, how will it be monitored? Need copies of ACLS of RN's and physicians, how and who will ensure ACLS is completed.
S 19. 205.530 e) – How are you going to ensure there is always an RN in the procedural areal at all times during the procedure? Incorporate into Quality Assurance and Performance Improvement.
T 20. 205.620 (a) 3)4)5) - Incorporate into Quality Assurance and Performance Improvement.

July 7, 2011
Consulting Committee

tor
-Gyn

The meeting commenced at 1:00pm. We will be reviewing policy, procedures and a review of pathology reports.

The committee will meet quarterly: September, December, March, and June.

On June 16, 2011, the Illinois Department of Public Health surveyed our P.T.T. A Plan of Correction was submitted to us.

We have instituted a procedure for granting privileges at the P.T.C. for a new staff physician:

1. Resume
2. Current Illinois License
3. Illinois Hospital Affiliation
4. Notarized letter stating privileges
5. Outstanding malpractice issues
6. ACLS certified
7. Applicant's expectation
8. OR skills evaluated by the Medical Director
9. Type of privilege granted

Should any concerns arise they will be discussed and reviewed by the Medical Director. All staff physicians are being reviewed and brought up to current requirements. Dr. Stewart Kernes is not on staff at this time. If he needs to be reinstated, his credentials will be reviewed and privileges applied for will be evaluated.

Discussion was held about a circulating nurse. The requirement is that an R.N must be in the OR during invasive procedures. We will drop down to 2 procedure rooms. We only have 3 R.N.s on staff, so we will have to try some other options.

The physician will now give all intravenous sedation.

All medication will be secured in a locked box in the individual operating rooms. The R.N. will be responsible for checking the medications in and out with the recovery room nurse. The count shall be done before and after surgery.

Discussion was held in depth about ACLS certification and how that will be accomplished. The physicians are looking into dates and courses. Certification will be documented as the course.

Chart pages were reviewed and changes are being discussed as how to validate that the physician and nurse have reviewed the chart. The physicians will review the chart as changes are made and printed. The Consulting Committee will review the final chart pages in question.

We now have a document that requires the staff physicians to sign off semi-annually after the Policy and Procedure Manual has been reviewed.

The new transfer agreement, and laboratory acceptance from Methodist Medical Hospital was reviewed and accepted.

20 Path reports and charts were reviewed.

5 Path reports—Dr.
8 Path reports—Dr.
7 Path reports—Dr.

All charts were accepted.

Meeting adjournment: 3:05

Respectfully Submitted,

Margaret A. Van Duyn
Administrator

M.D.

).O.

M.D.

Recovery Room
Admitting and Discharge Criteria

Each woman requires assessment immediately after the abortion to ensure that the uterus is contracting, bleeding is not excessive, and she is clinically stable.

All patients will be checked upon arrival, blood pressure, pulse and respiration. If the patient is overly sleepy, an O_2 saturation will be done. This information will be compared to the OR notes.

Routine Assessment:

1. Alertness and mental state
2. Degree of pain and disability
3. Admitting and discharge vital signs
4. Uterine seize and tone, usually assessed by abdominal examination
5. Amount of bleeding
6. Any other concerns the patient may have.

Pain management is essential. The pain is assessed and written in the chart upon Admit and Discharge along with vital signs. The recovery is responsible. Most pain results from uterine cramping, but all atypical pain, and pain in another area, shall be documented. This type of cramping should decrease in 15 minutes.

Severe pain is unusual after an abortion, if pain continues a hematometra may be forming.

Normal bleeding varies by gestational age. Passing clots can be considered normal; more may pass in larger gestation.

Excessive bleeding requires assessment by the clinician if bleeding does not respond to uterine massage or low dose uterotonic medication.

Discharge Criteria:

Patient is discharged on the written order of the physician. The following criteria will be met before discharge:

1. Vital signs are within normal limits (documented)
2. Bleeding is controlled (documented) must be moderate or less
3. Pain is less than 2 (1-5) and is documented
4. All paperwork, prescriptions, questions and aftercare will be reviewed and checked off.
5. Who is with the patient, if the patient has not had I.V. sedation, she may drive.
6. If I.V. sedation is administered, who is driving will be documented and the patients driver will be present before release.
7. Time of release will be documented.

Ex.
D4

Recovery Room Patient Care

1. Once OR nurse has placed patient in recliner, situate patient.
    a. Have blue pad already placed on chair
    b. Elevate feet by placing chair in reclined position
    c. Place white blanket over patient
    d. Give patient an ice pack to put over abdomen
    e. Give patient cup of Sierra Mist and cookies
    f. Ask if ride is already waiting for them (call if necessary)
    g. Ask how patient is doing and inform that cramping will calm down in about 15 minutes.
2. Patient's blood pressure is immediately taken and assessed.
3. Patient's initial post-op charting
    a. Write chair number in tab by name
    b. Write time patient arrived to post-op
    c. Write down blood pressure and pulse
    d. Indicate patient's pain level.
4. Visual assessment of patient is completed. Review patient IV site for redness. Apply ice on injecting site if needed. Document in chart if abnormal.
5. Recovery Time:
    a. No anesthesia and ride = at least 30 minutes
    b. Anesthesia and ride = at least 40 minutes
    c. No anesthesia and no ride = at least 45 minutes
    d. Patient is not allowed to have anesthesia if driving themselves
    e. Patient time may increase if patient has an abnormal assessment
6. Blood pressure is reassessed 5 minutes before discharge.
7. Medications are administered by nurse in post-op per Physicians orders.
8. Review patients chart for known allergies and daily medications before dispensing medications.
9. All patients receive and antibiotic. Standard is Doxycycline, 100mg, dispense #6 take twice a day with water and food and informed to avoid sunlight and antacids. If allergy to Doxycycline or other antibiotic then substitute Amoxocillin 500mg #15 for 5 days or another as instructed by the Physician.

10. All patients that are 12 weeks gestation or further received Methergine 0.2mg #6 one at dinner and bedtime today then three times a day until gone per standing order.

11. RH card is given to patients with negative blood types that received the RhoGam shot during the procedure.

12. Doctor's notes to excuse from work or school are given as indicated on post-op orders. Doctor notes state patient is able to resume normal activities after three days.

13. Birth control information is given as directed per Physician.

14. Any other information is given as directed by the Physician.

15. Abnormalities in Post-Op:

    a. Nausea/vomiting/restlessness/diaphoreses. Retake patient's blood pressure for possible drop from pre-procedure blood pressure. If low blood pressure is discovered and symptomatic, patient may receive 0.4 Atropine IM x 1 dose to elevate blood pressure symptoms. Patient is educated about need of medication due to blood pressure dropping and informed they will feel better in 5-10 minutes. Caffeine beverages are given as needed to assist in raising blood pressure.
    b. If patient has extreme nausea/vomiting that does not ease after vomiting, give patient Tigan 200mg IM per direct order of the Physician.
    c. Increased abdominal pain that does not ease after 10 minutes fundal massage to check for fundal bogginess. Possible return to Sono and possible return to procedure room for recheck and/or re-suction by Physician.
    d. Patients that did not receive any anesthesia but are having severe cramping/also those who have had anesthesia may have Toradol 30mg Po/IM as directed by the physician. Patients are informed the use of non-narcotic anti-inflammatory that helps with cramping.
    e. Patients who received anesthesia and are very drowsy and hard to arouse Spo_2 is assessed if low then 90% patient encouraged to deep breath if very drowsy and decreased reaction to sternal rub, standing orders to reverse anesthesia with Romazicon, after physician evaluation.
    f. All abnormal situations in post-op are relayed to physicians for orders.

