DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

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

PROOF OF SERVICE

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

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

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

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

Marcia Hollins
Illinois Department of Public Health

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

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

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

FINAL ORDER

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

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

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

7-24-15
Date

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

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

CONSENT AGREEMENT AND REQUEST FOR FINAL ORDER

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

RECITALS

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

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

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

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

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

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

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

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

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

ARTICLE I
Respondent's Consideration

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

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

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

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

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

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

a. Design Development Submittal: September 4, 2015.

b. IDPH Review Complete: September 18, 2015.

c. Construction Document IDPH Submittal (100%): January 8, 2016.

d. IDPH Review Complete: February 5, 2016.

e. Building Permit/Bidding Completion: April 14, 2016.

f. Construction Completion: December 14, 2016.

g. Pre-occupancy Certification Submission: December 14, 2016.

h. IDPH Occupancy Permit: January 14, 2017.

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Date of procedure.

b. Type of procedure.

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

d. Gestational age of pregnancy.

e. American Society of Anesthesiologists Physical Classification.

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

g. Hospital transfer, if any.

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

ARTICLE II
Department's Consideration

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

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

ARTICLE III
General Provisions

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

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

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

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

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

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

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

[redacted]

7/24/2015

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

Date

ALBANY MEDICAL SURGICAL CENTER

[redacted]

July 24, 2015

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

Date

Attachment A

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

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

PROOF OF SERVICE

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

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

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

John K. Hughes
Hughes Socol Piers Resnick & Dym, Ltd.
70 W Madison Street
Suite 4000
Chicago, IL 60602

That said document was deposited in the United States Post Office at Chicago, Illinois, on the 11th day of March, 2015.

[redacted]

Marcia Hollins
Illinois Department of Public Health

Cc: Karen Senger, OHCR

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

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

NOTICE OF LICENSE REVOCATION;
NOTICE OF FINE ASSESSMENT;
AND NOTICE OF OPPORTUNITY FOR ADMINISTRATIVE HEARING

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

NOTICE OF LICENSE REVOCATION

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

ALLEGATIONS OF NONCOMPLIANCE

The Department has found conditions in the Facility that are threatening to the public interest, health, safety or welfare. These conditions include, but are not limited to, a substantial or continued failure to comply with the Act or rules promulgated thereunder as referenced below and in the attached exhibits; violations of provisions of the Act and the rules promulgated thereunder; and a failure to correct violations of the Act and the Code previously identified by the Department. These conditions and failure to comply with both the Act and Code have resulted in the facility's inability to meet the public interest, health, safety or welfare needs of the community. Provisions of the Code which the Department alleges have been violated include, but are not limited to, the following: 77 Ill. Admin. Code 205.840(b)(1), 77 Ill. Admin. Code 205.840(b)(2), and 77 Ill. Admin. Code 205.840(b)(3).

1. On August 28, 2013, the Department conducted a licensure survey of Respondent (hereinafter "August 2013 survey") to determine compliance with the requirements of the

Act and the Code, including the 2000 Edition of NFPA 101, Life Safety Code (hereinafter "Life Safety Code"). The Department observed conditions in the Facility that threaten the public interest, health, safety or welfare and made findings that Respondent substantially failed to comply with the Act and the Code. The nature of each failure is further described in the Statement of Deficiencies which is attached hereto as Exhibit A and made a part hereof. These conditions include, but are not limited to:

a. A violation of Section L012 of the Life Safety Code: Construction Type. This requirement regulates the number of stories and building materials permitted for ambulatory surgery centers and assures reasonable survivability of the building in a fire emergency.
b. A violation of Section L106 of the Life Safety Code: Emergency Generator. This requirement regulates the emergency generator, which provides emergency power to the facility to maintain exit paths and provide power for life sustaining equipment when normal power is lost for any reason.
c. A violation of Section L130 of the Life Safety Code: One Way Flow (infection control, functions outside of ASTC). This requirement assures that all patient and staff services required by code are located within the ambulatory surgery center and are protected by the life safety systems and emergency electrical system.
d. A violation of Section L145 of the Life Safety Code: Emergency Generator. This requirement regulates the distribution of emergency power to assure unnecessary electrical loads are not added to the emergency electrical system which may cause overload to emergency electrical panels and/or generator.

2. On September 5, 2013, Respondent was served the Statement of Deficiencies relating to the August 2013 survey and informed of the requirement to submit a Plan of Correction (hereinafter "POC") within ten calendar days of receipt of the Statement of Deficiencies pursuant to Section 5/10c of the Act and Section 205.830 of the Code.

3. On or about September 12, 2013, Respondent requested that the POC deadline be extended from September 20, 2013 to October 3, 2013. The Department allowed the extension. Respondent also requested a meeting with the Department to discuss the violations. The Department granted the request and met with Respondent on October 22, 2013.

4. Respondent failed to submit the POC by October 3, 2013.

5. On or about January 30, 2014, Respondent submitted a POC via email to the Department. The POC was not signed or dated and thereby not properly executed.

6. On or about February 28, 2014, over four months following the POC extended deadline of October 3, 2013, Respondent submitted a properly executed POC to the Department along with a request for another in-person meeting with the Department.

7. On or about March 10, 2014, the Department sent correspondence to Respondent stating the POC was not acceptable pursuant to Section 5/10c of the Act and Section 205.830 of

the Code. The Department outlined the POC's deficiencies and informed Respondent that it must submit an acceptable POC within ten days of receipt to comply with the Act and Code.

8. Respondent failed to submit the revised POC within ten days of receipt of the Department's correspondence.

9. On May 19, 2014, the Department attended a second in-person meeting with Respondent pursuant to Respondent's request.

10. On June 26, 2014, counsel for Respondent requested an extension to July 22, 2014 to submit a revised POC. The Department allowed the extension.

11. On or about July 23, 2014, the Department received a revised POC from Respondent. On or about August 1, 2014, the Department received addendums to the July 23, 2014 POC.

12. On or about August 7, 2014, the Department sent correspondence to Respondent stating the July 23, 2014 POC was not acceptable pursuant to Section 5/10c of the Act and Section 205.830 of the Code. The Department once again outlined the POC's deficiencies and informed Respondent that it must submit an acceptable POC within ten days of receipt to comply with the Act and Code.

13. On or about August 11, 2014, counsel for Respondent submitted a letter to the Department alleging purported corrections. However, Respondent did not comply with the Act and the Code and tender an acceptable POC to the Department.

14. On August 21, 2014, the Department conducted a licensure survey revisit of the Facility (hereinafter "August 2014 survey"). The Department determined that Respondent continued to substantially fail to comply with the Act and Code. The nature of each failure is further described in the Statement of Deficiencies which is attached hereto as Exhibit B and made a part hereof. Conditions identified but not corrected since August 2013 and that threaten the public interest, health, safety or welfare include, but are not limited to:

    a. A violation of Section L012 of the Life Safety Code: Construction Type. This requirement regulates the number of stories and building materials permitted for ambulatory surgery centers. This assures reasonable survivability of the building in a fire emergency.
    b. A violation of Section L106 of the Life Safety Code: Emergency Generator. This requirement regulates the emergency generator, which provides emergency power to the facility to maintain exits paths and provide power for life sustaining equipment when normal power is lost for any reason.
    c. A violation of Section L130 of the Life Safety Code: One Way Flow (infection control, functions outside of ASTC). This requirement assures that all patient and staff services required by code are located within the ambulatory surgery center and are protected by the life safety systems and emergency electrical system.

d. A violation of Section L145 of the Life Safety Code: Emergency Generator. This requirement regulates the distribution of emergency power to assure unnecessary electrical loads are not added to the emergency electrical system which may cause overload to emergency electrical panels and/or generator.

15. On August 26, 2014, the Department served the Statement of Deficiencies relating to the August 2014 survey to Respondent and informed Respondent of the requirement to submit a POC within ten calendar days of receipt of the Statement of Deficiencies pursuant to Section 5/10c of the Act and Section 205.830 of the Code.

16. On September 8, 2014, the Department received an unsigned POC from Respondent.

17. On or about October 14, 2014, the Department sent correspondence to Respondent stating the September 8, 2014 POC was not acceptable pursuant to Section 5/10c of the Act and Section 205.830 of the Code. The Department outlined the POC's deficiencies and informed Respondent that it must submit an acceptable POC within ten days of receipt to comply with the Act and Code.

18. On October 28, 2014, Respondent submitted a revised POC to the Department. The revised POC did not address the deficiencies the Department outlined on October 14, 2014 and was not acceptable pursuant to the Act or Code.

19. On or about November 24, 2014, the Department sent correspondence to the Respondent outlining the deficiencies contained in the revised POC.

20. On December 9, 2014, Respondent submitted another revised POC to the Department. The revised POC did not address the identified deficiencies and was not acceptable pursuant to the Act and Code.

21. On January 5, 2015, the Department conducted a complaint investigation survey at the Facility (hereinafter "January 2015 survey"). The Department determined that Respondent substantially failed to comply with the Act and Sections 205.320 and 205.620 of the Code. The nature of each failure is further described in the Statement of Deficiencies which is attached hereto as Exhibit C and made a part hereof. The Department found conditions that threaten the public interest, health, safety or welfare, including, but are not limited to:

    a. A violation of Section 205.320 of the Code: Presence of a Qualified Physician. This requires that a qualified physician shall be present at the facility at all times during the operative and postoperative period for all patients.
    b. A violation of Section 205.620(a) of the Code: Statistical Data. 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 survey or inspection [including, but not limited to]:
        i. the number and type of complications reported, including the specific procedure associated with each complication;

ii. the number of patients requiring transfer to a licensed hospital for treatment of complications (including a list of the procedure performed and the complications that prompted each transfer);

c. A violation of Section 205.620(b) of the Code: Statistical Data. This clinical data [referenced in Paragraph 21(b)(i)(ii) above] shall be collected and maintained quarterly, with reports completed no later than January 31, April 30, July 31 and October 31 for the preceding quarter.

22. On February 13, 2015, the Department sent the Respondent a comprehensive recitation of its efforts to effectuate Respondent's compliance with the Act and Code. The correspondence to the Respondent further outlined the deficiencies contained in the POC referenced in Paragraph 20 above and provided the Respondent one final opportunity to comply with the Act and Code.

23. Consequent to the January 2015 survey, the Department issued a Notice of Violations; Notice of Fine Assessment; and Notice of Opportunity for Administrative Hearing (hereinafter "Notice"), attached hereto as Exhibit D and made a part hereof, to the Respondent on February 13, 2015.

24. Pursuant to Section 5/10c of the Act and Sections 205.820b)4) and 205.830 of the Code, the aforementioned Notice required the Respondent to file a POC to address the cited violations within ten days of receipt of the Notice. To date, and in violation of the Act and Code, the Respondent has not submitted a POC to address the violations cited in the Notice consequent to the January 2015 survey.

25. On February 28, 2015, Respondent submitted another revised POC to the Department relating to the August 2014 survey. The revised POC did not address all the identified deficiencies and was not acceptable pursuant to the Act and Code.

The findings from the August 2013 survey, the August 2014 survey, and January 2015 survey are hereby incorporated into this Notice of Revocation and are more fully set forth in the Statements of Deficiencies, attached as Exhibit A, Exhibit B, and Exhibit C.

These conditions constitute a substantial or continued failure on the part of Respondent to comply with the Act and with the rules and regulations promulgated thereunder or incorporated therein. The Respondent has failed to demonstrate the capacity to safely provide one of more of its services to patients. The Respondent has violated the Act and Code by conduct which is detrimental to the health, safety, or welfare of its patients. The Department finds that the public interest, health, safety, or welfare requires that Respondent's license to operate an Ambulatory Surgical Treatment Center be REVOKED immediately.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 10d of the Act and Section 205.850 of the Code, the Department hereby assesses a total fine of Forty Thousand Dollars ($40,000.00) as follows:

1. Pursuant to Section 10d of the Act and Section 205.850 of the Code, the Department hereby assesses a fine of Ten Thousand Dollars ($10,000.00) for violations of Life Safety Code Section L012 as previously set forth herein:
   (September 2013 – January 2015) 16 months x $625.00/month = $10,000.00

2. Pursuant to Section 10d of the Act and Section 205.850 of the Code, the Department hereby assesses a fine of Ten Thousand Dollars ($10,000.00) for the violations of Life Safety Code Section L106 as previously set forth herein:
   (September 2013 – January 2015) 16 months x $625.00/month = $10,000.00

3. Pursuant to Section 10d of the Act and Section 205.850 of the Code, the Department hereby assesses a fine of Ten Thousand Dollars ($10,000.00) for the violations of Life Safety Code Section L130 as previously set forth herein:
   (September 2013 – January 2015) 16 months x $625.00/month = $10,000.00

4. Pursuant to Section 10d of the Act and Section 205.850 of the Code, the Department hereby assesses a fine of Ten Thousand Dollars ($10,000.00) for the violations of Life Safety Code Section L145 as previously set forth herein:
   (September 2013 – January 2015) 16 months x $625.00/month = $10,000.00

NOTICE OF OPPORTUNITY FOR HEARING

The licensee has a right to a hearing to contest these actions pursuant to, without limitation, Section(s) 5/10b, 5/10c, 5/10d, 5/10f, and 5/10g of the Act and Section 205.860 of the Code. **A written request for hearing must be sent within ten days of receipt of this Notice.** Such request for a hearing must be sent to Snigdha Acharya, Deputy General Counsel, Illinois Department of Public Health, 122 South Michigan Avenue, 7th Floor, Chicago, Illinois 60603.

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

ANSWER BY RESPONDENT

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

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

Nirav D. Shah, M.D., J.D.
Director
Illinois Department of Public Health

Dated this 10th day of March 2015

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	08/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	Initial Comments On August 28, 2013 the Life Safety portion of an Ambulatory Surgical Treatment Center Annual Licensure Survey was conducted at the above facility by Surveyor 13755. He was accompanied during the survey walk-through by the provider's Administrator and maintenance personnel. The ASTC is located in a facility comprised of a single story building with a basement attached to a two story building. The ASTC occupancy is located in the single story building with a basement and was determined to be of minimum Type II (000) construction type with no sprinkler protection. The adjacent two story building is utilized for certain required functional areas of the ASTC and was determined to be of Type III (200) with no sprinkler protection. The two story Type III (200) business occupancy building is not permitted to house the ASTC occupancy in accordance with 21.1.6.3. See L130 deficiencies relating to required ASTC functional areas located within the Business occupancy building. The ASTC occupancy was surveyed as an Existing Ambulatory Health Care Occupancy under the 2000 Edition of the NFPA 101 Life Safety Code, including Chapter 21 and the 77 IL Administrative Code 205, Ambulatory Surgical Treatment Center Licensing Requirements. The adjacent Business occupancy was surveyed as an Existing Business Occupancy under the 2000 Edition of the NFPA 101 Life Safety Code, including Chapter 39. Unless otherwise noted, those code sections listed herein that do not include a reference to a specific NFPA code and year of issue (such as NFPA 70 1999) are taken from the 2000 Edition of the NFPA 101 Life Safety Code.	L 000		