16. Patients are released from Post-op, and then RN does not leave until the last patient has left the premises.

Pt. # _____ Pt. Name _____ Date ____/____/____

RECOVERY ROOM

Time	BP	Pulse	Pain	Flow	Comments
A			1 2 3 4 5		
D			1 2 3 4 5	S M H	

MEDICATIONS

I.V. medication given: _____

SONO _____

____ Ergonovine 0.2mg 1 P.O. upon admit
____ Doxycycline 100 mg 1 B.I.D. #6
____ Ergonovine 0.2 mg T.I.D. #6
____ Ergonovine 0.2 mg #2 Take 1 @dinner 1 @ bedtime
____ Tri-Cyclen Lo 28-Day Disp 1 Rx Ref x 2
____ Ibuprofen 800 mg #10

Scant Tissue - check up explained _____Staff/Intitial
____ Rh Immune Card: given with explanation
____ Postcare emerg. # B.C. and medications
____ Work / School Excuse
____ Femcon Fe Disp 1 Ref x 2
____ Loestrin 24 Fe 28 Disp 1 Ref x 2
____ Nuva Ring Disp 1 Ref x 2

NURSES NOTES/POST-OP INSTRUCTIONS

Other: _____

_____

_____

_____

Discharged to Driver:_____ _____ RN/LP

Patient discharged on the written order of the physcian. Condition at discharge is satisfactory and pt. ambulating with out assistance.

Time _____ _____RN/LPN _____ M.D

PATH REPORT

Date _____ Fax ☐ Reg ☐ GMS: _____ Diag: _____

Follow up: _____

_____

_____

CHECK UP

Date _____ Preg. Test _____ Hgb _____ Sono _____

Follow Up _____

_____

Medication _____

_____ M.

Revised 08/11

Ex E5

OSHA, Fire Drill, Disaster, and Emergency Training

DATE:

OSHA TRAINER: MARGARET VAN DUYN RMT

PATIENT EMERGENCY TRAINER: P1 + P3 ACLS 7/21/11

POLICY/PROCEDURE TRAINER: "

(Name)	July 14 (date)	July 27 (date)
	OSHA / Emerg Fire/Bomb	Post Op. Em.
1. WB 49 (Wanda Beck Head Nurse)		
2. TW 85 Inj/Sono		
3. PK 15 Surg pup		
4. BB 134		
5. MY 175		
6. TJ 177 R.R. Nurse		
7. BK 185		
8. JM 195		
9. RA 201 Phlebotomist		
10. WQ 209		
11. MC 206		
12. HP 210		
13. HC 212 ACLS 7/28/11		
14.		
15.		
16. P-2 ACLS 3/4/10		
17.		
18.		
19.		
20.		

Margaret Van Duyn
Administrator

P1
Staff Physician

FIRE/BOMB/TORNADO EMERGENCY PROCEDURES

FIRE

Every Employee is familiar with the following locations:

Pull station locations:

1. Front waiting room
2. Under Front Desk (Silent Police Alarm)
3. Back Door
4. OR Hallway
5. Hallway to front door

Fire Extinguishers:

1. Front waiting room
2. Receptionist Area
3. By Doctor's Room
4. Back Door
5. By Counseling Room #4
6. By Pre-op
7. Front Door
8. Hallway by Recovery
9. Recovery

In the event of a fire, R.A.C.E. and P.A.S.S. procedures will be followed.

R.A.C.E

R = **RESCUE** anyone in immediate danger from the fire while avoiding endangerment of one's own life.

A = **ALARM** the director and staff physician and ensure activation of pull station alarm box. Silent police notification alarm is located under the front receptionist desk.

C = **CONFINE** the fire by closing all doors and windows

E = **EXTINGUISH** the fire by using P.A.S.S. with correct type of extinguisher for the fire or **EVACUATE** the area if the fire is too large for a fire extinguisher.

Each employee will evacuate the patients and patient's support persons under the discretion of the Director and staff physician. Employees will evacuate according to the evacuation routes posted in every hallway of the clinic, always using the closest route to safety. All staff and patients will meet at tree line of the back parking lot. Front receptionist responsible to bring daily patient roster so that all patients can be accounted for.

P.A.S.S

P = **PULL** the pin on the fire extinguisher

A = **AIM** the extinguisher nozzle at the base of the fire

S = **SQUEEZE** or press the handle

S = **SWEEP** from side to side until the fire is extinguished.

BOMB THREAT

1. Activate the police call button at the front reception desk.
2. Notify the director and/or physician
3. Help route the patients through the appropriate exits
4. Follow directions from the police as deemed appropriate.

TORNADO

1. Designated tornado safe spot is the O.R. hallway. All persons in the building shall immediately go the O.R. hallway in the event of a tornado warning.
2. All patients must be accounted for by the nursing staff. Nursing supervisor will report any missing persons to director.
3. All staff must be accounted for by their immediate supervisor. Supervisors will report any missing staff to the director.
4. All persons will stay in the tornado safe spot until the ALL CLEAR is issued by the National Weather Service.

EMERGENCY PATIENT CARE WILL BE FOLLOWED BY THE PROTOCOL LISTED AS Emergency Transfer and Reporting and Emergency Evacuation Plan will be followed.

Revised July 12, 2011

EX E5

PROVISION FOR FIRST AID AND EMERGENCY

Any medical emergencies occurring during a procedure at the Clinic will be dealt with as follows:

1. The Emergency Telephone Number 911 will be called for transporting the patient to the Emergency Room of Methodist Hospital of Central Illinois where we maintain a transfer agreement. If necessary, the patient will be admitted.

Should an emergency arise while the patient is at home, the following is the Clinic's procedure:

1. The patient will call the Clinic number which is a 24-hour answering service. Her call will be immediately referred to the staff person or doctor on call who will advise her to go to the Methodist Hospital Emergency entrance. She will be met there by the Clinic Coordinator, nurse, or other Clinic Representative who will stay with her until all emergency services have been provided and the patient returns home. If hospital admittance is required, the Clinic Representative will help also with this process.

FAINTING

Vaso depressor syncope, the most common type of fainting episode, is usually characterized by a sudden fall in blood pressure and a slowing of the heart. The causative stimuli may be fear, anxiety, or pain. In the early phase, there may be motor weakness, epigastric distress, perspiration, restlessness, yawning and sighing respirations. The patient may appear anxious with a pale face and cold, moist extremities. After several minutes, light-headedness, blurring of vision, and sudden loss of consciousness may occur.

The patient should be placed in the recumbent position with his head lower than the rest of his body. Airway should be maintained. Inhalation of aromatic spirits of ammonia may help revive the patient.

1. Apply O_2 at 6 LPM per mask to re-oxygenate.

CONVULSIVE SEIZURES

Paroxysmal disorders of cerebral function sudden in onset and of brief duration, characterized by recurrent attacks involving changes in the state of consciousness, motor activity, or sensory phenomena.

Signs and symptoms

Rigidity of body muscles, usually lasting from a few seconds to perhaps a half a minute, followed by jerky movements. During the period of rigidity the patient may stop breathing, bite his tongue severely, and become incontinent. There is a gradual subsidence of all symptoms.

Treatment

1. Prevent patient from hurting himself. Remove all objects from the vicinity which could cause injury. Loosen clothing if possible.

2. Turn patient on side to clear airway. Apply oxygen at 6 LPM per mask to aid in respirations. Monitor pulse ox. Observe for respiratory failure. If respiratory failure occurs, call 911, insert oral airway if no gag reflex or if gag reflex still present, use ambu bag that is connected to oxygen tank to aid respirations.

3. If convulsions continue with no apparent diminishing, call the emergency squad for transportation to the hospital. If convulsions continue administer 10 mg Valium IM.

If patient has history of seizures or epilepsy, request Valium orders from docto and reevaluate with physician.

SHOCK: ANAPHYLACTIC

Signs and Symptoms

Typically, in 1 to 15 minutes, the patient complains of a sense of uneasiness and becomes agitated and flushed. Palpitation, parasthesias, pruritus, throbbing in the ears, coughing, sneezing, and difficulty breathing are other typical complaints. The patient is flushed and has a rapid pulse. The patient with vasovagal syncope (common faint) develops pallor and a slow pulse. NOTIFY THE PHYSICIAN IMMEDIATELY.

Treatment

1. LACTATED RINGERS SOLUTION IV should be started immediately with an 18 gauge needle if possible (20 gauge at least), running wide open.

2. ADRENALINE 1:1000 (0.5 mgm) - 0.5 cc in 10 cc of saline injected into IV as a bolus - slowly - 10.5 in 45 to 60 seconds.

3. DECADRON (Dexamethasone) - 25 mgm injected into IV as a bolus.

4. PHENERGAN (Antihistamine) - 25 mgm (1/2 of tubex) injected into IV as bolus, slowly 45 to 60 seconds. Remainder of tubex given IM.

Pulse should be monitored constantly. If possible, one person with stethoscope should be listening to chest.

Blood pressure should be checked every two to three minutes if possible.

The patient's airway status should be evaluated. If possible, an airway which keeps the tongue up and forward should be placed in the mouth during the early stages of treatment. An endotracheal tube should be available to use if needed.

Oral airway should be inserted then use the ambu bag connected to oxygen at 15 LPM - oral airway can be only used if no gag reflex. Otherwise, assist respirations with ambu bag making sure head and neck are positioned properly. To check for proper airway management monitor chest rise and fall NOT abdomen rise and fall.

If it is suspected the anaphylactic shock is from the Versed then Romazicon (Flumazenil) 0.2 mg should be administered IVP over 15 seconds after approval from doctor.

Note time of all events including administration of original drug. Prepare complete record for patient record and transfer.

ABRASIONS, CONTUSIONS AND LACERATIONS

If abrasions, contusions, and lacerations occur and are of a minor nature, the wound should be cleaned and bandaged if necessary. If wound occurred in a fall, check for signs of fracture (pain, swelling, disfigurement, loss of motion).

Should the wound not be of a minor nature, or if signs of fracture exist, the emergency squad will be called to transport the patient to the hospital for treatment. Checking for signs and symptoms of fracture and check for distal and proximal pulses.

While waiting for the emergency squad and if the bleeding is severe, the following procedures are recommended:

1. Direct pressure
   Hold a thick dressing over the wound and apply firm pressure. If bleeding is controlled, do not remove the dressing. If bleeding continues and soaks through the dressing, add additional dressings and apply pressure even more firmly.

2. Elevation
   Unless there is evidence of fracture, a severely bleeding wound of the hand, neck, arm, or leg should be elevated. Direct pressure should be continued.

3. Pressure on the Supplying Artery
   If direct pressure plus elevation does not control the bleeding, it may be necessary to apply pressure to the supplying artery - the brachial artery for control of the arm wound and the femoral artery for control of the leg wound.

4. CAUTION!
   Usage of the pressure points to control bleeding should be used only when necessary and only from the length of time it takes to control the bleeding. Prolonged pressure in effect acts as a tourniquet with the resulting danger of loss of limb.

5. Head Injury
   In the event of head injury, evaluate pupil status, immobilize head and neck, keep the patient immobile, and check for changes in consciousness, (drowsiness, confusion, agitation), vomiting or loss of motion in extremities. If above changes occur, transport patient to hospital by emergency squad for evaluation.

EMERGENCY SURGICAL PROCEDURES

PERFORATIONS

If the operating physician believes or suspects he has perforated the uterus, he will inform the patient of the possible problem and determine correct follow-up.

LACERATIONS OF THE CERVIX

Operating physician's decision - may pack the vagina with 2" sterile packing or suture if necessary.

ATONY

In cases of uterine relaxation with more than a normal amount of bleeding, notify the physician immediately.

DRUG LIST

Current and up-to-date drugs are listed on the crash cart.

OTHER EMERGENCIES

Clinic staff is currently trained in C.P.R. and trained in shock, respiratory failure, cardiac arrest, etc.

EMERGENCIES

1. Patient Tracking

2. First Aid & Emergency

3. Protocols
    a. Fainting
    b. Convulsive Seizures
    c. Shock: Anaphylactic
    d. Abrasions, Contusions, Lacerations

4. Emergency Surgical Procedures

5. Emergency Transfer and Reporting

6. CPR Instructions/Crash Cart

7. Emergency Eyewash Instructions

8. Fire Drill Procedure

9. Fire/Bomb/Tornado Emergency Procedure

10. Extremist Activity Protocols

11. Evacuation Plan

12. Clinic Diagram

13. Reporting Threats or Acts of Violence

14. Incident Report

PROCEDURE FOR A FIRE DRILL

1. All of the major rooms contain a fire extinguisher. Locate these so you know where they are ahead of time. Read the instructions so you know how to use them if necessary. Attempt to extinguish fire with fire extinguisher or by smothering with pillow.

2. There is a fire alarm in the hallway on the way to the recovery room. Pull this to alert the fire station of the fire..

3. There are exits through the front door, utility room hall, recovery room and the back procedure hallway has an exit door.

4. First priority is to protect yourself and the patients. Get them out through the closest door. Do not worry about purses, etc. You and the patients are more important.

5. All employees will have a practice fire drill yearly.

6. All new employees will be advised of the fire drill procedure.

EMERGENCY EVACUATION PLAN FOR NATIONAL HEALTH CARE INC.

IN THE EVENT OF A FIRE, BOMB THREAT, CHEMICAL SPILL, MASS DISASTER OR OTHER EMERGENCY, THE CLINIC DIRECTOR IS RESPONSIBLE FOR DETERMINING THAT AN EMERGENCY EXISTS AND MANAGEMENT OF EMERGENCY PROCEDURES. IF THE CLINIC DIRECTOR IS NOT PRESENT, THE SUPERVISOR OF THE DAY SHALL ASSUME THIS RESPONSIBILITY. STAFF WHO BELIEVE AN EMERGENCY SITUATION EXISTS SHOULD NOTIFY THE NURSING SUPERVISOR.

1. Clinic director will designate staff person as runner to alert all areas of the clinic that an emergency is in progress and that the evacuation plan is to be implemented. In the clinic director's absence, the nursing supervisor will designate a runner.

2. The clinician is responsible for patients in the examination rooms. The medical assistant assisting the clinician will evacuate patients from the bathroom nearest to examination rooms.

3. Recovery room nurse and medical assistant are responsible for patients in their areas as well as the recovery bathroom. Non-ambulatory patients to be transferred to ambulance gurneys, covered with extra blankets and exited by way of the recovery room exit. Ambulatory patients to be wrapped in blankets and exited through recovery.

4. Patient advocates and/or medical assistants checking in patients are responsible for patients awaiting or receiving check-in services. Medical assistant working in the laboratory is responsible for removing patients from holding room and then for assignment to recovery.

5. O.R. Technician is responsible to physician and/or nurse anesthetist for removing patient in surgery and for further instructions such as emergency equipment.

6. Receptionist/phone person is responsible for calling local emergency services at 911 an for evacuating waiting room and bathroom. Assist nursing supervisor in clearing patients.