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	**08/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	Continued From page 1 Unless otherwise noted, all deficiencies cited herein were found through random observation during the survey walk-through, staff interview, or document review. The Licensing requirements are NOT MET as evidenced by the deficiencies cited under the following L-Tags.	L 000		
L 012	20.1.6.1/21.1.6.1 Construction Type 21.1.6 Minimum Construction Requirements 21.1.6.2 Buildings of one story in height housing ambulatory health care facilities shall be of any construction type in accordance with NFPA 220. 21.1.6.3 Buildings two or more stories in height..... shall be Type I, Type II (222), Type II (111), Type III (211) Type IV (2HH), or Type V (111) construction. Exception: Buildings of unprotected construction (000), if protected throughout by an approved supervised automatic sprinkler system. This Regulation is not met as evidenced by: The building housing certain ASTC required functional spaces is not of an acceptable construction type to comply with 21.1.6.3. Findings include: A. The ASTC surgical area is located within the one-story with a basement portion of the building which is of minimum Type II (000) construction type as permitted under 21.1.6.2. However, the two-story Business occupancy building houses	L 012		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	**08/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 012	Continued From page 2 multiple ASTC required functional spaces (see L130). Although the one-story with a basement building was reviewed as the ASTC occupancy and the two-story building was reviewed only as a Business occupancy, it provides required functional spaces for the ASTC occupancy. Not all required functional spaces in the Business occupancy building are permitted to be outside the ASTC occupancy as outlined under IL Administrative Code 205.1350. Therefore, the entire facility must be considered the ASTC occupancy and be of a permitted construction type. The Business occupancy building is determined to be Type III (200) construction type and not provided with a sprinkler system to comply with 21.1.6.3 Exception.	L 012		
L 020	20.3.1/21.3.1, 38.3.1/39.3.1 VERTICAL OPENINGS, SHAFTS, STAIRS Vertical openings such as stairways, elevator shaftways, escalators, HVAC shafts and building service shaftways are enclosed in accordance with Section 8.2.5. (Note: Some exceptions are permitted in 38.3.1.1 and 39.3.1.1) This Regulation is not met as evidenced by: Vertical openings are not protected in accordance with NFPA 101-2000, 21.3.1, 39.3.1.1 and 8.2.5. Findings include: A. The ASTC occupancy is located in the one-story-with-basement portion of the building constructed of masonry bearing walls and concrete plank floors and roof. The basement is utilized for a storage room/work shop and staff	L 020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	**08/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 020	Continued From page 3 locker rooms. Miscellaneous plumbing and electrical penetrations through the floor are not protected in accordance with tested UL design assemblies to afford a minimum 1-hour separation between the floor levels as required by 21.3.7.1, 39.3.2.1 & 8.4.1.1(1), and 21.1.6.4. B. Refer to L032 deficiencies regarding enclosure of exit stairs relative to protection of vertical openings.	L 020		
L 029	38.2.1/39.3.2 HAZARDOUS AREAS 39.3.2.1 Hazardous Areas: Hazardous areas that include, but are not limited to general storage, boiler or furnace rooms, and maintenance shops shall be protected in accordance with Section 8.4. High hazard areas shall comply with 39.3.2.2. This Regulation is not met as evidenced by: Hazardous areas are not protected to comply with NFPA 101-2000, 21.3.2, 39.3.2, and 8.4. A. The Men's and Women's Locker rooms for the ASTC are located in the basement and accessed through the general storage area. The location and arrangement does not comply with the requirements of 21.3.2, 39.3.2, and 8.4 relative to the separation of hazardous storage areas. Access and exiting from the Locker rooms does not comply with 7.5.1.7 relative to movement through the hazardous storage area. B. Three of three Storage rooms on the second floor of the Business occupancy used for the storage of boxes of file records are not protected as hazardous areas in accordance with 39.3.2.1	L 029		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	**08/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 029	Continued From page 4 and 8.4.1.1. The building is not sprinklered nor is 1-hour enclosure provided, including at ceilings and doors. C. The second floor Utility room containing a gas-fired water heater was not protected as a hazardous area in accordance with 39.3.2.1 and 8.4.1.1. The building is not sprinklered nor is 1-hour enclosure provided, including at ceilings and doors. The door was labeled as fire rated but installed in a non-rated wood frame. The door also had a ventilation louver which does not comply with the requirements for the fire label.	L 029		
L 032	20.2.4/21.2.4 TWO REMOTE EXITS At least two exits, located remote from each other are provided for each floor or fire section of the building. 20.2.4.1,20.2.4.2,20.2.4.3/21.2.4.1, 21.2.4.2 21.2.4.3 This Regulation is not met as evidenced by: Exits are not provided in accordance with 21.2.4.1, 39.2.2.3.1 and 7.2.2. Findings include: A. The ASTC occupancy means of egress Stairs from the Basement level are not in accordance with 7.2.2.5 relative to enclosure and 7.1.3.2.1 relative to separation. 1. The exit stair from the basement which leads only to the exterior is not separated from the interior Storage/workshop area by fire rated construction to comply with 7.1.3.2.1(a) and 7.1.3.2.1(c). The door with window and wood frame is not minimum 1-hour rated and the door is not self-closing.	L 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	**08/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 032	Continued From page 5 2. The exit stair from the basement which leads only to the exterior is utilized as a storage area for a gasoline powered lawn mower stored on an overhead shelf. Wood planking used as a ramp for material deliveries is stored along one side of the steps. A ladder and other miscellaneous materials are stored within the stair enclosure. All of the afore mentioned is prohibited under 7.1.3.2.3. 3. The exit stair from the basement which leads only to the exterior was observed to have a clothes dryer exhaust vent running through the stair enclosure in non-compliance with 7.1.3.2.1(e). 4. The exit stair from the basement which leads only to the exterior was observed to lack at least one handrail (when considered an existing stair as permitted under 7.2.2.4.2 exception no. 3). Handrails at both sides of the stair are required for new construction to comply with 7.2.2.4.2. 5. The exit stair from the basement which leads only to the exterior was observed to have the exterior door at the top of the stair equipped with a slide bolt lock in addition to panic hardware in non-compliance with 7.2.1.5.4 and 7.2.1.5.6. 6. The exit stair from the basement which appears to discharge to the adjacent Business occupancy stair which leads through an exit passageway to the exterior was observed to have a door at the basement level which was not self-closing to a latched condition. The frame lacked a strike plate and the door could not be confirmed to be minimum 1-hour rated because the label was painted.	L 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	**08/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 032	Continued From page 6 7. The exit stair from the basement which appears to discharge to the adjacent Business occupancy stair which leads through an exit passageway to the exterior was observed to have a door at the main level from the ASTC OR/Recovery area which was not self-closing to a latched condition. 8. The exit stair from the basement which appears to discharge to the adjacent Business occupancy stair which leads through an exit passageway to the exterior was observed to have a permanently installed hinged wooden ramp along one side of the stair in non-compliance with 7.1.3.2.3. 9. The exit stair from the basement which appears to discharge to the adjacent Business occupancy stair which leads through an exit passageway to the exterior was observed to have an unrated ceiling and access panel assembly at the ceiling on the discharge level in non-compliance with 7.1.3.2.1(a). 10. The exit stair from the basement was not provided with exit signage at the main level to direct the exit path into the Business occupancy stair which appears to serve as the discharge for the ASTC stair from the basement to make clear the intended path of exit. A door from the ASTC OR/Recovery area swings into the stair at this level. The door from the stair to the Business occupancy stair swings in the direction of exit travel in compliance with 7.2.1.4.3. B. The Business occupancy means of egress Stair from the second floor level is not in accordance with 7.2.2.5 relative to enclosure and 7.1.3.2.1 relative to separation.	L 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	**08/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 032	Continued From page 7 1. The exit stair in the Business occupancy which serves as the discharge for the ASTC stair from the basement and also serves as an exit for the first and second floors of the Business occupancy is not separated with 1-hour rated construction to comply with 7.1.3.2.1(a) and 7.1.3.2.1(c). The ceiling at the second floor is suspended acoustical tile open to the underside of the wood frame roof system and adjacent spaces. The door at the second floor is labeled, but is in a wood frame and has a non-rated window cut into the door. The door did not self-close to a latched condition. 2. The exit stair in the Business occupancy which serves as the discharge for the ASTC stair from the basement and also serves as an exit for the first and second floors of the Business occupancy was observed to have a storage closet under the stair containing a housekeeping cart and a storage closet under the landing storing housekeeping equipment in non-compliance with 7.1.3.2.1(d) and 7.1.3.2.3. A hand cart was also observed to be stationed in the stair at the first floor. 3. The exit stair in the Business occupancy which serves as the discharge for the ASTC stair from the basement and also serves as an exit for the first and second floors of the Business occupancy was observed to have a metal access panel at the ceiling of the discharge level which could not be confirmed to be fire rated to comply with 7.1.3.2.1(a). 4. The exit stair in the Business occupancy which serves as the discharge for the ASTC stair from the basement and leads through an exit passageway space which leads to the exterior	L 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	**08/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 032	Continued From page 8 was observed to have a return air register in the exit passageway which could not be confirmed to be provided with fire damper protection at the duct penetration of the enclosure to comply with 7.1.3.2.1(e) exception no. 1 and 8.2.3.2.4. The exit passageway also contained a large potted plant in non-compliance with 7.1.3.2.3. 5. The exit stair in the Business occupancy near the waiting room is not separated with 1-hour rated construction to comply with 7.1.3.2.1(a) and 7.1.3.2.1(c). This exit stair does not otherwise comply with 7.2.2.5.1 Exception which allows in existing buildings, where a two story exit enclosure connects the story of exit discharge with an adjacent story, the exit shall be permitted to be enclosed only on the story of exit discharge, provided that not less than 50 percent of the number and capacity of exits on the story of exit discharge are independent of such enclosures. This stair is open to both levels. C. The Business occupancy designated exterior exit at the waiting room adjacent the stair to the second floor is not maintained to comply with 7.1.10 and 7.2.1.5. 1. The door and path thereto is obstructed by chairs in non-compliance with 7.1.10.2.1. 2. The door is equipped with panic hardware and a thumb turn dead bolt lock in non-compliance with 7.2.1.5.4 and 7.2.1.5.6. The door is normally kept locked. 3. The door is provided with "emergency exit only" signage which is bolted to the panic device bar rather than being independently mounted. The signage encumbers the use of the panic device.	L 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	**08/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 046	20.2.9.1/21.2.9.1 Emergency Illumination Emergency lighting shall be provided in accordance with 7.9 and 21.2.9.2. This Regulation is not met as evidenced by: Emergency lighting is not provided in accordance with 21.2.9.1 and 7.9. Findings include: A. The facility utilizes a generator system for emergency power and battery powered emergency lighting. A checklist is provided that documents that checking of the battery powered system(s) is done on a monthly basis. However, no information is available as a written policy to describe what procedures are performed during the required monthly and annual inspection/testing of the battery powered emergency lighting system to comply with 7.9.3. 1. Battery powered emergency lighting system could not be confirmed to be tested every 30 days for a duration of 30 seconds. Testing of lamps could not be determined from the testing documentation because a list of lighting locations observed was not available or recorded. 2. Battery powered systems are not confirmed to be tested annually for a duration of 90 minutes. Testing of lamps could not be determined from the testing documentation because a list of lighting locations observed was not available or recorded. 3. Upon random testing of the battery powered emergency lighting, fixtures failed to operate at OR II and at the Business occupancy stair from the second floor. B. Illumination of the means of egress is not provided in accordance with 21.2.8 and 7.8. The	L 046		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	**08/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 046	Continued From page 10 exit discharge locations are not provided with illumination to comply with 7.8.1.4 and 7.9. 1. The ASTC exterior exit door and adjacent exterior door from the stair from the basement are provided with a single lamp fixture above the ASTC exterior exit door. Failure of this single fluorescent lamp will leave the area in darkness in non-compliance with 7.8.1.4. This lighting was not confirmed to be connected to the emergency generator to comply with 7.9.2.1. 2. No lighting is provided at the designated exterior exit door near the waiting room stair to comply with 7.8.1.4 and 7.9.2.1. 3. Lighting provided at the exterior exit door from the interior stair/exit passageway from the second floor could not be confirmed to be of instant-on type (fluorescent, incandescent, quartz, LED, halogen) and to be connected to the emergency generator to comply with 7.9.1.2 and 7.9.2.1. This lighting could not be determined to adequately illuminate the main waiting room entry door (if this door becomes the required exit).	L 046		
L 048	21.7.1, 4.6.10.1 Written Fire Plan, &/or Interim Measures There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. A simple floor plan, showing the evacuation routes, is posted in prominent locations on all floors. 31.4.1.1 This Regulation is not met as evidenced by: The written Fire & Emergency Policy &	L 048		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	**08/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 048	Continued From page 11 Procedures for the facility are not in accordance with 21.7.1.1. Findings include: A. The Fire Safety Policy #7.2, Title Fire Response Plan (specific to Elston location only) last revision 12/1/06 notes that fire alarm notification system is activated by: manual pulls, fire sprinkler system, and Heat and/or smoke detection devices. The Elston location is not provided with sprinkler protection.	L 048		
L 050	21.7.1.2 FIRE DRILLS Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift, using the fire alarm system, except at night. The staff is familiar with procedures and is aware that drills are part of established routine. 21.7.1.2 This Regulation is not met as evidenced by: Fire drills are not conducted to comply with NFPA 101-2000, 21.7.1 and 21.7.2. Findings include: A. Fire Drill records do not document that alarm signals are functional to verify that the signal has been transmitted to the monitoring agency and/or fire department to comply with 21.7.2.1. Response documents do not indicate that transmission of the signal to the monitoring agency was verified to be received during the fire alarm system activation. B. The Fire Drill for the first quarter conducted on 3/20/13 was not determined to qualify with required training procedures because response documentation was not fully completed.	L 050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	**08/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 12	L 051		
L 051	20.3.4/21.3.2 FIRE ALARM SYSTEM A manual fire alarm system, not a pre-signal type, is provided to automatically warn the building occupants. The fire alarm system is arranged to automatically transmit an alarm to summon the fire department. 20.3.4 and 21.3.4 This Regulation is not met as evidenced by: The fire alarm system is not maintained in accordance with 21.3.4.1, 9.6.1.4 and NFPA 72-1999. A. Semi-annual and annual testing of the fire alarm system components by a third party is not documented to be performed as required by NFPA 72-1999, 7-3.2. No testing documentation was available on-site for review at the time of the survey.	L 051		
L 075	Waste Receptacles 20.7.5.3, 21.7.5.5 Soiled linen or trash collection receptacles do not exceed 32 gallons (121L) in capacity. Mobile soiled linen or trash collection receptacles with capacity greater than 32 gallons (121L) are located in a room protected as a hazardous area. 20.7.5.3, 21.7.5.5 This Regulation is not met as evidenced by: Soiled linen and trash collection facilities are not in compliance with 21.7.5.5. Findings include: A. The Cover Gown Room was observed to contain a cart with gowning apparel, a clean linen storage cart and quantities of soiled linen/trash	L 075		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	**08/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 075	Continued From page 13 storage greater than 32 gal. (three 20+ gal. bags and a trash receptacle). The quantity of soiled/trash materials stored constitutes a higher degree of hazard than normal to the occupancy. The room is not sprinklered or 1-hour rated including a minimum 3/4-hour rated self-closing door to comply with 21.7.5.5, 21.3.2, 39.3.2 and 8.4.1.1(1).	L 075		
L 106	Type I ESS 3.4.2.2, 3.4.2.1.4 The ASC with life support equipment has a Type I Essential Electrical System powered by a generator with a transfer switch and separate power supply. The EES is in accordance with NFPA 99. 3.4.2.2, 3.4.2.1.4 This Regulation is not met as evidenced by: The ASTC generator system is not in compliance with NFPA 99-1999, 3-4.2.2 and 3-4.2.1.4. Findings include: A. The ASTC is permitted under its License to administer anesthesia and required by IL Administrative Code 205.1780 to have an emergency generator. Section 205.115 requires compliance with NFPA 99-1999 Health Care Facilities, NFPA 110-1999 Standard for Emergency and Standby Power Systems and NFPA 70-1999 National Electric Code. NFPA 99-1999, 3-4.2.2.1 and NFPA 70-1999, 517-45(c) Essential Electrical Systems for Ambulatory Health Care Centers requires compliance with 517-30 thru 517-35 for those areas classified as Critical Care. Critical Care is defined as those areas in which patients are intended to be subject to invasive procedures and where connected to	L 106		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	**08/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 106	Continued From page 14 line-operated, patient-care-related electrical appliances. 1. The generator is not provided with a remote manual stop to comply with NFPA 110-1999, 3-5.5.6. 2. The generator is located in an exterior enclosure which is not equipped to be maintained at a minimum temperature not less than 32 degrees F or otherwise provided with a starting battery heater to maintain battery temperature at a minimum 50 degrees F and automatically shuts off when battery temperature reaches 90 degrees F (and when prime mover is running) to comply with NFPA 110-1999, 3-3.1. 3. The generator was not observed to be provided with a remote alarm annunciator panel to comply with NFPA 99-1999, 3-4.1.1.15 and NFPA 110-1999, 3-5.5.2 to provide visual and audible alarms for the following conditions: a. Overcrank (fail to start) b. Low water temperature c. High water temperature d. Low lube oil pressure e. Overspeed f. When battery charger malfunctions g. When control switch not in auto position B. The natural gas fuel supply for the roof mounted generator is not installed in accordance with NFPA 110-1999, 5-9.7. The fuel supply for the generator is not connected ahead of the building's main shut-off valve and marked as supplying an emergency generator. The building's main gas shut-off valve is not marked or tagged to indicate the existance of a separate Emergency Power Supply shut-off valve.	L 106		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	**08/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 106	Continued From page 15 C. The emergency power system is not installed in accordance with NFPA 70-1999, 517-19. 1. Each Critical Care patient bed location (ORs and Stage 1 Recovery) and each General Care patient bed location (Stage II Recovery) is not provided with receptacles from at least two branch circuits; at least one from normal power supply and at least one from the emergency power supply to comply with NFPA 70-1999, 517-19(a) & 517-18(a). 2. Each Critical Care patient bed location at Stage I Recovery is not provided with at least 6 receptacles to comply with NFPA 70-1999, 517-19(b). 3. Each General Care patient bed location at Stage II Recovery is not provided with at least 4 receptacles to comply with NFPA 70-1999, 517-18(b) 4. Available existing emergency receptacles are not provided with labels to identify the panel and circuit from which they are fed to comply with NFPA 99-1999, 3-4.2.2.4 and NFPA 70-1999, 517 -19 & 517-33(c).	L 106		
L 130	as indicated OTHER REFERENCED REQUIREMENTS Other Referenced Requirements: NFPA 70 - 2002 NFPA 13 -1999 NFPA 25 - 1998 Illinois State Plumbing Code Illinois Accessibility Code	L 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	**08/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 130	Continued From page 16 As Indicate below: This Regulation is not met as evidenced by: Based on random observation during the survey walk-through, document review, and staff interview, the facility is not in compliance with a series of Life Safety and other code requirements that are not documented under other L-Tags. Findings include: A. Due to the number, variety, and severity of the life safety deficiencies observed during the survey walk-through, the provider shall institute appropriate interim life safety measures until all cited deficiencies are corrected. The provider shall include, as an attachment to its Plan of Correction (PoC) and referenced therein, a detailed narrative and proposed schedule for all such measures. The narrative shall describe all measures to be implemented, as well as the frequency with which they are to be conducted, and shall indicate the manner in which the measures are to be documented. The narrative shall also include comments related to changes in the interim life safety measures to remain in place as work toward the completion of its PoC progresses. B. The Cover Gown Room is utilized for storage of soiled/trash materials in the same room as clean linen and gowning apparel which violates basic infection control principles. The same room can not be used for both clean and soiled activities. Each activity requires different ventilation conditions including negative pressure relationship (exhaust) for Soiled environments and positive pressure relationship (greater supply air) for Clean environments to comply with IL Administrative Code 205.1540(f) and 205. Table A. C. The ASTC Locker rooms located in the	L 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	**08/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 130	Continued From page 17 basement which are accessed through the storage room area are not provided in accordance with IL Administrative Code 205.1370(k). 1. Changing rooms for male and female are provided, but the toilet, lavatory, and shower facilities are a shared room. Therefore, toilets and lavatories for male and female are not provided. 2. A lounge for the exclusive use of the personnel working within the surgical area does not appear to be provided. 3. The one-way flow for staff entering the surgical area through the locker rooms is not provided. Staff entering the surgical area must traverse the stair, proceed through the general storage area of the basement (deemed to be a hazardous area), enter the locker rooms to change/gown, and reverse direction and follow the same path through the genaeral storage area of the basement and proceed up the stairs to enter the surgical area. The stair provides the only interior access to the basement storage room which allows co-mingling of both gowned and ungowned personnel. D. The ASTC surgical area is not provided with a minimum 8'-0" wide corridor for transport of stretcher borne patients to an exit to comply with IL Administrative Code 205.1400(a)1. E. The doors providing access to the OR/Procedure rooms and the Stage I Recovery room needing access for stretchers were not confirmed to be minimum 3'-8" width to comply with IL Administrative Code 205.1400(b)3.	L 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	**08/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 130	Continued From page 18 F. The Recovery rooms (Stage I & Stage II) are not provided with toilet facilities within the recovery rooms to comply with IL Administrative Code 205.1360(d)3. A toilet room is provided within the surgical environment but movement through the general circulation hall is required. G. Change areas for patients in accordance with IL Administrative Code 205.1370(l) are not provided within the ASTC occupancy. Changing areas outside the ASTC occupancy in the adjacent Business occupancy appear to be available and utilized. H. Interview spaces for private interviews relating to social services, credit, and admissions is not provided within the ASTC occupancy to comply with IL Administrative Code 205.1350(d). Interview areas outside the ASTC occupancy in the adjacent Business occupancy appear to be available and utilized. I. Examination rooms are not provided within the ASTC occupancy to comply with IL Administrative Code 205.1360(a). Exam rooms outside the ASTC occupancy in the adjacent Business occupancy appear to be available and utilized. J. A control station located to permit visual surveillance of all traffic that enters the semi-restricted surgical environment (ASTC occupancy) to comply with in accordance with IL Administrative Code 205.1370(a) does not appear to be provided. K. The 'Central Supply' room believed to provide the support services for the surgical area Soiled Workroom required by IL Administrative Code 205.1370(e) & (f) appeared to be located outside	L 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	**08/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 130	Continued From page 19 the ASTC occupancy in the Business occupancy portion of the building.	L 130		
L 144	Generator Testing 3.4.4.1, NFPA 110, 8.4.2 Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1, NFPA 110, 8.4.2 This Regulation is not met as evidenced by: The emergency generator system is not inspected and tested in accordance with NFPA 99-1999, 4.3.3.1 and NFPA 110-1999, 6.4.2. Findings include: A. The facility is provided with a roof mounted natural gas fired generator system indicated to be new in 2001. The system is indicated to be 35 KW, 120/240v, single phase power. 1. The generator system weekly and monthly testing does not appear to indicate tabulation of load values for each run of the generator. Generator logs indicate "0" for all amp load tabulations. It could not be determined that loads are actually applied to the generator system. 2. Documentation indicates that the transfer time for emergency power was 30-45 seconds, thus not within the maximum 10 seconds permitted by IL Administrative Code 205.1780 and NFPA 99-1999, 3-4.4.1.1(a). 3. The starting battery is not documented to be maintained in accordance with NFPA 99-1999,	L 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	**08/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 144	Continued From page 20 3-4.4.1.3 and NFPA 110-1999, 6-3.6. If the generator is provided with a 'maintenance free' battery which precludes the checking of the electrolyte levels and specific gravity testing on a weekly basis, conductance testing of the 'maintenance free' battery is not otherwise documented (as permitted under NFPA 110-2005, 8.3.7.1).	L 144		
L 145	Type 1 EES 3.4.2.2.2 The Type I EES is divided into the critical branch, life safety branch and the emergency system in accordance with NFPA 99. 3.4.2.2.2 This Regulation is not met as evidenced by: The ASTC Essential Electrical System is not installed as a Type I system in comformance with Licensing Requirements, NFPA 110, NFPA 99 and NFPA 70. Findings include: A. The ASTC is permitted under its License to administer anesthesia and required by IL Administrative Code 205.1780 to have an emergency generator. Section 205.115 requires compliance with NFPA 99-1999 Health Care Facilities and NFPA 70-1999 National Electric Code. NFPA 99-1999, 3-4.2.2.1 and NFPA 70-1999, 517-45(c) Essential Electrical Systems for Ambulatory Health Care Centers requires compliance with 517-30 thru 517-35. NFPA 99-1999, 3-4.2.2.1 and NFPA 70-1999, 517-30(b)2 require the generating system to be comprised of a Life Safety branch and a Critical branch. The installed system did not appear to be arranged to provide power from two separate branches because only a single "emergency" panel was observed with mixed loads required to be on	L 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	**08/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