7. Supervisor of the day is responsible for verifying that all staff have been informed of the emergency in progress. This individual will check all rooms including bathrooms after persons have been evacuated.

8. Supervisor of the day shall take a list of patients scheduled for the day to aid in accounting for patients after evacuation. The supervisor shall also account for all employees following evacuation.

ALL EVACUEES TO MOVE OUT INTO THE PARKING LOT AWAY FROM THE BUILDING IN LOCATION THAT DOES NOT BLOCK ACCESS FOR EMERGENCY VEHICLES. PATIENTS TO BE ATTENDED TO ACCORDING TO THEIR NEEDS AND ARE NOT TO BE LEFT ALONE EMERGENCY EQUIPMENT AS DETERMINED BY MEDICAL STAFF SHOULD BE REMOVED TIME OF EVACUATION. IN THE EVENT OF A MASS DISASTER SUCH AS AN EARTHQUA FLOOD OR TORNADO, PUBLIC SERVICES MAY NOT BE IMMEDIATELY AVAILABLE AND EQUIPMENT NECESSARY TO MAINTAIN PATIENT'S STATUS SHOULD BE REMOVED SU AS OXYGEN, CRASH CART, IV FLUIDS, ETC.

REPORTING THREATS OF VIOLENCE OR ACTS OF VIOLENCE

Threats of violence or acts of violence against reproductive health care providers violate federal and state criminal statutes, including the new Freedom of Access to Clinic Entrances Act (FACE) 18 U.S.C. 248. This act makes it a federal crime to threaten, injure, intimidate or interfere with persons seeking or providing reproductive health services.

If you are threatened, observe suspicious activity or require emergency assistance, please do the following:

a. for emergency assistance call your local police department at telephone number 911.

b. to report threats of violence or acts of violence call your local police at telephone number 911, then the Federal Bureau of Investigation (FBI) at telephone number 676-1922.

Ex F6

Machine Maintenance Policy

It is imperative that all of our equipment be in operating condition. Keeping the equipment in proper working order will be done in the following way:

1. Yearly maintenance checks
    a. Aspiration machine
    b. Gleamer lights
    c. Centrifrige (Lab)
    d. O_2 tank
    e. Autoclaves

At this time a chart is kept with yearly service dates. This service is provided by Kirks Medical Equipment.

Each clinic day before procedures start and patients arrive the following is done.

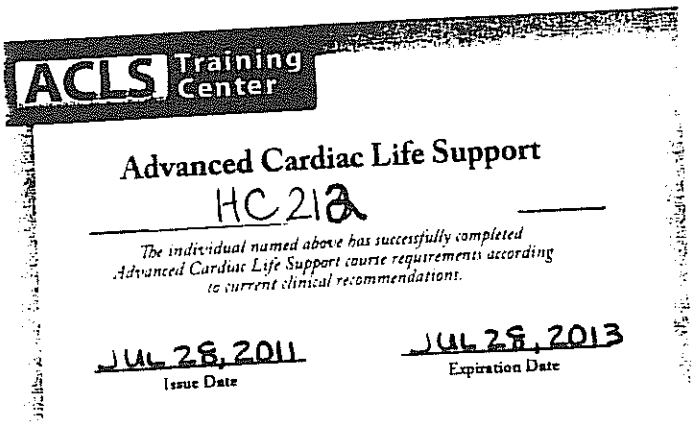
1. Vacuum machines are turned on and checked for proper pressure
2. Lights are checked to be sure that they are working
3. O2 valve is checked and pressure recorded
4. Autoclave will be put on vent to warm up sterilizers and check water level. They are then ready to go.

These checks will be recorded daily.

Daily Machine Checks

Machine/Brand/Model#	Date/Int.	Date/Int.	Date/Int.	Date/Int.	Date/Int.	Date/Int.	Date/Int.	Date/Int.
Vacuum Curettage (OR 3)/Berkeley/VCII								
Vacuum Curettage (OR 2)/Berkeley/VCII								
Vacuum Curettage (OR 1)/Berkely/SVII								
Gleamer Light (OR 3)/GL13106								
Gleamer Light (OR 2)/GL13106								
Gleamer Light (OR 1)/GL13106								
Centrifuge (Lab)/Dade/569								
Oxygen Tank/E-tank								
Autoclave/Pelton-Crane/OCR								
Autoclave/Tuttanauer/2340M								
Autoclave/Tuttanauer/2340M								

Revised 8/11



ACLS Training Center

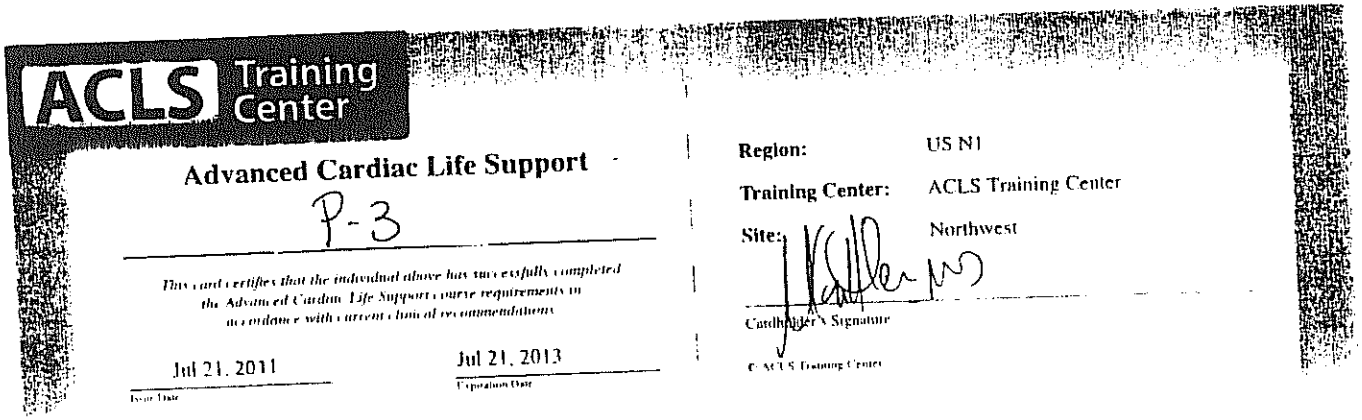
Advanced Cardiac Life Support

HC 21a

The individual named above has successfully completed Advanced Cardiac Life Support course requirements according to current clinical recommendations.

JUL 28, 2011
Issue Date

JUL 28, 2013
Expiration Date



ACLS Training Center

Advanced Cardiac Life Support

P-3

This card certifies that the individual above has successfully completed the Advanced Cardiac Life Support course requirements in accordance with current clinical recommendations

Jul 21, 2011
Issue Date

Jul 21, 2013
Expiration Date

Region: US N1

Training Center: ACLS Training Center

Site: Northwest

J K Miller MD
Cardiologist's Signature

ACLS Provider
Pacific Medical Training

Advanced Cardiac Life Support

P-2

This card certifies that the individual above has successfully completed the Advanced Cardiac Life Support course requirements in accordance with current clinical recommendations

MAY 5,2010 — MAY 5,2012

Region: Multi-Region

Training Center: Pacific Medical Training

Site: Southwest

Cardholder's Signature

H 8

Physician Tissue Review

Month _____ **Year**_____

Surgery Date: _____ Charts Review Date _____ Physician_____

Comments: _____

_____

Surgery Date: _____ Charts Review Date _____ Physician_____

Comments: _____

_____

Surgery Date: _____ Charts Review Date _____ Physician_____

Comments: _____

_____

Surgery Date: _____ Charts Review Date _____ Physician_____

Comments: _____

_____

Surgery Date: _____ Charts Review Date _____ Physician_____

Comments: _____

_____

Surgery Date: _____ Charts Review Date _____ Physician_____

Comments: _____

_____

Surgery Date: _____ Charts Review Date _____ Physician_____

Comments: _____

_____

End of Month Review

_____
Benard Smith, M.D
Medical Director

_____
Margaret Van Duyn
Administrator

Revised July 12, 20111

EX
I 9

Procedure Policy Review
Yearly Review

January 2011

Date: _____ _____
Medical Director

Comments: _____
_____
_____
_____
_____

January 2012

Date: _____ _____
Medical Director

Comments: _____
_____
_____
_____
_____

January 2013

Date: _____ _____
Medical Director

Comments: _____
_____
_____
_____
_____

Policy Procedure and Procedural Change

The Policy and Procedure Manual will be reviewed yearly. A comment section will be provided.

Incorporated in this section is also a procedural change. Whenever a change is made in the clinic, it will always be discussed by the Consulting Committee but in addition will be reviewed and signed off by the Medical Director. This will also be noted in the Q.I.

The Administrator will check this for completion yearly and whenever there is a procedural change.

Revised July 12, 2011

Procedure Change

Date: _____

Describe Change: _____

_____

_____

_____

_____

_____
Medical Director

_____
Administrator

Revised July 13, 2011

J 10

Job Orientation and Certification

Filed in Employee Chart

Employee: _____

Position: _____

Training Start Date: _____

Facilitator: _____

Comments: _____

_____

_____

_____

_____

_____

Training Completion Date: _____

_____
Employee Signature

_____
Facilitator

_____
Date

_____
Administrator

This will be filed in the employee record. Every task the employee is assigned will be evaluated in this manner.

Revised 7-13-11

J 10
K 11

Lidocaine Medication Log

All bottles will be labeled and initialed by the compounding nurse.

The compounding nurse will oversee the drawing up of the medication and she will initial the following log.

Personnel trained to draw up the Lidocaine Mix will also be listed. The Administrator will be responsible to follow.

Date	# Drawn	# Discarded	RN/LPN	Assistant/Administrator

Revised 8-02-11

Pertains to All QI EX 16

Q.I. (QUALITY IMPROVEMENT TEAM)

Team Members Management

Executive Director	Margaret Van Duyn
Medical Director	Bernard Smith M.D.
Laboratory Director	Bernard Smith M.D.

Working Q.I. Team

Director	Margaret Van Duyn
Lab & Sono	TW 85
Recovery Room	TS 177
Operating Room	WB 49 Wendy Beth RN
Counseling	TS 177
Surg. Prep.	PK 15
Officer Manager	RA 201

The Q.I. team will review problems by the work area involved. Every quarter we will all discuss the problem areas together.

Q.I. reports will be put in writing on a quarterly basis and kept in a binder.

The Q.I. team review includes, but not limited to, the following:

1. Policy and procedural change
2. Patient care
3. Monitoring employees and staff training
4. Ensure reviews, maintenance and inspections are performed as scheduled
5. Keeping paperwork up to date and current

Ex 17

Pt. # _____ Pt. Name _____ Date ____/____/____

SONO

1. LMP _____ Calc WK _____ Gravida ____ Para ____ SONO WEEKS _____

Sac Seen _____ Yolk Sac _____ Fetal Pole _____ CRL _____ B.P.D. _____

Other _____ _____ lr

LAB

2. Preg Test Sens: _____ Hgb _____ Rh _____

Rho-Gam _____ Tech _____

PRE-OP

3. Time _____ B.P. _____ Pulse _____

Misoprostol info: ☐ _____ Pt. Int. Misoprostol 200 mcg#2 ☐ _____ Int.

P.E.

4. Gest _____ Ant _____ Mid _____ Post _____ Adnexa _____

Abnormalities were noted in the following areas: Heart _____ Lungs _____ Abd _____ Pelvis _____

OR NOTES

Admit Time _____ B.P. _____ Pulse _____ O_2 Sat _____

A. Paracervical block, Lidocaine HCL 1% 15 ml 20 ml Additives in block: 5cc 8.4% Sodium Bicarbonate 0.2 ml Vasopress per 45cc Lidocaine

☐ Fentanyl 50 mcg given I.V. Midazolam HCL 2.5 mg ☐ 2.0 mg ☐ Time _____ _____ M.D./RN

B. Cervix dilated to _____ Uterine Depth _____ Cannula _____ mm Blood Loss: _____ mL Tissue to P.L.

Rho - GAM: Cervical ☐ IM ☐ Mini 50ug ☐ Full 300ug ☐ Methergine 0.2 mg/cervical ☐ Pitocin 10 units / cervical ☐

C. L.O.C. Alert & Responsive ☐ Easily Arousable ☐ Other: _____

_____

_____

_____

I have reviewed the patient's medical history, performed a physical exam and found them to be within the clinic's guidelines.

_____ RN

_____ M.

Discharge: Satisfactory ☐ Walked to RR c assist. ☐

EX - 7 a U

National Health Care Inc. Quarter:_____ Year: _____
Quarterly Abortion Report

	Jan	Feb	Mar	Qtr1	Apr	May	Jun	Qtr2	Jul	Aug	Sep	Qtr3	Oct	Nov	Dec	Qtr4	Year Totals
Total Number of Patients																	
12 Weeks or Less (LMP)																	
13 to 16 weeks (LMP)																	
Medical AB < 9 wks																	
No. of Follow-up																	
ABORTION INCIDENTS																	
No. of Incomplete Abs																	
No. of Failed Abortions																	
No. of Perforations																	
No. of Infections																	
No. of Hemorrhages																	
No. of Ectopic Pregnancy																	
No. of Deaths*																	
Other (Specifiy_____)																	
INCIDENT MANAGEMENT																	
No. of Resuctions																	
No. of Hospitalizations																	
No. of Transfusions																	
No. of Laparotomies																	
No. of Laparoscopies																	

*Submit immediately an Abortion Incident Report

RULES AND REGULATIONS	IN COMPLIANCE YES	NO	N/A	COMMENTS
SUBPART B: OWNERSHIP AND MANAGEMENT **Section 205.220 Organizational Plan** An organizational plan shall be known to the staff and available for public information in the facility. The document shall clearly set forth the organization, duties, responsibility, accountability and relationships of professional staff and other personnel. All owners, administrators, professional staff and ancillary personnel shall act in accordance with this document. This document shall be submitted to the Department with the initial application and thereafter will be reviewed at regular inspections by the Department.		✓		organizational chart Opt - Ø delineation between physicians, RNs, LPNs, Surg Tech, & lab staff, sonogram staff counseling staff

RULES AND REGULATIONS	IN COMPLIANCE YES	NO	N/A	COMMENTS
Section 205.230 Standards of Professional Work Management and/or the owner of the ambulatory surgical treatment center shall maintain proper standards of professional work in the licensed facility.				
(a) A qualified consulting committee shall be appointed in writing by the management and/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 consulting committee shall meet not less than quarterly and shall document all meetings with written minutes. These written minutes shall be maintained a the facility and shall be available for inspection by the Department.		✓		
(1) 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 a consulting physician of that specialty on the consulting committee.	✓			
(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.		✓		Procedure for granting privileges