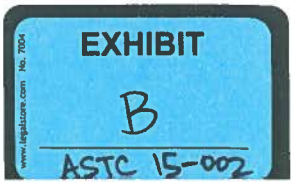
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 145	Continued From page 21 either the Life Safety branch or the Critical branch in accordance with NFPA 99-1999, 3-4.2.2.2. The emergency panel did not have all circuits identified as to their functional use to comply with NFPA 70-1999, 384-13. A one-line diagram of the emergency electrical distribution system was not reviewed.	L 145		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 000}	Initial Comments On August 21, 2014 a Life Safety Code Follow-up survey to the Ambulatory Surgical Treatment Center Annual Licensure Survey was conducted at the above facility by Surveyor 13755. He was accompanied during the survey walk-through by the provider's Administrator and maintenance personnel. Correction of some deficiencies were verified to be complete based upon direct observation during the survey walk-through, staff interview, or document review. Unresolved deficiencies or uncompleted corrections remain. On August 28, 2013 the Life Safety portion of an Ambulatory Surgical Treatment Center Annual Licensure Survey was conducted at the above facility by Surveyor 13755. He was accompanied during the survey walk-through by the provider's Administrator and maintenance personnel. The ASTC is located in a facility comprised of a single story building with a basement attached to a two story building. The ASTC occupancy is located in the single story building with a basement and was determined to be of minimum Type II (000) construction type with no sprinkler protection. The adjacent two story building is utilized for certain required functional areas of the ASTC and was determined to be of Type III (200) with no sprinkler protection. The two story Type III (200) business occupancy building is not permitted to house the ASTC occupancy in accordance with 21.1.6.3. See L130 deficiencies relating to required ASTC functional areas located within the Business occupancy building. The ASTC occupancy was surveyed as an Existing Ambulatory Health Care Occupancy under the 2000 Edition of the NFPA 101 Life Safety Code, including Chapter 21 and the 77 IL	{L 000}		