RULES AND REGULATIONS	IN COMPLIANCE YES	NO	N/A	COMMENTS
Section 205.230 Standards of Professional Work (Continued)				
(3) Credentials shall be provided by those physicians seeking practice privileges. These credentials shall be reviewed by the credentials committee and specific practice privileges identified and recorded. Record of such accepted practice privileges shall be available for facility staff use and public information within the facility.		✓		ϕ privileges
(4) Each member of the medical staff granted specific surgical practice privileges shall provide a notarized statement or documentation indicating the name of the Illinois' licensed hospital(s) where they have skilled-equivalent practice privileges. Such statements or documentation shall be available for inspection by the Department. A list of privileges granted each medical staff member of the ambulatory surgical treatment center shall be available at all times for use by the staff of the center and for inspection by Department staff. As used in this subsection, "skilled-equivalent" means the ability to perform similar procedures requiring the same level of training and expertise.		✓		ϕ copy of privileges or skilled-equivalent @ any Illinois hospital notarized in file

RULES AND REGULATIONS	IN COMPLIANCE YES	NO	N/A	COMMENTS
Section 205.230 Standards of Professional Work (Continued)				
(5) The consulting committee shall act as a tissue committee and shall review at least quarterly pathological reports from procedures performed by each physician on the staff. Evidence of such review shall be recorded in the minutes.		✓		@ quarterly mtgs
(b) A qualified physician shall be designated "Medical Director."				Dr Bernard Smith
(1) The Medical Director shall secure compliance with the policies and procedures pertaining to medical and surgical procedures, approved by the consulting committee.		✓		only the Administrator approved P&P manual @ doc. Consulting committee passed these.
(2) The Medical Director shall be responsible for the implementation of 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.		✓		(1) LPNs giving IV meds. (2) Med Assist (CMA) compounding meds. (3) Sonography by nurse 5 training

RULES AND REGULATIONS	IN COMPLIANCE YES	NO	N/A	COMMENTS
Section 205.230 Standards of Professional Work (Continued)				
(3) The Medical Director shall establish and secure compliance of standards for the observation of patients by nursing personnel during the postoperative period.	✓			
Section 205.240 Policies and Procedures Manual				
The management/owner of the ambulatory surgical treatment center shall formulate a written policies and procedures manual. This shall be done in cooperation with the medical and professional staff and shall be approved by the consulting committee. These 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 manual shall be available to all staff in the center and shall be followed by them at all times in the performance of their duties.	✓ to policies but Ø documentation Consulting committee ✓ Sed Anesthesia			LPN's giving IV sedation Ø ACLS or PALS for RN's 1 of 4 physicians = ACLS 2 of 4 physicians = PALS

RULES AND REGULATIONS	IN COMPLIANCE YES	NO	N/A	COMMENTS
Section 205.310 Personnel Policies Each ambulatory surgical treatment center shall have written personnel policies including job descriptions for each staff position, which shall include minimum qualifications required for the position. There shall be a documented procedure for orientation of new employees to the facility's policies and procedures as well as the personnel policies including a copy of the appropriate job description.		✓		Ø Job descriptions readily Ø orientation process and log of orientation Ø updated competencies Ø personnel file for E-5, E-11, E-15
(a) Prior to employing any individual in a position that requires a State license, the ambulatory surgical treatment center shall contact the Illinois Department of Financial and Professional Regulation to verify the individual's license is active. A copy of the license shall be placed in the individual's personnel file.	✓			
(b) The ambulatory surgical treatment center shall check the status of all applicants with the Health Care Worker Registry prior to hiring.			✓	
Section 205.320 Presence of Qualified Physician A qualified physician shall be present at the facility until all patients are medically discharged. The discharge criteria shall be defined by the qualified consulting committee.	~~✓~~	✓		Physician is present but Ø DC criteria. Ø consulting committee meetings

RULES AND REGULATIONS	IN COMPLIANCE YES	NO	N/A	COMMENTS
Section 205.330 Nursing Personnel				
(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 time, on the premises, when patients are present.	✓			
(b) Nursing care may be provided by student nurses and licensed practical nurses who have been trained in observation and emergency techniques for preoperative and postoperative care of surgical patients and who are under the direct personal supervision of a registered nurse at all times.		✓		Ø training documentation 3 of 3 LPN's.
Section 205.340 Basic Life Support				
At least one person who is certified in "Basic Life Support" by the American Heart Association shall be on the premises while patients are present.		✓		

RULES AND REGULATIONS	IN COMPLIANCE YES	NO	N/A	COMMENTS
Section 205.350 Laboratory Services Each ambulatory surgical treatment center shall meet each of the following requirements: (a) Possess a valid Clinical laboratory Improvement Amendments (CLIA) certificate for those tests performed by the facility (57 Fed. Reg. 40, pp 7135-7139, February 28, 1992-Medicare, Medicaid and CLIA Programs; Regulations Implementing the Clinical Laboratory Improvement Amendments of 1988 (CLIA), No further editions or amendments included).	✓			
(b) Have a written agreement with a laboratory which possesses a valid CLIA certificate to perform any required laboratory procedures which are not performed in the center.		✓		see laboratory form from methodist..

RULES AND REGULATIONS	IN COMPLIANCE YES	NO	N/A	COMMENTS
Section 205.410 Equipment Equipment shall be in good working order and shall be available in numbers sufficient to provide good patient care based on the procedures to be performed in the facility.		✓		ØP.M. on any equipment Portable O_2 tank — "in refill line" 10/16/2002 in hallway next to crash cart.
(a) Monitoring equipment, suction apparatus, oxygen and related items available within the surgical and postoperative recovery area. Cardiac pulmonary resuscitation equipment shall be available in all facilities.	✓			Rm#3/ Barkly model VC II, 1- Gleamer light, 1-Welch Allyn BP machine Sterilizer Area: 1-Pelton-Crane 2 ~~Tuttnauer~~ Tuttnauer Sonogram Rm - Sono machine Lab Rm - Centrifuge
(b) The facility shall have written procedures governing the care, use, sterilization, storage and disposal of all materials to insure that an adequate supply of sterile equipment is available for each procedure.	✓			
(c) The facility shall have written procedures to assure safety in storage and use of inhalation anesthetics and medical gases in accordance with NFPA Standard No. 99.			✓	
(d) The facility shall be written procedures to assure the safety in storage and use of all narcotics and medications in accordance with state and federal law.		✓		Fentanyl + Midazolam - on each procedure stand in 3 of 3 Rm Rm#1 open fentanyl + [illegible] [illegible] Rm#2 " open + [illegible] midazolam Vials open + Ødated Rm#3 [illegible] 1 vial Atropine in each room. Misoprostol 100 mcg/ [illegible] bottle + [illegible] bottle in Rec Rm unlocked drawer ~~[illegible]~~ ~~[illegible]~~ Counseling Rm c̄ 10 [illegible]

Med cups c̄ 2 Aleve in each on lampstand.