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 000}	Continued From page 1 Administrative Code 205, Ambulatory Surgical Treatment Center Licensing Requirements. The adjacent Business occupancy was surveyed as an Existing Business Occupancy under the 2000 Edition of the NFPA 101 Life Safety Code, including Chapter 39. Unless otherwise noted, those code sections listed herein that do not include a reference to a specific NFPA code and year of issue (such as NFPA 70 1999) are taken from the 2000 Edition of the NFPA 101 Life Safety Code. Unless otherwise noted, all deficiencies cited herein were found through random observation during the survey walk-through, staff interview, or document review. The Licensing requirements are NOT MET as evidenced by the deficiencies cited under the following L-Tags.	{L 000}		
{L 012}	20.1.6.1/21.1.6.1 Construction Type 21.1.6 Minimum Construction Requirements 21.1.6.2 Buildings of one story in height housing ambulatory health care facilities shall be of any construction type in accordance with NFPA 220. 21.1.6.3 Buildings two or more stories in height..... shall be Type I, Type II (222), Type II (111), Type III (211) Type IV (2HH), or Type V (111) construction. Exception: Buildings of unprotected construction (000), if protected throughout by an approved supervised automatic sprinkler system.	{L 012}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 012}	Continued From page 2 This Regulation is not met as evidenced by: The building housing certain ASTC required functional spaces is not of an acceptable construction type to comply with 21.1.6.3. Findings include: A. The ASTC surgical area is located within the one-story with a basement portion of the building which is of minimum Type II (000) construction type as permitted under 21.1.6.2. However, the two-story Business occupancy building houses multiple ASTC required functional spaces (see L130). Although the one-story with a basement building was reviewed as the ASTC occupancy and the two-story building was reviewed only as a Business occupancy, it provides required functional spaces for the ASTC occupancy. Not all required functional spaces in the Business occupancy building are permitted to be outside the ASTC occupancy as outlined under IL Administrative Code 205.1350. Therefore, the entire facility must be considered the ASTC occupancy and be of a permitted construction type. The Business occupancy building is determined to be Type III (200) construction type and not provided with a sprinkler system to comply with 21.1.6.3 Exception.	{L 012}	A new quick response sprinkler system will be installed in the one story ASTC (Type II (000)) and the adjacent 2 story (Type III (200)). The system will be installed in accordance with NFPA 13, 1999 edition. Plans completed .....02/20/15 Plan review IDPH.....03/20/15 Plan approval/Chicago.....04/30/15 Bid.....05/30/15	
{L 020}	20.3.1/21.3.1, 38.3.1/39.3.1 VERTICAL OPENINGS, SHAFTS, STAIRS Vertical openings such as stairways, elevator shaftways, escalators, HVAC shafts and building service shaftways are enclosed in accordance with Section 8.2.5. (Note: Some exceptions are permitted in 38.3.1.1 and 39.3.1.1)	{L 020}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 020}	Continued From page 3 This Regulation is not met as evidenced by: Vertical openings are not protected in accordance with NFPA 101-2000, 21.3.1, 39.3.1.1 and 8.2.5. Findings include: A. The ASTC occupancy is located in the one-story-with-basement portion of the building constructed of masonry bearing walls and concrete plank floors and roof. The basement is utilized for a storage room/work shop and staff locker rooms. Miscellaneous plumbing and electrical penetrations through the floor are not protected in accordance with tested UL design assemblies to afford a minimum 1-hour separation between the floor levels as required by 21.3.7.1, 39.3.2.1 & 8.4.1.1(1), and 21.1.6.4. UPDATE 8/21/14: Some plumbing penetrations at the Basement level were observed to be sealed with a spray-foam product identified as "Great Stuff" insulating foam sealant by Dow. This product is a polyurethane-based insulating foam sealant typically not meeting the requirements for firestopping. A UL tested design was not identified to confirm this material and the installation meets the firestopping requirements of ASTM E-814 (UL1479) testing. Duct penetrations could not be confirmed to have fire dampers and other pipe penetrations were observed to remain unsealed. B. Refer to L032 deficiencies regarding enclosure of exit stairs relative to protection of vertical openings.	{L 020}		
{L 029}	38.2.1/39.3.2 HAZARDOUS AREAS 39.3.2.1 Hazardous Areas: Hazardous areas	{L 029}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 029}	Continued From page 4 that include, but are not limited to general storage, boiler or furnace rooms, and maintenance shops shall be protected in accordance with Section 8.4. High hazard areas shall comply with 39.3.2.2. This Regulation is not met as evidenced by: Hazardous areas are not protected to comply with NFPA 101-2000, 21.3.2, 39.3.2, and 8.4. A. The Men's and Women's Locker rooms for the ASTC are located in the basement and accessed through the general storage area. The location and arrangement does not comply with the requirements of 21.3.2, 39.3.2, and 8.4 relative to the separation of hazardous storage areas. Access and exiting from the Locker rooms does not comply with 7.5.1.7 relative to movement through the hazardous storage area. B. Three of three Storage rooms on the second floor of the Business occupancy used for the storage of boxes of file records are not protected as hazardous areas in accordance with 39.3.2.1 and 8.4.1.1. The building is not sprinklered nor is 1-hour enclosure provided, including at ceilings and doors. C. The second floor Utility room containing a gas-fired water heater was not protected as a hazardous area in accordance with 39.3.2.1 and 8.4.1.1. The building is not sprinklered nor is 1-hour enclosure provided, including at ceilings and doors. The door was labeled as fire rated but installed in a non-rated wood frame. The door also had a ventilation louver which does not comply with the requirements for the fire label.	{L 029}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 032}	Continued From page 5	{L 032}		
{L 032}	20.2.4/21.2.4 TWO REMOTE EXITS At least two exits, located remote from each other are provided for each floor or fire section of the building. 20.2.4.1,20.2.4.2,20.2.4.3/21.2.4.1, 21.2.4.2 21.2.4.3 This Regulation is not met as evidenced by: Exits are not provided in accordance with 21.2.4.1, 39.2.2.3.1 and 7.2.2. Findings include: A. The ASTC occupancy means of egress Stairs from the Basement level are not in accordance with 7.2.2.5 relative to enclosure and 7.1.3.2.1 relative to separation. 1. Corrected 8/21/14. 2. The exit stair from the basement which leads only to the exterior is utilized as a storage area for a gasoline powered lawn mower stored on an overhead shelf. Wood planking used as a ramp for material deliveries is stored along one side of the steps. A ladder and other miscellaneous materials are stored within the stair enclosure. All of the afore mentioned is prohibited under 7.1.3.2.3. UPDATE 8/21/14: The gasoline powered lawn mower and wood plank used as ramp was observed to be removed. However, the ladder and other miscellaneous stored materials were observed to remain. 3. Corrected 8/21/14. 4. Corrected 8/21/14. 5. Corrected 8/21/14. 6. Corrected 8/21/14.	{L 032}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 032}	Continued From page 6 7. Corrected 8/21/14. 8. Corrected 8/21/14. 9. The exit stair from the basement which appears to discharge to the adjacent Business occupancy stair which leads through an exit passageway to the exterior was observed to have an unrated ceiling and access panel assembly at the ceiling on the discharge level in non-compliance with 7.1.3.2.1(a). 10. The exit stair from the basement was not provided with exit signage at the main level to direct the exit path into the Business occupancy stair which appears to serve as the discharge for the ASTC stair from the basement to make clear the intended path of exit. A door from the ASTC OR/Recovery area swings into the stair at this level. The door from the stair to the Business occupancy stair swings in the direction of exit travel in compliance with 7.2.1.4.3. UPDATE 8/21/14: It could not be confirmed whether this exit stair and entire path to the exterior was provided with emergency lighting. Existing directional exit signage within the Business occupancy stair is not visible along the path from the exit stair from the basement to identify the continuation of the exit path. Battery powered lighting was not observed within the exit stair from the basement and the fluorescent lighting provided could not be confirmed by staff to be connected to the generator system. Surveyor notes that if emergency lighting is powered by the generator system, the generator is a required emergency generator system which must comply with NFPA 99 and 110. B. The Business occupancy means of egress Stair from the second floor level is not in	{L 032}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 032}	Continued From page 7 accordance with 7.2.2.5 relative to enclosure and 7.1.3.2.1 relative to separation. 1. The exit stair in the Business occupancy which serves as the discharge for the ASTC stair from the basement and also serves as an exit for the first and second floors of the Business occupancy is not separated with 1-hour rated construction to comply with 7.1.3.2.1(a) and 7.1.3.2.1(c). The ceiling at the second floor is suspended acoustical tile open to the underside of the wood frame roof system and adjacent spaces. The door at the second floor is labeled, but is in a wood frame and has a non-rated window cut into the door. The door did not self-close to a latched condition. 2. Corrected 8/21/14. 3. The exit stair in the Business occupancy which serves as the discharge for the ASTC stair from the basement and also serves as an exit for the first and second floors of the Business occupancy was observed to have a metal access panel at the ceiling of the discharge level which could not be confirmed to be fire rated to comply with 7.1.3.2.1(a). 4. The exit stair in the Business occupancy which serves as the discharge for the ASTC stair from the basement and leads through an exit passageway space which leads to the exterior was observed to have a return air register in the exit passageway which could not be confirmed to be provided with fire damper protection at the duct penetration of the enclosure to comply with 7.1.3.2.1(e) exception no. 1 and 8.2.3.2.4. The exit passageway also contained a large potted plant in non-compliance with 7.1.3.2.3.	{L 032}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 032}	Continued From page 8 5. The exit stair in the Business occupancy near the waiting room is not separated with 1-hour rated construction to comply with 7.1.3.2.1(a) and 7.1.3.2.1(c). This exit stair does not otherwise comply with 7.2.2.5.1 Exception which allows in existing buildings, where a two story exit enclosure connects the story of exit discharge with an adjacent story, the exit shall be permitted to be enclosed only on the story of exit discharge, provided that not less than 50 percent of the number and capacity of exits on the story of exit discharge are independent of such enclosures. This stair is open to both levels. C. The Business occupancy designated exterior exit at the waiting room adjacent the stair to the second floor is not maintained to comply with 7.1.10 and 7.2.1.5. 1. The door and path thereto is obstructed by chairs in non-compliance with 7.1.10.2.1. 2. The door is equipped with panic hardware and a thumb turn dead bolt lock in non-compliance with 7.2.1.5.4 and 7.2.1.5.6. The door is normally kept locked. 3. The door is provided with "emergency exit only" signage which is bolted to the panic device bar rather than being independently mounted. The signage encumbers the use of the panic device. UPDATE 6/21/14: This door is no longer identified by exit signage as an exit. However, the panic device and dead bolt lock remain. The panic device implies that exiting is available but is encumbered by the dead bolt lock, thru-bolts remaining on the push bar and the the chairs. The encumbrances contradict the intended	{L 032}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 032}	Continued From page 9 function of the panic device.	{L 032}		
{L 046}	20.2.9.1/21.2.9.1 Emergency Illumination Emergency lighting shall be provided in accordance with 7.9 and 21.2.9.2. This Regulation is not met as evidenced by: Emergency lighting is not provided in accordance with 21.2.9.1 and 7.9. Findings include: A. The facility utilizes a generator system for emergency power and battery powered emergency lighting. A checklist is provided that documents that checking of the battery powered system(s) is done on a monthly basis. However, no information is available as a written policy to describe what procedures are performed during the required monthly and annual inspection/testing of the battery powered emergency lighting system to comply with 7.9.3. 1. Battery powered emergency lighting system could not be confirmed to be tested every 30 days for a duration of 30 seconds. Testing of lamps could not be determined from the testing documentation because a list of lighting locations observed was not available or recorded. UPDATE 8/21/14: Forms have been created which identify the lighting being tested, but no procedures have been documented on the forms except for the most recent 8/13/14 testing. This deficiency will remain until sufficient documentation is available for review to indicate a standardized recordkeeping procedure is established and the preprinted forms or written policy define the required procedures. 2. Battery powered systems are not	{L 046}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 046}	Continued From page 10 confirmed to be tested annually for a duration of 90 minutes. Testing of lamps could not be determined from the testing documentation because a list of lighting locations observed was not available or recorded. UPDATE 8/21/14: No documentation of a 90 minute test of the battery powered emergency lighting systems was confirmed to be available or previously provided for review. 3. Corrected 8/21/14. B. Illumination of the means of egress is not provided in accordance with 21.2.8 and 7.8. The exit discharge locations are not provided with illumination to comply with 7.8.1.4 and 7.9. 1. The ASTC exterior exit door and adjacent exterior door from the stair from the basement are provided with a single lamp fixture above the ASTC exterior exit door. Failure of this single fluorescent lamp will leave the area in darkness in non-compliance with 7.8.1.4. This lighting was not confirmed to be connected to the emergency generator to comply with 7.9.2.1. UPDATE 8/21/14: A dual lamp fixture has been provided, but it could not be confirmed by staff or observation whether this lighting is powered by an emergency battery powered lighting system or the generator system. Surveyor notes that if this emergency lighting is powered by the generator system upon loss of normal utility power, the generator is a required emergency generator system which must comply with NFPA 99 and 110. Battery powered emergency lighting logs do not indicate that exit discharge lighting is included as a battery powered system being maintained.	{L 046}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 046}	Continued From page 11 2. Corrected 8/21/14. 3. Lighting provided at the exterior exit door from the interior stair/exit passageway from the second floor could not be confirmed to be of instant-on type (fluorescent, incandescent, quartz, LED, halogen) and to be connected to the emergency generator to comply with 7.9.1.2 and 7.9.2.1. This lighting could not be determined to adequately illuminate the main waiting room entry door (if this door becomes the required exit). UPDATE 8/21/14: Multiple lamp fixture are provided, but it could not be confirmed by staff or observation whether this lighting is powered by an emergency battery powered lighting system or the generator system. Surveyor notes that if this emergency lighting is powered by the generator system upon loss of normal utility power, the generator is a required emergency generator system which must comply with NFPA 99 and 110. Battery powered emergency lighting logs do not indicate that exit discharge lighting is included as a battery powered system being maintained.	{L 046}		
{L 048}	21.7.1, 4.6.10.1 Written Fire Plan, &/or Interim Measures There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. A simple floor plan, showing the evacuation routes, is posted in prominent locations on all floors. 31.4.1.1 This Regulation is not met as evidenced by: The written Fire & Emergency Policy &	{L 048}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 048}	Continued From page 12 Procedures for the facility are not in accordance with 21.7.1.1. Findings include: A. Corrected 8/21/14. B. (New 8/21/14) The Fire Response Plan dated as revised 9/17/13 and submitted for review as part of the Plan of Correction has the following deficiencies: 1. Under the "General" paragraph it is noted to "Reference attached evacuation drawing.", but a drawing attachment is not provided. 2. Under "Fire Alarm Notification System" it is noted that "the manager or her/his designee will be responsible for pulling the fire alarm at the Elston location only." The identified "RACE" procedure applies to any staff or occupant discovering any fire condition and not to a designated person. 3. Under "Operating Room/ Recovery Room Employee Procedures" refers to movement of patients to another area of the building considered to be an evacuation zone. The evacuation zones are defined in the "General" paragraph as "area of refuge"..."protected by a 1-hour smoke wall." The movement of occupants from the Recovery evacuation zone area to the OR area evacuation zone and vice-versa does not meet this requirement because both these areas are within the same smoke compartment and not separated from each other by 1-hour rated construction. 4. Under the paragraph "Manageable Fire" the policy indicates that staff discovering a fire they feel is manageable should first try and extinguish the fire. This does not follow the	{L 048}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 048}	Continued From page 13 "RACE" procedure. Discovery of any fire must follow the Rescue, Alarm, Contain, Extinguish/Evacuate protocol.	{L 048}		
{L 050}	21.7.1.2 FIRE DRILLS Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift, using the fire alarm system, except at night. The staff is familiar with procedures and is aware that drills are part of established routine. 21.7.1.2 This Regulation is not met as evidenced by: Fire drills are not conducted to comply with NFPA 101-2000, 21.7.1 and 21.7.2. Findings include: A. Fire Drill records do not document that alarm signals are functional to verify that the signal has been transmitted to the monitoring agency and/or fire department to comply with 21.7.2.1. Response documents do not indicate that transmission of the signal to the monitoring agency was verified to be received during the fire alarm system activation. UPDATE 8/21/14: Fire drill record forms have been revised, but they lack documentation to confirm that a fire alarm signal has been transmitted to the monitoring agency and/or fire department as part of the drill to comply with 21.7.2. B. Corrected 8/21/14.	{L 050}		
{L 051}	20.3.4/21.3.2 FIRE ALARM SYSTEM A manual fire alarm system, not a	{L 051}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 051}	Continued From page 14 pre-signal type, is provided to automatically warn the building occupants. The fire alarm system is arranged to automatically transmit an alarm to summon the fire department. 20.3.4 and 21.3.4 This Regulation is not met as evidenced by: The fire alarm system is not maintained in accordance with 21.3.4.1, 9.6.1.4 and NFPA 72-1999. A. Semi-annual and annual testing of the fire alarm system components by a third party is not documented to be performed as required by NFPA 72-1999, 7-3.2. No testing documentation was available on-site for review at the time of the survey. UPDATE 8/21/14: Semi-annual testing of the fire alarm system has been documented to have been performed. However, no documentation to confirm sensitivity testing of the smoke detection devices every 2 years or provide documentation to allow testing every 5 years to comply with NFPA 72-1999, 7-3.2.1 is available.	{L 051}		
{L 075}	Waste Receptacles 20.7.5.3, 21.7.5.5 Soiled linen or trash collection receptacles do not exceed 32 gallons (121L) in capacity. Mobile soiled linen or trash collection receptacles with capacity greater than 32 gallons (121L) are located in a room protected as a hazardous area. 20.7.5.3, 21.7.5.5 This Regulation is not met as evidenced by: Soiled linen and trash collection facilities are not	{L 075}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 075}	Continued From page 15 in compliance with 21.7.5.5. Findings include: A. The Cover Gown Room was observed to contain a cart with gowning apparel, a clean linen storage cart and quantities of soiled linen/trash storage greater than 32 gal. (three 20+ gal. bags and a trash receptacle). The quantity of soiled/trash materials stored constitutes a higher degree of hazard than normal to the occupancy. The room is not sprinklered or 1-hour rated including a minimum 3/4-hour rated self-closing door to comply with 21.7.5.5, 21.3.2, 39.3.2 and 8.4.1.1(1). UPDATE 8/21/14: The soiled linen storage facilities have been relocated to an exterior closet accessed from the parking lot area. However, at the time of the follow-up survey, this storage location was observed to contain a wooden cabinet with "E" size oxygen cylinders. The storage of oxygen cylinders with combustibles does not comply with NFPA 99-1999, 8-3.1.11.2(c) because in a non-sprinklered location there is not 20' of separation between the oxygen storage and the combustibles.	{L 075}		
{L 106}	Type I ESS 3.4.2.2, 3.4.2.1.4 The ASC with life support equipment has a Type I Essential Electrical System powered by a generator with a transfer switch and separate power supply. The EES is in accordance with NFPA 99. 3.4.2.2, 3.4.2.1.4 This Regulation is not met as evidenced by: The ASTC generator system is not in compliance with NFPA 99-1999, 3-4.2.2 and 3-4.2.1.4.	{L 106}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 106}	Continued From page 16 Findings include: A. The ASTC is permitted under its License to administer anesthesia and required by IL Administrative Code 205.1780 to have an emergency generator. Section 205.115 requires compliance with NFPA 99-1999 Health Care Facilities, NFPA 110-1999 Standard for Emergency and Standby Power Systems and NFPA 70-1999 National Electric Code. NFPA 99-1999, 3-4.2.2.1 and NFPA 70-1999, 517-45(c) Essential Electrical Systems for Ambulatory Health Care Centers requires compliance with 517-30 thru 517-35 for those areas classified as Critical Care. Critical Care is defined as those areas in which patients are intended to be subject to invasive procedures and where connected to line-operated, patient-care-related electrical appliances. 1. The generator is not provided with a remote manual stop to comply with NFPA 110-1999, 3-5.5.6. 2. The generator is located in an exterior enclosure which is not equipped to be maintained at a minimum temperature not less than 32 degrees F or otherwise provided with a starting battery heater to maintain battery temperature at a minimum 50 degrees F and automatically shuts off when battery temperature reaches 90 degrees F (and when prime mover is running) to comply with NFPA 110-1999, 3-3.1. 3. The generator was not observed to be provided with a remote alarm annunciator panel to comply with NFPA 99-1999, 3-4.1.1.15 and NFPA 110-1999, 3-5.5.2 to provide visual and audible alarms for the following conditions: a. Overcrank (fail to start)	{L 106}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 106}	Continued From page 17 b. Low water temperature c. High water temperature d. Low lube oil pressure e. Overspeed f. When battery charger malfunctions g. When control switch not in auto position B. The natural gas fuel supply for the roof mounted generator is not installed in accordance with NFPA 110-1999, 5-9.7. The fuel supply for the generator is not connected ahead of the building's main shut-off valve and marked as supplying an emergency generator. The building's main gas shut-off valve is not marked or tagged to indicate the existance of a separate Emergency Power Supply shut-off valve. C. The emergency power system is not installed in accordance with NFPA 70-1999, 517-19. 1. Each Critical Care patient bed location (ORs and Stage 1 Recovery) and each General Care patient bed location (Stage II Recovery) is not provided with receptacles from at least two branch circuits; at least one from normal power supply and at least one from the emergency power supply to comply with NFPA 70-1999, 517-19(a) & 517-18(a). 2. Each Critical Care patient bed location at Stage I Recovery is not provided with at least 6 receptacles to comply with NFPA 70-1999, 517-19(b). 3. Each General Care patient bed location at Stage II Recovery is not provided with at least 4 receptacles to comply with NFPA 70-1999, 517-18(b) 4. Available existing emergency receptacles	{L 106}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 106}	Continued From page 18 are not provided with labels to identify the panel and circuit from which they are fed to comply with NFPA 99-1999, 3-4.2.2.4 and NFPA 70-1999, 517 -19 & 517-33(c).	{L 106}		
{L 130}	as indicated OTHER REFERENCED REQUIREMENTS Other Referenced Requirements: NFPA 70 - 2002 NFPA 13 -1999 NFPA 25 - 1998 Illinois State Plumbing Code Illinois Accessibility Code As Indicate below: This Regulation is not met as evidenced by: Based on random observation during the survey walk-through, document review, and staff interview, the facility is not in compliance with a series of Life Safety and other code requirements that are not documented under other L-Tags. Findings include: A. Due to the number, variety, and severity of the life safety deficiencies observed during the survey walk-through, the provider shall institute appropriate interim life safety measures until all cited deficiencies are corrected. The provider shall include, as an attachment to its Plan of Correction (PoC) and referenced therein, a detailed narrative and proposed schedule for all such measures. The narrative shall describe all measures to be implemented, as well as the frequency with which they are to be conducted, and shall indicate the manner in which the measures are to be documented. The narrative shall also include comments related to changes	{L 130}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 130}	Continued From page 19 in the interim life safety measures to remain in place as work toward the completion of its PoC progresses. B. The Cover Gown Room is utilized for storage of soiled/trash materials in the same room as clean linen and gowning apparel which violates basic infection control principles. The same room can not be used for both clean and soiled activities. Each activity requires different ventilation conditions including negative pressure relationship (exhaust) for Soiled environments and positive pressure relationship (greater supply air) for Clean environments to comply with IL Administrative Code 205.1540(f) and 205. Table A. UPDATE 8/21/14: The Cover Gown Room is now identified and used as the "Interview/Social Services Exam Room". The multi-use function of this room does not comply with IL Administrative Code 205.1350(f) and 205.1360(a). The Interview/Social Services function cannot be shared with the Exam function. C. The ASTC Locker rooms located in the basement which are accessed through the storage room area are not provided in accordance with IL Administrative Code 205.1370(k). 1. Changing rooms for male and female are provided, but the toilet, lavatory, and shower facilities are a shared room. Therefore, toilets and lavatories for male and female are not provided. 2. A lounge for the exclusive use of the personnel working within the surgical area does not appear to be provided.	{L 130}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 130}	Continued From page 20 3. The one-way flow for staff entering the surgical area through the locker rooms is not provided. Staff entering the surgical area must traverse the stair, proceed through the general storage area of the basement (deemed to be a hazardous area), enter the locker rooms to change/gown, and reverse direction and follow the same path through the general storage area of the basement and proceed up the stairs to enter the surgical area. The stair provides the only interior access to the basement storage room which allows co-mingling of both gowned and ungowned personnel. UPDATE 8/21/14: The staff Lounge required by 205.1370(k) has been designated to also be the staff Changing room. These two functions are required to be separate functions in separate rooms to facilitate the separation of "clean gowned" personnel from "common ungowned" personnel for the purpose of infection control. The locker or changing room function is considered to be a transitional area where "clean gowning" takes place and once changed "clean gowned" personnel can move directly to the restricted areas. The staff lounge is considered exclusively for "clean gowned" personnel working within the restricted areas. Combining of these functional spaces does not provide for the ability for "common ungowned" staff to "avoid physical contact with clean personnel". D. The ASTC surgical area is not provided with a minimum 8'-0" wide corridor for transport of stretcher borne patients to an exit to comply with IL Administrative Code 205.1400(a)1. UPDATE 8/21/14: The clear width of the corridor measured in the hall leading to the exterior door is 59".	{L 130}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 130}	Continued From page 21 E. The doors providing access to the OR/Procedure rooms and the Stage I Recovery room needing access for stretchers were not confirmed to be minimum 3'-8" width to comply with IL Administrative Code 205.1400(b)3. UPDATE 8/21/14: The OR/Procedure room doors and the Stage I Recovery room door nearest to the OR/Procedure rooms is confirmed to be pairs of double swing doors providing the required 3'-8" width. However, the Stage II Recovery room doors are confirmed to provide only a 29" clear opening in noncompliance with IL Administrative Code 205.1400(b)2 which requires a minimum 3'-0" door and NFPA 101-2000, 21.2.3.3 which requires a minimum clear width of not less than 32". F. The Recovery rooms (Stage I & Stage II) are not provided with toilet facilities within the recovery rooms to comply with IL Administrative Code 205.1360(d)3. A toilet room is provided within the surgical environment but movement through the general circulation hall is required. G. Change areas for patients in accordance with IL Administrative Code 205.1370(l) are not provided within the ASTC occupancy. Changing areas outside the ASTC occupancy in the adjacent Business occupancy appear to be available and utilized. H. Interview spaces for private interviews relating to social services, credit, and admissions is not provided within the ASTC occupancy to comply with IL Administrative Code 205.1350(d). Interview areas outside the ASTC occupancy in the adjacent Business occupancy appear to be available and utilized.	{L 130}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 130}	Continued From page 22 UPDATE 8/21/14: The former "Cover Gown room" (located within the ASTC portion of the building) is now identified and used as the "Interview/Social Services Exam Room". The multi-use function of this room does not comply with IL Administrative Code 205.1350(f) and 205.1360(a). The Interview/Social Services function cannot be shared with the Exam function. The Interview/Social Services function appears to be located within the semi-restricted area of the ASTC rather than in a non-restricted environment. The provisions for staff and patients to enter the semi-restricted environment is not clear. I. Examination rooms are not provided within the ASTC occupancy to comply with IL Administrative Code 205.1360(a). Exam rooms outside the ASTC occupancy in the adjacent Business occupancy appear to be available and utilized. UPDATE 8/21/14: The former "Cover Gown room" (located within the ASTC portion of the building) is now identified and used as the "Interview/Social Services Exam Room". The multi-use function of this room does not comply with IL Administrative Code 205.1350(f) and 205.1360(a). The Interview/Social Services function cannot be shared with the Exam function. The Exam function appears to be located within the semi-restricted area of the ASTC rather than in a non-restricted environment. The provisions for staff and patients to enter the semi-restricted environment is not clear. J. A control station located to permit visual surveillance of all traffic that enters the	{L 130}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 130}	Continued From page 23 semi-restricted surgical environment (ASTC occupancy) to comply with in accordance with IL Administrative Code 205.1370(a) does not appear to be provided. UPDATE 8/21/14: Video surveillance of the OR/Procedure room and Recovery room area hall is provided near the "Interview/Social Services Exam Room". However, monitoring of the video surveillance is done from the 2nd floor Business/Phone Center office in the Business occupancy portion of the building. The video surveillance cannot restrict inappropriate or unauthorized entry into the semi-restricted areas. K. The 'Central Supply' room believed to provide the support services for the surgical area Soiled Workroom required by IL Administrative Code 205.1370(e) & (f) appeared to be located outside the ASTC occupancy in the Business occupancy portion of the building.	{L 130}		
{L 144}	Generator Testing 3.4.4.1, NFPA 110, 8.4.2 Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1, NFPA 110, 8.4.2 This Regulation is not met as evidenced by: The emergency generator system is not inspected and tested in accordance with NFPA 99-1999, 4.3.3.1 and NFPA 110-1999, 6.4.2. Findings include: A. The facility is provided with a roof mounted natural gas fired generator system indicated to be	{L 144}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 144}	Continued From page 24 new in 2001. The system is indicated to be 35 KW, 120/240v, single phase power. 1. The generator system weekly and monthly testing does not appear to indicate tabulation of load values for each run of the generator. Generator logs indicate "0" for all amp load tabulations. It could not be determined that loads are actually applied to the generator system. 2. Documentation indicates that the transfer time for emergency power was 30-45 seconds, thus not within the maximum 10 seconds permitted by IL Administrative Code 205.1780 and NFPA 99-1999, 3-4.4.1.1(a). 3. The starting battery is not documented to be maintained in accordance with NFPA 99-1999, 3-4.4.1.3 and NFPA 110-1999, 6-3.6. If the generator is provided with a 'maintenance free' battery which precludes the checking of the electrolyte levels and specific gravity testing on a weekly basis, conductance testing of the 'maintenance free' battery is not otherwise documented (as permitted under NFPA 110-2005, 8.3.7.1).	{L 144}		
{L 145}	Type 1 EES 3.4.2.2.2 The Type I EES is divided into the critical branch, life safety branch and the emergency system in accordance with NFPA 99. 3.4.2.2.2 This Regulation is not met as evidenced by: The ASTC Essential Electrical System is not installed as a Type I system in comformance with Licensing Requirements, NFPA 110, NFPA 99	{L 145}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 145}	Continued From page 25 and NFPA 70. Findings include: A. The ASTC is permitted under its License to administer anesthesia and required by IL Administrative Code 205.1780 to have an emergency generator. Section 205.115 requires compliance with NFPA 99-1999 Health Care Facilities and NFPA 70-1999 National Electric Code. NFPA 99-1999, 3-4.2.2.1 and NFPA 70-1999, 517-45(c) Essential Electrical Systems for Ambulatory Health Care Centers requires compliance with 517-30 thru 517-35. NFPA 99-1999, 3-4.2.2.1 and NFPA 70-1999, 517-30(b)2 require the generating system to be comprised of a Life Safety branch and a Critical branch. The installed system did not appear to be arranged to provide power from two separate branches because only a single "emergency" panel was observed with mixed loads required to be on either the Life Safety branch or the Critical branch in accordance with NFPA 99-1999, 3-4.2.2.2. The emergency panel did not have all circuits identified as to their functional use to comply with NFPA 70-1999, 384-13. A one-line diagram of the emergency electrical distribution system was not reviewed. UPDATE 8/21/14: Refer also to L032-A10 Update and L046-B Updates which identify locations where emergency lighting and exit lighting is required, but could not be confirmed by staff or observation whether this lighting is powered by an emergency battery powered lighting system or the generator system. Surveyor notes that if any emergency lighting or exit lighting is powered by the generator system upon loss of normal utility power, the generator is a required emergency generator system which must comply with NFPA 99 and 110. Battery powered emergency lighting logs do not indicate that exit discharge lighting,	{L 145}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE** **CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 145}	Continued From page 26 exit signage or other emergency means of egress lighting is included as a battery powered system being maintained.	{L 145}		