RULES AND REGULATIONS	IN COMPLIANCE YES	NO	N/A	COMMENTS
Section 205.410 Equipment (Continued) (e) Facilities using laser equipment shall maintain documentation that the equipment is registered with the Illinois Emergency Management Agency as is required by the Laser System Act of 1997 [420 ILCS56]. The facility shall also have a written safety and maintenance program related to the use of the laser equipment.			✓	
Section 205.420 Sanitary Facility (a) The ambulatory surgical treatment center shall insure maintenance of a sanitary facility with all equipment in good working order. Written procedures shall include provision for garbage and refuse removal, insect and rodent control, maintenance of water, heat, ventilation and air conditioning, and electrical service.		✓		Requisition type forms for [illegible] 1994 + the 2 [illegible] 1995. "we call them [illegible] problems" Sterilizer cleaning food on the cart (2 cups of nut snacks) + cookie (pkg.) emesis basins + open bandaids + open 2x2's 3 of 3 proc. rooms
(b) Any blood, blood components, organs, semen, or other human tissue showing exposure to Human Immunodeficiency Virus (HIV) as evidenced by two of three reactive ELISA test results (according to the package insert – product circular), or exposure to any other identified causative agent of Acquired Immunodeficiency Syndrome (AIDS), and any blood, blood components, organs, semen, or other human tissue originating from a patient diagnosed with AIDS or ARC as defined in 77 Ill. Adm. Code 693.20, shall be disposed of by the center in accordance with subsection (c) of this Section, or delivered in accordance with subsection (d) of this Section, to a research facility to use such blood, blood components, organs, semen, or other human tissue for AIDS research.	✓			Medication Closet 4 boxes c̄ meds + Pt care items on floor

RULES AND REGULATIONS	IN COMPLIANCE YES	NO	N/A	COMMENTS
Section 205.420 Sanitary Facility (Continued)				
(c) Any such blood, blood components, organs, semen, or other human tissue, and any other materials or paraphernalia exposed to, or contaminated by, such blood, blood components, organs, semen, or other human tissue shall be completely incinerated, sterilized, or sealed in order to render the materials innocuous before disposal or removal from the premises.				
(1) The incineration of materials shall be done in accordance with the requirements of the Pollution Control Board concerning the operation of an incinerator (35 Ill. Adm. Code 724).	✓			
(2) The sterilization of materials shall be done by autoclaving the materials in accordance with the recommendations of the manufacturer of the autoclave. The effectiveness of the autoclave shall be verified and documented at least weekly with a biological spore assay containing B. stearothermophilus.	✓			
(3) Incinerated or sterilized materials shall be disposed of through routine waste disposal methods.	✓			Cleaning see previous page of autoclave

RULES AND REGULATIONS	IN COMPLIANCE YES	NO	N/A	COMMENTS
Section 205.420 (c)(4) Sanitary Facility (Continued) (4) Materials which have not been incinerated or sterilized shall be disposed of by a waste hauler with a proper permit from the Illinois Environmental Protection Agency under rules of the Pollution Control Board (35 Ill. Adm. Code 809). These materials must be sealed, transported, and stored in biohazard containers. These containers shall be marked "Biohazard," bear the universal biohazard symbol, and be orange, orange and black, or red. The containers shall be rigid and puncture-resistant such as a secondary metal ~~or plastic~~ can with a lid that can be opened by a step-on pedal. These containers shall be lined with one or two high density polyethylene or polypropylene plastic bags with a total thickness of at least 2.5 mil. or equivalent material. The containers shall be sealed before being removed from the facility.	✓			
(d) When a center delivers such blood, blood components, organs, semen, or other human tissue to a research facility, the center shall file a report with the Department (Division of Laboratories) which shall include at least the following information:			✓	
(1) A copy of the request from the research facility for the blood, blood components, organs, semen, or other human tissue;				

RULES AND REGULATIONS	IN COMPLIANCE YES	NO	N/A	COMMENTS
Section 205.420 (d)(2) Continued				
(2) The quantity of blood, blood components, organs, semen, or other human tissue delivered;			✓	
(3) The name and location of the research facility to which the blood or other human tissue was delivered; and			✓	
(4) The date and time of delivery.			✓	
(e) A research facility, for the purposes of this Section, shall mean any clinical laboratory licensed under the Clinical Laboratory Act (Ill. Rev. Stat. 1987, ch. 111 ½ , par. 621 et. seq.), any blood bank licensed under the Illinois Blood Bank Act (Ill. Rev. Stat. 1987. ch 111 ½ , par. 601-101 et seq.) or any hospital licensed under the Hospital Licensing Act (Ill. Rev. Stat. 1987, ch. 111 ½, par. 142 et seq.)			✓	
Section 205.510 Emergency Care				
(a) Each facility shall have a written plan of procedure to be followed in case of fire, explosion, or non-patient medical emergency. This plan shall specify persons to be notified and actions to be taken and shall be known by all staff of the facility.		✓		Policy present but documentation of staff training
(b) Each facility shall be prepared to manage those emergencies which may be associated with procedures performed there.		✓		Policy present but documentation of staff training

RULES AND REGULATIONS	IN COMPLIANCE YES	NO	N/A	COMMENTS
Section 205.520 Preoperative Care				VS + pelvic + sonogram + lab work
(b) A complete medical history shall be obtained and the physical examination shall be complete. A pre-anesthetic evaluation shall be completed specifically identifying any patient sensitivity or contraindications to anesthesia.		✓		? 20 out of 30
(c) The laboratory examinations required on all admissions shall be determined by the Consulting Committee and shall be consistent with the scope and nature of the ambulatory surgical treatment center. The required list or lists of test shall be in written form and shall be available to all members of the Medical staff.	✓			
(d) Prior to procedures performed to terminate pregnancy, the physician shall establish the diagnosis of pregnancy by appropriate clinical evaluation and testing. In addition, the patient's blood Rh factor shall be determined.	✓			
(e) A written statement indicating informed consent and a signed authorization by the patient for the performance of the specific surgical procedure shall be procured and made part of the patient's clinical record.	✓			
(f) Surgical procedures shall not be performed on patient's having medical, surgical, or psychiatric conditions or complications as specified by the consulting committee in the facility's written policies.	✓			

RULES AND REGULATIONS	IN COMPLIANCE YES	NO	N/A	COMMENTS
g) Prior to admission to the facility for a surgical procedure, the patient shall be informed of the following:				
1) Patients who receive intranvenous sedation, or any other specific anesthesia technique designated by the Consulting Committee must not attempt to drive a motor vehicle immediately upon discharge from the facility.	✓			
2) Patients must make arrangements prior to admission for safe transportation from the facility upon discharge to return to home or to similar environment.	✓			
Section 205.530 Operative Care				
a) Surgical procedures shall be performed only by a qualified physician within the limits of the defined specific practice privileges that have been granted to that individual by the consulting or a committee designated by the consulting committee.		✓		© Anesthesiologists ACLS
b) Administration of Anesthesia				
1) For the purposes of this Section, anesthesia shall include intravenous sedation.				
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.				
A) A qualified anesthesiologist (as defined in 205.110)				
B) A physician licensed to practice medicine in all of its branches.				
C) A certified registered nurse anesthetist (as defined in Section 205.110) who is implementing the orders				

RULES AND REGULATIONS	IN COMPLIANCE YES	NO	N/A	COMMENTS
Section 205.530 continued of a qualified anesthesiologist, or the physician, who is performing the procedure. The qualified anesthesiologist or physician who has ordered the anesthesia must be on the premises of the facility during the administration of the anesthesia. E) A registered nurse. If the ASTC policy allows the registered nurse to deliver moderate sedation ordered by a physician licensed to practice medicine in all its branches the following are required: i) *The registered nurse must be under the supervision of a physician licensed to practice medicine in all its branches, podiatrist, or dentist during the delivery or monitoring of moderate sedation and have no other responsibilities during the procedure.* ii) *The registered nurse must maintain current Advanced Cardiac Life Support certification or Pediatric Advanced Life Support certification as appropriate to the age of the patient.* iii) *The supervising physician licensed to practice medicine in all its branches, podiatrist, or dentist must have training and experience in delivering and monitoring moderate sedation and possess clinical privileges at the ASTC to administer moderate sedation or analgesia.* iv) *The supervising physician licensed to practice medicine in all its branches, podiatrist, or dentist must remain physically present and available on the premises during the delivery of moderate sedation for diagnosis, consultation, and treatment of emergency medical conditions.*	✓	✓ ✓ ✓		