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

Ξ ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

NAME AND ADDRESS OF FACILITY: Albany Medical Surgical Center, 5086 North Elston Ave., Chicago, IL 60630

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
000 Section 205.320	An investigation survey was conducted on 1/5/15 for complaint #142856. The facility was not in compliance with Rules and Regulations for Ambulatory Surgical Treatment Centers for this survey as evidenced by: **Presence of a Qualified Physician** A qualified physician shall be present at the facility at all times during the operative and postoperative period for all patients. This requirement is not met as evidenced by: Based on document review and interview, it was determined for 3 of 14 (Pts #13, 14, & 15) patients who had surgical procedures on 12/20/14, the facility failed to ensure a physician was present during the postoperative period. Findings include: 1. Pt #2's clinical record included Pt #2 was a 22 year old pregnant female at 18 3/7 weeks		

DATE OF SURVEY _1/5/15_____ BY__30195_____ (Surveyor) _____ (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____ _____

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

Ξ ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

NAME AND ADDRESS OF FACILITY: Albany Medical Surgical Center, 5086 North Elston Ave., Chicago, IL 60630

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.320 (cont'd)	gestation who was admitted to the facility on 12/20/14 for a D & E by MD #1. The operative report included, "…palpation of the cervix revealed a high cervical laceration in the left posterior aspect of the cervix with possible extention into the fundus of the uterus…Upon recognition of the high cervical laceration, an ambulance was immediately called for transport to [Hospital] at 11:25 am. At 11:34, the Gynecology on call team and the Family Planning fellow at [Hospital] were informed of the patient, her condition, her pending arrival at [Hospital] ER and the need for surgical repair of the cervical injury…The patient remained stable during ambulance transport…Upon arrival to [Hospital] ER, the patient remained hemodynamically stable. I presented the patient to the ER physicians and the Gynecology team and transferred the patients care. [MD #1 accompanied Pt #1 in the ambulance for transfer] The plan was for diagnostic laparoscopy to evaluate the extent of the injury…" Pt #1 was transferred at 11:45 am, and the physician on duty (MD #1) left the facility at that time to accompany Pt #2.		

DATE OF SURVEY _1/5/15_____ BY__30195_____ _____
(Surveyor) (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____ _____

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

Ξ ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

NAME AND ADDRESS OF FACILITY: Albany Medical Surgical Center, 5086 North Elston Ave., Chicago, IL 60630

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.320 (cont'd)	2. On 1/5/15 at approximately 10:00 am, the clinical records were reviewed for the 14 patients admitted to the facility on 12/20/14 for surgical procedures. 3 of the 14 clinical records included that these patients were in the postoperative recovery room at the time the physician was not present in the facility. The times are as follows: -Pt #13 was a 24 year old female admitted to the facility on 12/20/14 for a D & E. Pt #13 was in recovery from 9:06 am - 12:15 pm. -Pt #14 was a 24 year old female admitted to the facility on 12/20/14 for a D & E. Pt #14was in recovery from 10:46 am - 12:51 pm. -Pt #15 was a 28 year old female admitted to the		

DATE OF SURVEY 1/5/15 BY 30195 (Surveyor)

(Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

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

Ξ ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

NAME AND ADDRESS OF FACILITY: Albany Medical Surgical Center, 5086 North Elston Ave., Chicago, IL 60630

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.320 (cont'd)	facility on 12/20/14 for a D & E. Pt #15 was in recovery from 11:43 am – 1:10 pm. 3. On 12/30/14 at approximately 10:00 am, an interview was conducted with the Medical Director (MD #3). MD #3 stated that the facility's practice is that when a patient is transferred to the hospital because of a complication during surgery, the physician doing the surgery accompanies the patient to the hospital in the ambulance. The surveyor asked MD #3 who was responsible for the patients at the facility in recovery during the time the physician was accompanying a patient to the hospital. MD #3 stated that there was always a registered nurse (RN), a nurse practitioner (NP) or physician's assistant (PA), and a certified registered nurse anesthetist (CRNA) at the		

DATE OF SURVEY 1/5/15 BY 30195 (Surveyor) _____ (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

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

Ξ ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

NAME AND ADDRESS OF FACILITY: Albany Medical Surgical Center, 5086 North Elston Ave., Chicago, IL 60630

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.320 (cont'd)	facility to be responsible for the care of the patients at the facility. MD #3 stated the physician was always available by phone during his/her absence from the facility. 4. The physician and staff schedules were reviewed for the dates of the 12 patient transfers. The schedules for each day on which surgeries were performed included one physician, one CRNA, and one advanced practice nurse or physician's assistant. The schedules did not include a physician on call to cover in case the physician needs to leave the facility if a patient is transferred. 5. On 1/5/15 at approximately 8:45 am, an interview was conducted with the Facility Administrator (E #2). E # stated that a physician (MD #4) is called to come to the facility when a patient is being transferred to assume care of the patients in recovery and continue the surgeries as scheduled. The physician does not leave the facility with the patient being transferred until		

DATE OF SURVEY _1/5/15_____ BY__30195_____ (Surveyor) _____ (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

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

☒ ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

NAME AND ADDRESS OF FACILITY: Albany Medical Surgical Center, 5086 North Elston Ave., Chicago, IL 60630

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.320 (cont'd)	MD #4 is present at the facility. The surveyor requested the facility's policy or procedure that required a physician's presence at the facility at all times when patients are in surgery or recovery and documentation of the physician on call schedule to cover when a patient needs to be transferred. E #2 stated that the facility does not have a policy or documentation that a physician is available to cover should the physician on duty need to leave the facility. E #2 stated that on 12/20/14, MD #4 was not available, and MD #1 (the physician/surgeon on duty) left the facility to accompany Pt #2 during transfer to the hospital at 11:45 am. At this time there were three patients in recovery with no physician present at the facility.		

DATE OF SURVEY _1/5/15_____ BY__30195_____ _____
(Surveyor) (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____ _____

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

Ξ ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

NAME AND ADDRESS OF FACILITY: Albany Medical Surgical Center, 5086 North Elston Ave., Chicago, IL 60630

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.620	**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...(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… (b) This clinical statistical data shall be collected and maintained quarterly, with reports completed no later than January 31, April 30, July 31 and October 31 for the preceding quarter. This requirement is not met as evidenced by:		

DATE OF SURVEY _1/5/15_____ BY__30195_____ (Surveyor)

_____ (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

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

Ξ ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

NAME AND ADDRESS OF FACILITY: Albany Medical Surgical Center, 5086 North Elston Ave., Chicago, IL 60630

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.620 (cont'd)	Based on document review and interview, it was determined for 1 of 1 (E #2) Facility Administrators, the facility failed to ensure the quarterly clinical statistical data reports included the number of patients who were transferred to a hospital. Findings include: 1. The statistical data collected quarterly by the facility was reviewed for the first 3 quarters of 2014 and included "0" patient transfers to a hospital. 2. On 12/29/14 at approximately 9:30 am, the list of patients transferred from the facility to a hospital from 01/ 2014 – 09/30/14 was reviewed and included 7 patients. 2. During an interview with the Facility Administrator (E #2) on 1/5/15 at approximately 10:00 am, E #2 stated that the		

DATE OF SURVEY _1/5/15_____ BY__30195_____ _____
(Surveyor) (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____ _____

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

Ξ ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

NAME AND ADDRESS OF FACILITY: Albany Medical Surgical Center, 5086 North Elston Ave., Chicago, IL 60630

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.620 (cont'd)	data was compiled by an outside company, and the facility was not able to enter the specific transfer data into the spreadsheet format used by that company. E #2 stated this would have to be done manually but had not been entered for the last four years.		

DATE OF SURVEY _1/5/15_____ BY__30195_____ (Surveyor)

_____ (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH, STATE OF ILLINOIS, Complainant, v. ALBANY MEDICAL SURGICAL CENTER, *License No. 7000789* Respondent.	)	Docket No. ASTC 15-001

PROOF OF SERVICE

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

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

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

That said document was deposited in the United States Post Office at Chicago, Illinois, on the 13 day of February, 2015.

[redacted]
Sharon Morris
Illinois Department of Public Health

Cc: Karen Senger, OHCR

EXHIBIT
D
ASTC 15-002

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH, STATE OF ILLINOIS, Complainant, v. ALBANY MEDICAL SURGICAL CENTER, *License No. 7000789* Respondent.	)	Docket No. ASTC 15-001

NOTICE OF VIOLATIONS; NOTICE OF FINE ASSESSMENT; AND NOTICE OF OPPORTUNITY FOR ADMINISTRATIVE HEARING

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

NOTICE OF VIOLATIONS

The Department has determined through inspection, review of records, or other means of investigation that Albany Medical Surgical Center (hereinafter "Respondent" or "Facility") located at 5086 North Elston Avenue, Chicago, Illinois 60630 is in substantial violation of the Act and the Ambulatory Surgical Treatment Center Licensing Requirements Code (77 Ill. Admin. Code 205) (hereinafter "Code"). In accordance with Sections 5/10b and 5/10g(a) of the Act, Section 205.820 of the Code, and Section 10-65(d) of the Illinois Administrative Procedure Act (5 ILCS 100/1-5 *et seq.*) (hereinafter "APA"), incorporated into the Act at 210 ILCS 5/10a, the Department hereby issues this Notice of Violations to the facility known as Albany Medical Surgical Center.

ALLEGATIONS OF NONCOMPLIANCE

The Department has found conditions in the Facility that are threatening to public interest, health, safety or welfare. These conditions include, but are not limited to, a substantial or continued failure to comply with the Act or rules promulgated thereunder as referenced below and in attached Exhibit A.

1. On January 5, 2015, the Department conducted a complaint investigation survey (hereinafter "Survey") at the Facility.

2. Consequent to the Survey, the Department determined that Respondent substantially failed to comply with the Act and Code Section 205.320, Presence of a 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.

3. Consequent to the Survey, the Department determined that Respondent substantially failed to comply with the Act and Code 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 ASTC;

        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 hospital for treatment of complications. The procedure performed and the complication that prompted each transfer shall be listed;

        5) The number of deaths, including the specific procedure that was performed; and

        6) The results of the monitoring of the ASTC's hand hygiene program in Section 205.550(h).

    b) The 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.

4. The nature of each failure referenced in Paragraphs 2 and 3 above is further described in the Statement of Deficiencies which is attached hereto as Exhibit A and made a part hereof.

PLAN OF CORRECTION

Respondent shall file with the Department a written plan of correction ("POC") as required by Section 5/10c of the Act and Sections 205.820b)4) and 205.830 of the Code for the deficiencies cited above within ten days of receipt of this notice. Such plan of correction shall state with particularity the method by which the facility intends to correct the violations and shall contain a stated date by which each violation shall be corrected. The POC is subject to approval by the Department and must be sent to: Karen Senger, Illinois Department of Public Health, Division of Health Care Facilities and Programs, Central Office Operations Section, 525 West Jefferson Street, 4th Floor, Springfield, Illinois 62761.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 10d of the Act and Sections 205.820b)3), 205.850a), and 205.850b) of the Code, the Department hereby assesses a fine of Ten Thousand Dollars ($10,000.00) for violations of Code Section 205.320 as previously set forth herein:

(January 5, 2015 – February 5, 2015) 30 days x $333.33/day = $10,000.00

Pursuant to Section 205.850c)1) of the Code, all fines shall be paid to the Department by Respondent no later than ten days after the notice of assessment, if the assessment is not contested by Respondent.

NOTICE OF OPPORTUNITY FOR HEARING

Respondent has a right to a hearing to contest these actions pursuant to, without limitation, Section(s) 5/10b, 5/10c, 5/10d, and 5/10g of the Act and Section 205.860 of the Code. **A written request for hearing must be sent within ten days of receipt of this Notice to the Department.** Such request for a hearing must be sent to Snigdha Acharya, Deputy General Counsel, Illinois Department of Public Health, 122 South Michigan Avenue, 7th Floor, Chicago, Illinois 60603.

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

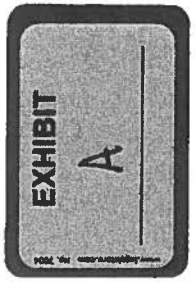
ANSWER BY RESPONDENT

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

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

Nirav D. Shah, M.D., J.D.
Director
Illinois Department of Public Health

Dated this 9 day of February 2015



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

☒ ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

NAME AND ADDRESS OF FACILITY: Albany Medical Surgical Center, 5086 North Elston Ave., Chicago, IL 60630

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
000 Section 205.320	An investigation survey was conducted on 1/5/15 for complaint #142856. The facility was not in compliance with Rules and Regulations for Ambulatory Surgical Treatment Centers for this survey as evidenced by: **Presence of a Qualified Physician** A qualified physician shall be present at the facility at all times during the operative and postoperative period for all patients. This requirement is not met as evidenced by: Based on document review and interview, it was determined for 3 of 14 (Pts #13, 14, & 15) patients who had surgical procedures on 12/20/14, the facility failed to ensure a physician was present during the postoperative period. Findings include: 1. Pt #2's clinical record included Pt #2 was a 22 year old pregnant female at 18 3/7 weeks		

DATE OF SURVEY 1/5/15 BY 30195 (Surveyor)

(Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

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

☒ ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

NAME AND ADDRESS OF FACILITY: Albany Medical Surgical Center, 5086 North Elston Ave., Chicago, IL 60630

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.320 (cont'd)	gestation who was admitted to the facility on 12/20/14 for a D & E by MD #1. The operative report included, "...palpation of the cervix revealed a high cervical laceration in the left posterior aspect of the cervix with possible extention into the fundus of the uterus...Upon recognition of the high cervical laceration, an ambulance was immediately called for transport to [Hospital] at 11:25 am. At 11:34, the Gynecology on call team and the Family Planning fellow at [Hospital] were informed of the patient, her condition, her pending arrival at [Hospital] ER and the need for surgical repair of the cervical injury...The patient remained stable during ambulance transport...Upon arrival to [Hospital] ER, the patient remained hemodynamically stable. I presented the patient to the ER physicians and the Gynecology team and transferred the patients care. [MD #1 accompanied Pt #1 in the ambulance for transfer] The plan was for diagnostic laparoscopy to evaluate the extent of the injury..." Pt #1 was transferred at 11:45 am, and the physician on duty (MD #1) left the facility at that time to accompany Pt #2.		

DATE OF SURVEY 1/5/15 BY 30195 (Surveyor) (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

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

ΞASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

NAME AND ADDRESS OF FACILITY: Albany Medical Surgical Center, 5086 North Elston Ave., Chicago, IL 60630

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.320 (cont'd)	2. On 1/5/15 at approximately 10:00 am, the clinical records were reviewed for the 14 patients admitted to the facility on 12/20/14 for surgical procedures. 3 of the 14 clinical records included that these patients were in the postoperative recovery room at the time the physician was not present in the facility. The times are as follows: -Pt #13 was a 24 year old female admitted to the facility on 12/20/14 for a D & E. Pt #13 was in recovery from 9:06 am - 12:15 pm. -Pt #14 was a 24 year old female admitted to the facility on 12/20/14 for a D & E. Pt #14was in recovery from 10:46 am - 12:51 pm. -Pt #15 was a 28 year old female admitted to the		

DATE OF SURVEY 1/5/15 BY 30195 (Surveyor) (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

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

Ξ ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

NAME AND ADDRESS OF FACILITY: Albany Medical Surgical Center
5086 North Elston Ave., Chicago, IL 60630

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.320 (cont'd)	facility on 12/20/14 for a D & E. Pt #15 was in recovery from 11:43 am – 1:10 pm. 3. On 12/30/14 at approximately 10:00 am, an interview was conducted with the Medical Director (MD #3). MD #3 stated that the facility's practice is that when a patient is transferred to the hospital because of a complication during surgery, the physician doing the surgery accompanies the patient to the hospital in the ambulance. The surveyor asked MD #3 who was responsible for the patients at the facility in recovery during the time the physician was accompanying a patient to the hospital. MD #3 stated that there was always a registered nurse (RN), a nurse practitioner (NP) or physician's assistant (PA), and a certified registered nurse anesthetist (CRNA) at the		

DATE OF SURVEY 1/5/15 BY 30195 (Surveyor) _____ (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

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

☒ ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

NAME AND ADDRESS OF FACILITY: Albany Medical Surgical Center, 5086 North Elston Ave., Chicago, IL 60630

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.320 (cont'd)	facility to be responsible for the care of the patients at the facility. MD #3 stated the physician was always available by phone during his/her absence from the facility. 4. The physician and staff schedules were reviewed for the dates of the 12 patient transfers. The schedules for each day on which surgeries were performed included one physician, one CRNA, and one advanced practice nurse or physician's assistant. The schedules did not include a physician on call to cover in case the physician needs to leave the facility if a patient is transferred. 5. On 1/5/15 at approximately 8:45 am, an interview was conducted with the Facility Administrator (E #2). E # stated that a physician (MD #4) is called to come to the facility when a patient is being transferred to assume care of the patients in recovery and continue the surgeries as scheduled. The physician does not leave the facility with the patient being transferred until		

DATE OF SURVEY 1/5/15 BY 30195 (Surveyor) (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

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

☒ ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

NAME AND ADDRESS OF FACILITY: Albany Medical Surgical Center, 5086 North Elston Ave., Chicago, IL 60630

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.320 (cont'd)	MD #4 is present at the facility. The surveyor requested the facility's policy or procedure that required a physician's presence at the facility at all times when patients are in surgery or recovery and documentation of the physician on call schedule to cover when a patient needs to be transferred. E #2 stated that the facility does not have a policy or documentation that a physician is available to cover should the physician on duty need to leave the facility. E #2 stated that on 12/20/14, MD #4 was not available, and MD #1 (the physician/surgeon on duty) left the facility to accompany Pt #2 during transfer to the hospital at 11:45 am. At this time there were three patients in recovery with no physician present at the facility.		

DATE OF SURVEY _1/5/15_____ BY__30195_____ (Surveyor) _____ (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

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

Ξ ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

NAME AND ADDRESS OF FACILITY: Albany Medical Surgical Center
5086 North Elston Ave., Chicago, IL 60630

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.620	**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...(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… (b) This clinical statistical data shall be collected and maintained quarterly, with reports completed no later than January 31, April 30, July 31 and October 31 for the preceding quarter. This requirement is not met as evidenced by:		

DATE OF SURVEY _1/5/15_____ BY__30195_____
(Surveyor)

_____
(Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

_____

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

Ξ ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

NAME AND ADDRESS OF FACILITY: Albany Medical Surgical Center, 5086 North Elston Ave., Chicago, IL 60630

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.620 (cont'd)	Based on document review and interview, it was determined for 1 of 1 (E #2) Facility Administrators, the facility failed to ensure the quarterly clinical statistical data reports included the number of patients who were transferred to a hospital. Findings include: 1. The statistical data collected quarterly by the facility was reviewed for the first 3 quarters of 2014 and included "0" patient transfers to a hospital. 2. On 12/29/14 at approximately 9:30 am, the list of patients transferred from the facility to a hospital from 01/ 2014 – 09/30/14 was reviewed and included 7 patients. 2. During an interview with the Facility Administrator (E #2) on 1/5/15 at approximately 10:00 am, E #2 stated that the		

DATE OF SURVEY 1/5/15 BY 30195 (Surveyor) _____ (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

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

☒ ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

NAME AND ADDRESS OF FACILITY: Albany Medical Surgical Center, 5086 North Elston Ave., Chicago, IL 60630

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.620 (cont'd)	data was compiled by an outside company, and the facility was not able to enter the specific transfer data into the spreadsheet format used by that company. E #2 stated this would have to be done manually but had not been entered for the last four years.		

DATE OF SURVEY 1/5/15 BY 30195 (Surveyor)

(Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

Attachment B

BLOOM
COMPANIES, LLC
Infrastructure Innovation and Ingenuity

Chicago Branch
600 W. Fulton St.
Suite 701
Chicago, IL 60661
P: 312-876-9500
F: 312-876-9600

Green Bay Branch
3049 Ramada Way
Suite 200
Green Bay, WI 54304
P: 920-347-0850
F: 920-347-0851

St. Paul Branch
7300 N. Hudson Blvd.
Suite 120
St. Paul MN 55128
P: 651-735-1801
F: 651-735-1803

May 15, 2015

[redacted] Division Chief
Division of Life Safety and Construction
Office of Health Care Regulations
525-535 West Jefferson Street
Sprinfield, Illinois 62761-0001

Re: Albany Medical Surgical Center
Chicago, Illinois
As-builts and Concept Plan per PoC Response

Dear [redacted],

Bloom Companies, LLC is pleased to submit this PoC Response, per our discussions last week. for you review and comment.

Sincerely,

[redacted]

Bloom Companies, LLC
Steven B. Grassi AIA LEED AP
Senior Architect

CC; [redacted] Albany Medical Surgical Center
[redacted] IDPH

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: 01 - MAIN BUILDING B. WING	R 08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	5086 NORTH ELSTON AVENUE CHICAGO, IL 60630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(L 000)	Initial Comments	(L 000)		8/31/2016

On August 21, 2014 a Life Safety Code Follow-up survey to the Ambulatory Surgical Treatment Center Annual Licensure Survey was conducted at the above facility by Surveyor 13755. He was accompanied during the survey walk-through by the provider's Administrator and maintenance personnel. Correction of some deficiencies were verified to be complete based upon direct observation during the survey walk-through, staff interview, or document review. Unresolved deficiencies or uncompleted corrections remain.

On August 28, 2013 the Life Safety portion of an Ambulatory Surgical Treatment Center Annual Licensure Survey was conducted at the above facility by Surveyor 13755. He was accompanied during the survey walk-through by the provider's Administrator and maintenance personnel.

The ASTC is located in a facility comprised of a single story building with a basement attached to a two story building. The ASTC occupancy is located in the single story building with a basement and was determined to be of minimum Type II (000) construction type with no sprinkler protection. The adjacent two story building is utilized for certain required functional areas of the ASTC and was determined to be of Type III (200) with no sprinkler protection. The two story Type III (200) business occupancy building is not permitted to house the ASTC occupancy in accordance with 21.1.6.3. See L130 deficiencies relating to required ASTC functional areas located within the Business occupancy building.

The ASTC occupancy was surveyed as an Existing Ambulatory Health Care Occupancy under the 2000 Edition of the NFPA 101 Life Safety Code, including Chapter 21 and the 77 IL

This PoC is being submitted based upon the following:
1. A replacement facility is to constructed [redacted] and is to be operational within app. 15 months. This facility is to be fully compliant with State of Illinois ASTC Licensing requirements including but not limited to applicable provisions of NFPA 101 and 99 (see Attachments #1 and 2).
2. Prior to completion of the replacement facility, all citations have been or are in the process of being corrected that do not require structural changes to the facility and its systems (see PoC detail).
3. In order to protect occupants during the period prior to full compliance, Interim Life Safety measures have been enacted in the form of an Interim Life Safety Plan and ongoing fire watch (see Attachment # 3).
4. During this interim time, Clinic practice will be limited to pregnancy terminations through 23.5 weeks and routine gynecological practice. The current Clinic single specialty ASTC license will be subject to licensure revocation if services are performed other than those stated above.

Illinois Department of Public [redacted]
LABORATORY DIRECTOR'S OR

TITLE: PRES.

(X6) DATE: 9/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 000}	Continued From page 1 Administrative Code 205, Ambulatory Surgical Treatment Center Licensing Requirements. The adjacent Business occupancy was surveyed as an Existing Business Occupancy under the 2000 Edition of the NFPA 101 Life Safety Code, including Chapter 39. Unless otherwise noted, those code sections listed herein that do not include a reference to a specific NFPA code and year of issue (such as NFPA 70 1999) are taken from the 2000 Edition of the NFPA 101 Life Safety Code. Unless otherwise noted, all deficiencies cited herein were found through random observation during the survey walk-through, staff interview, or document review. The Licensing requirements are NOT MET as evidenced by the deficiencies cited under the following L-Tags.	{L 000}		
{L 012}	20.1.6.1/21.1.6.1 Construction Type 21.1.6 Minimum Construction Requirements 21.1.6.2 Buildings of one story in height housing ambulatory health care facilities shall be of any construction type in accordance with NFPA 220. 21.1.6.3 Buildings two or more stories in height..... shall be Type I, Type II (222), Type II (111), Type III (211) Type IV (2HH), or Type V (111) construction. Exception: Buildings of unprotected construction (000), if protected throughout by an approved supervised automatic sprinkler system.	{L 012}	See response L 000 and Attachments #1,2 and 3.	8/31/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: 01 - MAIN BUILDING B. WING	R 08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	5086 NORTH ELSTON AVENUE CHICAGO, IL 60630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 012}	Continued From page 2 This Regulation is not met as evidenced by: The building housing certain ASTC required functional spaces is not of an acceptable construction type to comply with 21.1.6.3. Findings include: A. The ASTC surgical area is located within the one-story with a basement portion of the building which is of minimum Type II (000) construction type as permitted under 21.1.6.2. However, the two-story Business occupancy building houses multiple ASTC required functional spaces (see L130). Although the one-story with a basement building was reviewed as the ASTC occupancy and the two-story building was reviewed only as a Business occupancy, it provides required functional spaces for the ASTC occupancy. Not all required functional spaces in the Business occupancy building are permitted to be outside the ASTC occupancy as outlined under IL Administrative Code 205.1350. Therefore, the entire facility must be considered the ASTC occupancy and be of a permitted construction type. The Business occupancy building is determined to be Type III (200) construction type and not provided with a sprinkler system to comply with 21.1.6.3 Exception.	{L 012}		
{L 020}	20.3.1/21.3.1, 38.3.1/39.3.1 VERTICAL OPENINGS, SHAFTS, STAIRS Vertical openings such as stairways, elevator shaftways, escalators, HVAC shafts and building service shaftways are enclosed in accordance with Section 8.2.5. (Note: Some exceptions are permitted in 38.3.1.1 and 39.3.1.1)	{L 020}	L 012 A. See Attachment No. 1 Schedule, and No. 2 for Design Scope/Concept Plan. See also attachment No. 3 for Interim Life Safety Plan. The ASTC code compliant Surgical Area will be provided in the [redacted]	8/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: 01 - MAIN BUILDING B. WING	R 08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	5086 NORTH ELSTON AVENUE CHICAGO, IL 60630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 020}	Continued From page 3	{L 020}		

This Regulation is not met as evidenced by:
Vertical openings are not protected in accordance with NFPA 101-2000, 21.3.1, 39.3.1.1 and 8.2.5. Findings include:

A. The ASTC occupancy is located in the one-story-with-basement portion of the building constructed of masonry bearing walls and concrete plank floors and roof. The basement is utilized for a storage room/work shop and staff locker rooms. Miscellaneous plumbing and electrical penetrations through the floor are not protected in accordance with tested UL design assemblies to afford a minimum 1-hour separation between the floor levels as required by 21.3.7.1, 39.3.2.1 & 8.4.1.1(1), and 21.1.6.4.