RULES AND REGULATIONS	IN COMPLIANCE YES	NO	N/A	COMMENTS
Section 205.530 continued v) *The supervising physician licensed to practice medicine in all its branches, podiatrist, or dentist must maintain current Advanced Cardiac Life Support certification or Pediatric Advanced Life Support certification as appropriate to the age of the patient.*		✓		
vi) *Local, minimal, and moderate sedation shall be defined by the Division of Professional Regulation of the Department of Financial and Professional Regulation. Registered nurses shall be limited to administering medications for moderate sedation at doses rapidly reversible pharmacologically as determined by rule by the Division of Professional Regulation of the Department of Financial and Professional Regulation.* (Section 6.7(b) of the Act)	✓			
vii) *Nothing in* the Act or this Section *precludes a registered nurse from administering medication for the delivery of local or minimal sedation ordered by a physician licensed to practice medicine in all its branches, podiatrist, or dentist.* (Section 6.7(a) of the Act)	✓			
3) An anesthesia assistant who is licensed as a physician's assistant pursuant to the Physician Assistant Practice Act of 1987 [225 ILCS 95] may assist in the administration of anesthesia only under the direct supervision of a qualified anesthesiologist (as defined in Section 205.110 of this Part).			✓	
4) The person administering anesthesia, or a person who has equivalent practice privileges, shall be present in the facility during the recovery of the patient to whom anesthesia was administered.	✓			

RULES AND REGULATIONS	IN COMPLIANCE YES	NO	N/A	COMMENTS
Section 205.530 continued 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, podiatric physician, or dentist, each of whom shall have practice privileges at the facility, or by a consulting radiologist approved by the consulting committee. A copy of the x-ray report shall be filed in the patient's clinical record within seven days.			✓	
e) *A registered nurse, qualified by training and experience in operating room nursing, shall be 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. (Section 6.5(2.5) of the Act)	✓			10/2c = CPAP + Plupcusin

RULES AND REGULATIONS	IN COMPLIANCE YES	NO	N/A	COMMENTS
Section 205.540 Postoperative Care				
(a) Patients shall be observed 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. No patient shall be required to leave the center in less than one (1) hour following the procedures.	✓			
(b) Rh factor sensitization prophylaxis shall be provided to all Rh negative patients following procedures performed to terminate pregnancy, in accordance with standard medical procedures.	✓			
(c) Patients in whom a complication is known or suspected to have occurred during or after the performance of a surgical procedure, shall be informed of such condition and arrangements made for treatment of the complication. In the event of admission to an inpatient facility a summary of care given in the ambulatory surgical treatment center concerning the suspected complication shall accompany the patient.	✓			
See section 205.710 b) 2 for compliance with 205.740 d) or follow 205.540 d) 1-3				

RULES AND REGULATIONS	IN COMPLIANCE YES	NO	N/A	COMMENTS
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. **OR** **205.540 d)** d) To ensure availability of follow-up care at a licensed hospital, the ambulatory surgical treatment center shall provide written documentation of one of the following: 1) A transfer agreement with a licensed hospital within approximately 15 minutes travel time of the facility. 2) A statement that the medical director of the facility has full admitting privileges at a licensed hospital within approximately 15 minutes travel time and that he/she will assume responsibility for all facility patients requiring such follow-up care. 3) A statement that each staff physician, dentist, or podiatrist has admitting privileges in a licensed hospital within 15 minutes travel time of the facility.				2007 is last agreement

RULES AND REGULATIONS	IN COMPLIANCE YES	NO	N/A	COMMENTS
Section 205.540 Postoperative Care (Continued)				
(e) Written instructions shall be issued to all patients in accordance with the standards approved by the consulting committee of the ambulatory surgical treatment center and shall include the following:	✓			
(1) Symptoms of complications associated with procedures performed.	✓			
(2) Limitations and/or restrictions of activities of the patient.	✓			
(3) Specific telephone number to be used by the patient, at anytime, should any complication or question arise.	✓			
(4) A date for follow-up or return visit after the performance of the surgical procedure which shall be scheduled within six weeks.	✓			
(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.	✓			
(g) Information on availability of family planning services shall be provided, when desired by the patient, to all patients undergoing a pregnancy termination procedure. When, in the physician's opinion, it is in the best interest of the patient and with the patient's consent, family planning services may be initiated prior to the discharge of the patient.	✓			

RULES AND REGULATIONS	IN COMPLIANCE YES	NO	N/A	COMMENTS
Section 205.610 Clinical Records				
Accurate and complete clinical records shall be maintained 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:				
(a) patient identification	✓			
(b) admitting information including patient history, physical examination findings, diagnosis or need for medical services		✓		
(c) pre-counseling notes	✓			
(d) signed informed consent	✓			
(e) confirmation of pregnancy (when abortion is performed)	✓			
(f) signed physician orders	✓			
(g) laboratory test reports, pathologist's report of tissue, and radiologist's report of x-rays	✓			
(h) anesthesia record	✓			
(i) operative record	✓			
(j) medication and medical treatments	✓			

RULES AND REGULATIONS	IN COMPLIANCE YES	NO	N/A	COMMENTS
(k) recovery room progress notes	✓			
(l) physician and nurses' progress notes	✓			
(m) condition at time of discharge	✓			
(n) patient instructions	✓			
(o) post counseling notes	✓			
Section 205.620 Statistical Data				
(a) Each ambulatory surgical treatment center shall collect, compile and maintain the following clinical statistical data at the facility to be made available to the Department during a survey or inspection, or upon the Department's request:				
(1) the total number of surgical cases treated by the center;	✓			
(2) the number of each specific surgical procedure performed;	✓			
(3) the number and type of complications reported, including the specific procedure associated with each complication;		✓		
(4) the number of patients requiring transfer to a licensed hospital for treatment of complications. List the procedure performed and the complication that prompted each transfer; and		✓		

RULES AND REGULATIONS	IN COMPLIANCE YES	NO	N/A	COMMENTS
(5) the number of deaths, including the specific procedure that was preformed.		✓		
(b) This clinical statistical data shall be collected, compiled and maintained quarterly, with reports completed no later than January 31, April 30, July 31 and October 31 for the preceding quarter.	✓			
SUBPART G: LIMITED PROCEDURE SPECIALTY CENTERS				
Section 205.710 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 performed within 18 weeks assessed gestational age (beginning on the first day of the last menstrual period), and other gynecologic procedures related to the termination of pregnancy. Assessed gestational age may be determined by patient history or by clinical assessment.				
2) The center does not use general, epidural, or spinal anesthesia for any of the procedures performed. If intravenous sedation is used, mechanical ventilation devices and intubation equipment shall be available on site.				oral airways - ambu bags ? AED + ET tubes

RULES AND REGULATIONS	IN COMPLIANCE YES	NO	N/A	COMMENTS
3) The program narrative and policies of the facility are limited to the performance of procedures to terminate pregnancy and other procedures related to the termination of pregnancy. (b) The following exceptions and modifications of the requirements of the Part apply to pregnancy termination specialty centers. Pregnancy termination specialty centers shall comply with each of the requirements of this Part, unless specifically excepted or modified by the provisions of this subsection. 1) The initial and renewal application need only include the name, address, and telephone number of all owners, administrators, and medical directors of the center (in lieu of compliance with Section 205.120(b)(5) through (7) and Section 205.125(b)(5) through (7)). However, the other information required in these provisions shall be maintained at the center and be available for inspection by the Department. The information shall include the original or notarized copies of credentials of all licensed or certified personnel. 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. **Section 250.710 b) 3) – 22) is in the various LSC sections it relates to**				