UPDATE 8/21/14: Some plumbing penetrations at the Basement level were observed to be sealed with a spray-foam product identified as "Great Stuff" insulating foam sealant by Dow. This product is a polyurethane-based insulating foam sealant typically not meeting the requirements for firestopping. A UL tested design was not identified to confirm this material and the installation meets the firestopping requirements of ASTM E-814 (UL1479) testing. Duct penetrations could not be confirmed to have fire dampers and other pipe penetrations were observed to remain unsealed.

L 020 A. Existing Spray Foam was removed, see attachment No. 4 for intumescent sealant and UL details. Work has been completed. — 3/31/15

B. Refer to L032 deficiencies regarding enclosure of exit stairs relative to protection of vertical openings.

Please refer to L 032

{L 029} 38.2.1/39.3.2 HAZARDOUS AREAS {L 029}

39.3.2.1 Hazardous Areas: Hazardous areas

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: 01 - MAIN BUILDING B. WING	R 08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	5086 NORTH ELSTON AVENUE CHICAGO, IL 60630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 029}	Continued From page 4 that include, but are not limited to general storage, boiler or furnace rooms, and maintenance shops shall be protected in accordance with Section 8.4. High hazard areas shall comply with 39.3.2.2. This Regulation is not met as evidenced by: Hazardous areas are not protected to comply with NFPA 101-2000, 21.3.2, 39.3.2, and 8.4. A. The Men's and Women's Locker rooms for the ASTC are located in the basement and accessed through the general storage area. The location and arrangement does not comply with the requirements of 21.3.2, 39.3.2, and 8.4 relative to the separation of hazardous storage areas. Access and exiting from the Locker rooms does not comply with 7.5.1.7 relative to movement through the hazardous storage area. B. Three of three Storage rooms on the second floor of the Business occupancy used for the storage of boxes of file records are not protected as hazardous areas in accordance with 39.3.2.1 and 8.4.1.1. The building is not sprinklered nor is 1-hour enclosure provided, including at ceilings and doors. C. The second floor Utility room containing a gas-fired water heater was not protected as a hazardous area in accordance with 39.3.2.1 and 8.4.1.1. The building is not sprinklered nor is 1-hour enclosure provided, including at ceilings and doors. The door was labeled as fire rated but installed in a non-rated wood frame. The door also had a ventilation louver which does not comply with the requirements for the fire label.	{L 029}	L 029 A. see attachment No. 1 Schedule,and No.2 for Design Scope/Concept Plan. See calso attachment No. 3 for Interim Life Safety Plan. The ASTC code compliant Locker rooms will be provided [redacted] L 029 B. The three Storage rooms have been re-purposed to Office/ Conference Rooms. All stored materials have been re-located to an off site storage facility. Work completed. L029 C. the Utility Room enclosure will be remodeled as part of the proposed relocation of the new ASTC, see Schedule attachments No. 1 and 2. An hourly Fire Watch has been implemented see Attachment No. 3	8/31/16 3/14/15 8/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 032}	Continued From page 5	{L 032}		
{L 032}	20.2.4/21.2.4 TWO REMOTE EXITS	{L 032}		

At least two exits, located remote from each other are provided for each floor or fire section of the building. 20.2.4.1,20.2.4.2,20.2.4.3/21.2.4.1, 21.2.4.2 21.2.4.3

This Regulation is not met as evidenced by: Exits are not provided in accordance with 21.2.4.1, 39.2.2.3.1 and 7.2.2. Findings include:

A. The ASTC occupancy means of egress Stairs from the Basement level are not in accordance with 7.2.2.5 relative to enclosure and 7.1.3.2.1 relative to separation.

1. Corrected 8/21/14.

2. The exit stair from the basement which leads only to the exterior is utilized as a storage area for a gasoline powered lawn mower stored on an overhead shelf. Wood planking used as a ramp for material deliveries is stored along one side of the steps. A ladder and other miscellaneous materials are stored within the stair enclosure. All of the afore mentioned is prohibited under 7.1.3.2.3.

UPDATE 8/21/14: The gasoline powered lawn mower and wood plank used as ramp was observed to be removed. However, the ladder and other miscellaneous stored materials were observed to remain.

L 032 A.2. All stored materials, including the ladder were removed. The shelving was also removed. — 08/22/14

3. Corrected 8/21/14.
4. Corrected 8/21/14.
5. Corrected 8/21/14.
6. Corrected 8/21/14.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: 01 - MAIN BUILDING B. WING	R 08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	5086 NORTH ELSTON AVENUE CHICAGO, IL 60630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 032}	Continued From page 6 7. Corrected 8/21/14. 8. Corrected 8/21/14. 9. The exit stair from the basement which appears to discharge to the adjacent Business occupancy stair which leads through an exit passageway to the exterior was observed to have an unrated ceiling and access panel assembly at the ceiling on the discharge level in non-compliance with 7.1.3.2.1(a). 10. The exit stair from the basement was not provided with exit signage at the main level to direct the exit path into the Business occupancy stair which appears to serve as the discharge for the ASTC stair from the basement to make clear the intended path of exit. A door from the ASTC OR/Recovery area swings into the stair at this level. The door from the stair to the Business occupancy stair swings in the direction of exit travel in compliance with 7.2.1.4.3. UPDATE 8/21/14: It could not be confirmed whether this exit stair and entire path to the exterior was provided with emergency lighting. Existing directional exit signage within the Business occupancy stair is not visible along the path from the exit stair from the basement to identify the continuation of the exit path. Battery powered lighting was not observed within the exit stair from the basement and the fluorescent lighting provided could not be confirmed by staff to be connected to the generator system. Surveyor notes that if emergency lighting is powered by the generator system, the generator is a required emergency generator system which must comply with NFPA 99 and 110. B. The Business occupancy means of egress Stair from the second floor level is not in	{L 032}	L 032 A.9. The exit stair / enclosure and access panel will be remodeled to include USG 1 hour rated ceilings / horizontal shaft wall. , UL 415. See Attachment # 1, 2 and 5. L 032.10. The Owner ordered signage on September 9, 2014. signs have been posted. L 032 A.10. Directional Exit Sign has been relocated to be visible. Exit Stair lighting has been replaced with battery powered fixture.	8/31/16 10/14/14 10/14/14

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 032}	Continued From page 7	{L 032}		

accordance with 7.2.2.5 relative to enclosure and 7.1.3.2.1 relative to separation.

1. The exit stair in the Business occupancy which serves as the discharge for the ASTC stair from the basement and also serves as an exit for the first and second floors of the Business occupancy is not separated with 1-hour rated construction to comply with 7.1.3.2.1(a) and 7.1.3.2.1(c). The ceiling at the second floor is suspended acoustical tile open to the underside of the wood frame roof system and adjacent spaces. The door at the second floor is labeled, but is in a wood frame and has a non-rated window cut into the door. The door did not self-close to a latched condition.

2. Corrected 8/21/14.

3. The exit stair in the Business occupancy which serves as the discharge for the ASTC stair from the basement and also serves as an exit for the first and second floors of the Business occupancy was observed to have a metal access panel at the ceiling of the discharge level which could not be confirmed to be fire rated to comply with 7.1.3.2.1(a).

4. The exit stair in the Business occupancy which serves as the discharge for the ASTC stair from the basement and leads through an exit passageway space which leads to the exterior was observed to have a return air register in the exit passageway which could not be confirmed to be provided with fire damper protection at the duct penetration of the enclosure to comply with 7.1.3.2.1(e) exception no. 1 and 8.2.3.2.4. The exit passageway also contained a large potted plant in non-compliance with 7.1.3.2.3.

L 032 B.1.3.4.5 Both of the exit stairs will be remodeled to be code compliant 7.1.3.2(a) (c). See attachment No 1 for Schedule and Attachment No. 2 for Concept Plan. On an interim basis, the Life Safety Plan has been implemented, see Attachment #3.

8/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 032}	Continued From page 8 5. The exit stair in the Business occupancy near the waiting room is not separated with 1-hour rated construction to comply with 7.1.3.2.1(a) and 7.1.3.2.1(c). This exit stair does not otherwise comply with 7.2.2.5.1 Exception which allows in existing buildings, where a two story exit enclosure connects the story of exit discharge with an adjacent story, the exit shall be permitted to be enclosed only on the story of exit discharge, provided that not less than 50 percent of the number and capacity of exits on the story of exit discharge are independent of such enclosures. This stair is open to both levels. C. The Business occupancy designated exterior exit at the waiting room adjacent the stair to the second floor is not maintained to comply with 7.1.10 and 7.2.1.5. 1. The door and path thereto is obstructed by chairs in non-compliance with 7.1.10.2.1. 2. The door is equipped with panic hardware and a thumb turn dead bolt lock in non-compliance with 7.2.1.5.4 and 7.2.1.5.6. The door is normally kept locked. 3. The door is provided with "emergency exit only" signage which is bolted to the panic device bar rather than being independently mounted. The signage encumbers the use of the panic device. UPDATE 6/21/14: This door is no longer identified by exit signage as an exit. However, the panic device and dead bolt lock remain. The panic device implies that exiting is available but is encumbered by the dead bolt lock, thru-bolts remaining on the push bar and the the chairs. The encumbrances contradict the intended	{L 032}	L 032 C. Work has been completed, all chairs were moved. All door hardware has been removed. Blinds have been installed, as per discussion with IDPH.	09/03/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: 01 - MAIN BUILDING B. WING	R 08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	5086 NORTH ELSTON AVENUE CHICAGO, IL 60630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 032}	Continued From page 9 function of the panic device.	{L 032}		
{L 046}	20.2.9.1/21.2.9.1 Emergency Illumination Emergency lighting shall be provided in accordance with 7.9 and 21.2.9.2. This Regulation is not met as evidenced by: Emergency lighting is not provided in accordance with 21.2.9.1 and 7.9. Findings include: A. The facility utilizes a generator system for emergency power and battery powered emergency lighting. A checklist is provided that documents that checking of the battery powered system(s) is done on a monthly basis. However, no information is available as a written policy to describe what procedures are performed during the required monthly and annual inspection/testing of the battery powered emergency lighting system to comply with 7.9.3. 1. Battery powered emergency lighting system could not be confirmed to be tested every 30 days for a duration of 30 seconds. Testing of lamps could not be determined from the testing documentation because a list of lighting locations observed was not available or recorded. UPDATE 8/21/14: Forms have been created which identify the lighting being tested, but no procedures have been documented on the forms except for the most recent 8/13/14 testing. This deficiency will remain until sufficient documentation is available for review to indicate a standardized recordkeeping procedure is established and the preprinted forms or written policy define the required procedures. 2. Battery powered systems are not	{L 046}	L 046 A.1.2. See attachment No.7 for Policy (Page 5 of 5 7.1.1 Specific Guidance for our Facility) and Attachment No. 13 for log of emergency lighting being tested for a yearly 90 minute and monthly 30 second	8/31/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 046}	Continued From page 10 confirmed to be tested annually for a duration of 90 minutes. Testing of lamps could not be determined from the testing documentation because a list of lighting locations observed was not available or recorded. UPDATE 8/21/14: No documentation of a 90 minute test of the battery powered emergency lighting systems was confirmed to be available or previously provided for review. 3. Corrected 8/21/14. B. Illumination of the means of egress is not provided in accordance with 21.2.8 and 7.8. The exit discharge locations are not provided with illumination to comply with 7.8.1.4 and 7.9. 1. The ASTC exterior exit door and adjacent exterior door from the stair from the basement are provided with a single lamp fixture above the ASTC exterior exit door. Failure of this single fluorescent lamp will leave the area in darkness in non-compliance with 7.8.1.4. This lighting was not confirmed to be connected to the emergency generator to comply with 7.9.2.1. UPDATE 8/21/14: A dual lamp fixture has been provided, but it could not be confirmed by staff or observation whether this lighting is powered by an emergency battery powered lighting system or the generator system. Surveyor notes that if this emergency lighting is powered by the generator system upon loss of normal utility power, the generator is a required emergency generator system which must comply with NFPA 99 and 110. Battery powered emergency lighting logs do not indicate that exit discharge lighting is included as a battery powered system being maintained.	{L 046}	L 046.B.1 and 3. All outdoor exit lighting were replaced with fixtures that have a battery backup system. Fixtures are being tested and are on the form, see Attachment # 13.	12/29/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: 01 - MAIN BUILDING B. WING	R 08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	5086 NORTH ELSTON AVENUE CHICAGO, IL 60630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 046}	Continued From page 11 2. Corrected 8/21/14. 3. Lighting provided at the exterior exit door from the interior stair/exit passageway from the second floor could not be confirmed to be of instant-on type (fluorescent, incandescent, quartz, LED, halogen) and to be connected to the emergency generator to comply with 7.9.1.2 and 7.9.2.1. This lighting could not be determined to adequately illuminate the main waiting room entry door (if this door becomes the required exit). UPDATE 8/21/14: Multiple lamp fixture are provided, but it could not be confirmed by staff or observation whether this lighting is powered by an emergency battery powered lighting system or the generator system. Surveyor notes that if this emergency lighting is powered by the generator system upon loss of normal utility power, the generator is a required emergency generator system which must comply with NFPA 99 and 110. Battery powered emergency lighting logs do not indicate that exit discharge lighting is included as a battery powered system being maintained.	{L 046}		
{L 048}	21.7.1, 4.6.10.1 Written Fire Plan, &/or Interim Measures There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. A simple floor plan, showing the evacuation routes, is posted in prominent locations on all floors. 31.4.1.1 This Regulation is not met as evidenced by: The written Fire & Emergency Policy &	{L 048}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: 01 - MAIN BUILDING B. WING _____	R 08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	5086 NORTH ELSTON AVENUE CHICAGO, IL 60630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 048}	Continued From page 12 Procedures for the facility are not in accordance with 21.7.1.1. Findings include: A. Corrected 8/21/14. B. (New 8/21/14) The Fire Response Plan dated as revised 9/17/13 and submitted for review as part of the Plan of Correction has the following deficiencies: 1. Under the "General" paragraph it is noted to "Reference attached evacuation drawing.", but a drawing attachment is not provided. 2. Under "Fire Alarm Notification System" it is noted that "the manager or her/his designee will be responsible for pulling the fire alarm at the Elston location only." The identified "RACE" procedure applies to any staff or occupant discovering any fire condition and not to a designated person. 3. Under "Operating Room/ Recovery Room Employee Procedures" refers to movement of patients to another area of the building considered to be an evacuation zone. The evacuation zones are defined in the "General" paragraph as "area of refuge..."protected by a 1-hour smoke wall." The movement of occupants from the Recovery evacuation zone area to the OR area evacuation zone and vice-versa does not meet this requirement because both these areas are within the same smoke compartment and not separated from each other by 1-hour rated construction. 4. Under the paragraph "Manageable Fire" the policy indicates that staff discovering a fire they feel is manageable should first try and extinguish the fire. This does not follow the	{L 048}	L 048 B.1. See attachment No. 6 for Evacuation plans L 048B.2. See attachment No. 7 for updated Fire and Safety Policies, indicating that any and all staff should follow proper RACE procedures upon discovering any fire condition rather than determine if it is a manageable fire. L 048 B.3. The Operating Room/ Recovery Employee Procedures were revised in the interim, see attachment No.3. Interim Life Safety Measures. See also attachment No 1 for Schedule. The ASTC code compliant evacuation zones will be provided [redacted]	8/15/14 2/25/2015 8/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: 01 - MAIN BUILDING B. WING	R 08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	5086 NORTH ELSTON AVENUE CHICAGO, IL 60630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 048}	Continued From page 13 "RACE" procedure. Discovery of any fire must follow the Rescue, Alarm, Contain, Extinguish/Evacuate protocol.	{L 048}	L 048 B.4.See attachment No. 7 for updated Fire and Safety Policies indicating that any and all staff should follow proper RACE procedures upon discovering any fire condition rather than determining if it is a manageable fire.	2/25/2015
{L 050}	21.7.1.2 FIRE DRILLS Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift, using the fire alarm system, except at night. The staff is familiar with procedures and is aware that drills are part of established routine. 21.7.1.2 This Regulation is not met as evidenced by: Fire drills are not conducted to comply with NFPA 101-2000, 21.7.1 and 21.7.2. Findings include: A. Fire Drill records do not document that alarm signals are functional to verify that the signal has been transmitted to the monitoring agency and/or fire department to comply with 21.7.2.1. Response documents do not indicate that transmission of the signal to the monitoring agency was verified to be received during the fire alarm system activation. UPDATE 8/21/14: Fire drill record forms have been revised, but they lack documentation to confirm that a fire alarm signal has been transmitted to the monitoring agency and/or fire department as part of the drill to comply with 21.7.2. B. Corrected 8/21/14.	{L 050}	L 050A See attachment No. 8 for updated Fire Drill records transmitted to monitoring agency, Emergency 24, located in Des Plaines, IL.The initail drill transmission to the monitoring agency was held on September 3, 2014 and the signal was succesfully transmitted to Emergency 24.	9/3/2014
{L 051}	20.3.4/21.3.2 FIRE ALARM SYSTEM A manual fire alarm system, not a	{L 051}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 051}	Continued From page 14 pre-signal type, is provided to automatically warn the building occupants. The fire alarm system is arranged to automatically transmit an alarm to summon the fire department. 20.3.4 and 21.3.4 This Regulation is not met as evidenced by: The fire alarm system is not maintained in accordance with 21.3.4.1, 9.6.1.4 and NFPA 72-1999. A. Semi-annual and annual testing of the fire alarm system components by a third party is not documented to be performed as required by NFPA 72-1999, 7-3.2. No testing documentation was available on-site for review at the time of the survey. UPDATE 8/21/14: Semi-annual testing of the fire alarm system has been documented to have been performed. However, no documentation to confirm sensitivity testing of the smoke detection devices every 2 years or provide documentation to allow testing every 5 years to comply with NFPA 72-1999, 7-3.2.1 is available.	{L 051}	L 051A. See attachment No 9 for record of fire alarm system testing and sensitivity testing and Attachment No. 7 for Sensitivity Testing Policy	12/8/14
{L 075}	Waste Receptacles 20.7.5.3, 21.7.5.5 Soiled linen or trash collection receptacles do not exceed 32 gallons (121L) in capacity. Mobile soiled linen or trash collection receptacles with capacity greater than 32 gallons (121L) are located in a room protected as a hazardous area. 20.7.5.3, 21.7.5.5 This Regulation is not met as evidenced by: Soiled linen and trash collection facilities are not	{L 075}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: 01 - MAIN BUILDING B. WING	R 08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	5086 NORTH ELSTON AVENUE CHICAGO, IL 60630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 075}	Continued From page 15 in compliance with 21.7.5.5. Findings include: A. The Cover Gown Room was observed to contain a cart with gowning apparel, a clean linen storage cart and quantities of soiled linen/trash storage greater than 32 gal. (three 20+ gal. bags and a trash receptacle). The quantity of soiled/trash materials stored constitutes a higher degree of hazard than normal to the occupancy. The room is not sprinklered or 1-hour rated including a minimum 3/4-hour rated self-closing door to comply with 21.7.5.5, 21.3.2, 39.3.2 and 8.4.1.1(1). UPDATE 8/21/14: The soiled linen storage facilities have been relocated to an exterior closet accessed from the parking lot area. However, at the time of the follow-up survey, this storage location was observed to contain a wooden cabinet with "E" size oxygen cylinders. The storage of oxygen cylinders with combustibles does not comply with NFPA 99-1999, 8-3.1.11.2(c) because in a non-sprinklered location there is not 20' of separation between the oxygen storage and the combustibles.	{L 075}	L 075 A. Effective November 24,2014 the facility no longer has any oxygen tanks, of any size, in storage. All oxygen tanks are in use throughout the facility. K tanks have been in use in the OR's since 12/2006. A bi-weekly delivery of oxygen replaces all tanks. See Attachment #11 for copy of verification of bi-weekly exchange of tanks.	11/24/14
{L 106}	Type I ESS 3.4.2.2, 3.4.2.1.4 The ASC with life support equipment has a Type I Essential Electrical System powered by a generator with a transfer switch and separate power supply. The EES is in accordance with NFPA 99. 3.4.2.2, 3.4.2.1.4 This Regulation is not met as evidenced by: The ASTC generator system is not in compliance with NFPA 99-1999, 3-4.2.2 and 3-4.2.1.4.	{L 106}	L 106 A. 1.2.3 and B., C. 1.2.3.4. See attachment No 1 for Schedule and Attachment No. 2 [redacted] A fully compliant Type I EES generator will be installed as part of the ASTC [redacted] During the interim period, the need for Type I EES is addressed in the comments under L145.	8/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 106}	Continued From page 16	{L 106}		

Findings include:

A. The ASTC is permitted under its License to administer anesthesia and required by IL Administrative Code 205.1780 to have an emergency generator. Section 205.115 requires compliance with NFPA 99-1999 Health Care Facilities, NFPA 110-1999 Standard for Emergency and Standby Power Systems and NFPA 70-1999 National Electric Code. NFPA 99-1999, 3-4.2.2.1 and NFPA 70-1999, 517-45(c) Essential Electrical Systems for Ambulatory Health Care Centers requires compliance with 517-30 thru 517-35 for those areas classified as Critical Care. Critical Care is defined as those areas in which patients are intended to be subject to invasive procedures and where connected to line-operated, patient-care-related electrical appliances.

1. The generator is not provided with a remote manual stop to comply with NFPA 110-1999, 3-5.5.6.

2. The generator is located in an exterior enclosure which is not equipped to be maintained at a minimum temperature not less than 32 degrees F or otherwise provided with a starting battery heater to maintain battery temperature at a minimum 50 degrees F and automatically shuts off when battery temperature reaches 90 degrees F (and when prime mover is running) to comply with NFPA 110-1999, 3-3.1.

3. The generator was not observed to be provided with a remote alarm annunciator panel to comply with NFPA 99-1999, 3-4.1.1.15 and NFPA 110-1999, 3-5.5.2 to provide visual and audible alarms for the following conditions:
a. Overcrank (fail to start)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R 08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 106}	Continued From page 17 b. Low water temperature c. High water temperature d. Low lube oil pressure e. Overspeed f. When battery charger malfunctions g. When control switch not in auto position B. The natural gas fuel supply for the roof mounted generator is not installed in accordance with NFPA 110-1999, 5-9.7. The fuel supply for the generator is not connected ahead of the building's main shut-off valve and marked as supplying an emergency generator. The building's main gas shut-off valve is not marked or tagged to indicate the existance of a separate Emergency Power Supply shut-off valve. C. The emergency power system is not installed in accordance with NFPA 70-1999, 517-19. 1. Each Critical Care patient bed location (ORs and Stage 1 Recovery) and each General Care patient bed location (Stage II Recovery) is not provided with receptacles from at least two branch circuits; at least one from normal power supply and at least one from the emergency power supply to comply with NFPA 70-1999, 517-19(a) & 517-18(a). 2. Each Critical Care patient bed location at Stage I Recovery is not provided with at least 6 receptacles to comply with NFPA 70-1999, 517-19(b). 3. Each General Care patient bed location at Stage II Recovery is not provided with at least 4 receptacles to comply with NFPA 70-1999, 517-18(b) 4. Available existing emergency receptacles	{L 106}	L 106 B. See attachment No.1 for proposed Schedule and No.2 for Concept Plan. The natural gas fuel supply to the generator will be be installed in compliance with NFPA 110-1999,5-9.7 [redacted] L 106 C. 1.2.3.4. See attachment No 1 for proposed Schedule and No.2 for Concept Plan.. The emergency power system will be installed in accordance with NFPA 70-1999, 517-19 [redacted]	8/31/16 8/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000769	A. BUILDING: 01 - MAIN BUILDING B. WING	R 08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	5086 NORTH ELSTON AVENUE CHICAGO, IL 60630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 106}	Continued From page 18 are not provided with labels to identify the panel and circuit from which they are fed to comply with NFPA 99-1999, 3-4.2.2.4 and NFPA 70-1999, 517 -19 & 517-33(c).	{L 106}		
{L 130}	as indicated OTHER REFERENCED REQUIREMENTS Other Referenced Requirements: NFPA 70 - 2002 NFPA 13 -1999 NFPA 25 - 1998 Illinois State Plumbing Code Illinois Accessibility Code As Indicate below: This Regulation is not met as evidenced by: Based on random observation during the survey walk-through, document review, and staff interview, the facility is not in compliance with a series of Life Safety and other code requirements that are not documented under other L-Tags. Findings include: A. Due to the number, variety, and severity of the life safety deficiencies observed during the survey walk-through, the provider shall institute appropriate interim life safety measures until all cited deficiencies are corrected. The provider shall include, as an attachment to its Plan of Correction (PoC) and referenced therein, a detailed narrative and proposed schedule for all such measures. The narrative shall describe all measures to be implemented, as well as the frequency with which they are to be conducted, and shall indicate the manner in which the measures are to be documented. The narrative shall also include comments related to changes	{L 130}	L 130 A. B. C. D. E. F. G. H. I. J. K. A Safety/Fire Watch policy has been developed and implemented for an ongoing fire and safety watch See attachment No.7 and 10. This occurs on an hourly basis throughout the business hours. The maintenance supervision/designee conducts timely fire watches. The watches began January 14, 2014. See also attachment No 1 for proposed Schedule and attachment No. 2 for Concept Plan. See also attachment No. 3 for Interim Life Safety Plan,The ASTC code compliant facility will be provided [redacted]	1/14/14 8/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 130}	Continued From page 19	{L 130}		

in the interim life safety measures to remain in place as work toward the completion of its PoC progresses.

B. The Cover Gown Room is utilized for storage of soiled/trash materials in the same room as clean linen and gowning apparel which violates basic infection control principles. The same room can not be used for both clean and soiled activities. Each activity requires different ventilation conditions including negative pressure relationship (exhaust) for Soiled environments and positive pressure relationship (greater supply air) for Clean environments to comply with IL Administrative Code 205.1540(f) and 205.Table A.

UPDATE 8/21/14: The Cover Gown Room is now identified and used as the "Interview/Social Services Exam Room". The multi-use function of this room does not comply with IL Administrative Code 205.1350(f) and 205.1360(a). The Interview/Social Services function cannot be shared with the Exam function.

C. The ASTC Locker rooms located in the basement which are accessed through the storage room area are not provided in accordance with IL Administrative Code 205.1370(k).

1. Changing rooms for male and female are provided, but the toilet, lavatory, and shower facilities are a shared room. Therefore, toilets and lavatories for male and female are not provided.

2. A lounge for the exclusive use of the personnel working within the surgical area does not appear to be provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 130}	Continued From page 20	{L 130}		

3. The one-way flow for staff entering the surgical area through the locker rooms is not provided. Staff entering the surgical area must traverse the stair, proceed through the general storage area of the basement (deemed to be a hazardous area), enter the locker rooms to change/gown, and reverse direction and follow the same path through the general storage area of the basement and proceed up the stairs to enter the surgical area. The stair provides the only interior access to the basement storage room which allows co-mingling of both gowned and ungowned personnel.

UPDATE 8/21/14: The staff Lounge required by 205.1370(k) has been designated to also be the staff Changing room. These two functions are required to be separate functions in separate rooms to facilitate the separation of "clean gowned" personnel from "common ungowned" personnel for the purpose of infection control. The locker or changing room function is considered to be a transitional area where "clean gowning" takes place and once changed "clean gowned" personnel can move directly to the restricted areas. The staff lounge is considered exclusively for "clean gowned" personnel working within the restricted areas. Combining of these functional spaces does not provide for the ability for "common ungowned" staff to "avoid physical contact with clean personnel".

D. The ASTC surgical area is not provided with a minimum 8'-0" wide corridor for transport of stretcher borne patients to an exit to comply with IL Administrative Code 205.1400(a)1.

UPDATE 8/21/14: The clear width of the corridor measured in the hall leading to the exterior door is 59".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 130}	Continued From page 21	{L 130}		

E. The doors providing access to the OR/Procedure rooms and the Stage I Recovery room needing access for stretchers were not confirmed to be minimum 3'-8" width to comply with IL Administrative Code 205.1400(b)3.

UPDATE 8/21/14: The OR/Procedure room doors and the Stage I Recovery room door nearest to the OR/Procedure rooms is confirmed to be pairs of double swing doors providing the required 3'-8" width. However, the Stage II Recovery room doors are confirmed to provide only a 29" clear opening in noncompliance with IL Administrative Code 205.1400(b)2 which requires a minimum 3'-0" door and NFPA 101-2000, 21.2.3.3 which requires a minimum clear width of not less than 32".

F. The Recovery rooms (Stage I & Stage II) are not provided with toilet facilities within the recovery rooms to comply with IL Administrative Code 205.1360(d)3. A toilet room is provided within the surgical environment but movement through the general circulation hall is required.

G. Change areas for patients in accordance with IL Administrative Code 205.1370(l) are not provided within the ASTC occupancy. Changing areas outside the ASTC occupancy in the adjacent Business occupancy appear to be available and utilized.

H. Interview spaces for private interviews relating to social services, credit, and admissions is not provided within the ASTC occupancy to comply with IL Administrative Code 205.1350(d). Interview areas outside the ASTC occupancy in the adjacent Business occupancy appear to be available and utilized.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 130}	Continued From page 22	{L 130}		

UPDATE 8/21/14: The former "Cover Gown room" (located within the ASTC portion of the building) is now identified and used as the "Interview/Social Services Exam Room". The multi-use function of this room does not comply with IL Administrative Code 205.1350(f) and 205.1360(a). The Interview/Social Services function cannot be shared with the Exam function. The Interview/Social Services function appears to be located within the semi-restricted area of the ASTC rather than in a non-restricted environment. The provisions for staff and patients to enter the semi-restricted environment is not clear.

I. Examination rooms are not provided within the ASTC occupancy to comply with IL Administrative Code 205.1360(a). Exam rooms outside the ASTC occupancy in the adjacent Business occupancy appear to be available and utilized.

UPDATE 8/21/14: The former "Cover Gown room" (located within the ASTC portion of the building) is now identified and used as the "Interview/Social Services Exam Room". The multi-use function of this room does not comply with IL Administrative Code 205.1350(f) and 205.1360(a). The Interview/Social Services function cannot be shared with the Exam function. The Exam function appears to be located within the semi-restricted area of the ASTC rather than in a non-restricted environment. The provisions for staff and patients to enter the semi-restricted environment is not clear.

J. A control station located to permit visual surveillance of all traffic that enters the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 130}	Continued From page 23 semi-restricted surgical environment (ASTC occupancy) to comply with in accordance with IL Administrative Code 205.1370(a) does not appear to be provided. UPDATE 8/21/14: Video surveillance of the OR/Procedure room and Recovery room area hall is provided near the "Interview/Social Services Exam Room". However, monitoring of the video surveillance is done from the 2nd floor Business/Phone Center office in the Business occupancy portion of the building. The video surveillance cannot restrict inappropriate or unauthorized entry into the semi-restricted areas. K. The 'Central Supply' room believed to provide the support services for the surgical area Soiled Workroom required by IL Administrative Code 205.1370(e) & (f) appeared to be located outside the ASTC occupancy in the Business occupancy portion of the building.	{L 130}		
{L 144}	Generator Testing 3.4.4.1, NFPA 110, 8.4.2 Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1, NFPA 110, 8.4.2 This Regulation is not met as evidenced by: The emergency generator system is not inspected and tested in accordance with NFPA 99-1999, 4.3.3.1 and NFPA 110-1999, 6.4.2. Findings include: A. The facility is provided with a roof mounted natural gas fired generator system indicated to be	{L 144}	L 144 See attachment No 14 for the weekly and monthly testing of current generator. The NFPA 99-1999, 4.3.3.1 and NFPA 110-1999, 6.4.2 compliant generator will be provided in the redevelopment of adjacent structure. See also attachment No. 1 for Schedule and attachment No.2 for Concept Plan.	2/8/15 8/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 144}	Continued From page 24 new in 2001. The system is indicated to be 35 KW, 120/240v, single phase power. 1. The generator system weekly and monthly testing does not appear to indicate tabulation of load values for each run of the generator. Generator logs indicate "0" for all amp load tabulations. It could not be determined that loads are actually applied to the generator system. 2. Documentation indicates that the transfer time for emergency power was 30-45 seconds, thus not within the maximum 10 seconds permitted by IL Administrative Code 205.1780 and NFPA 99-1999, 3-4.4.1.1(a). 3. The starting battery is not documented to be maintained in accordance with NFPA 99-1999, 3-4.4.1.3 and NFPA 110-1999, 6-3.6. If the generator is provided with a 'maintenance free' battery which precludes the checking of the electrolyte levels and specific gravity testing on a weekly basis, conductance testing of the 'maintenance free' battery is not otherwise documented (as permitted under NFPA 110-2005, 8.3.7.1).	{L 144}	L 145A. The procedures currently taking place within this facility are limited exclusively to termination of pregnancy and routine gynecological practice. All of the electrical equipment utilized for these procedures is provided with integral battery back-up. Life support equipment is used for emergency purposes only. This situation is consistant with the exceptions 1 and 2 permitted to requirements for an essential electrical system in NFPA 21.2.9.2See attachment #12, Medical Director Letter, items 16 and 17 for emergency life support equipment, such as emergency defibrillators and nasal and oral suction machines. The facility further guarantees that the situation will remain the same, i.e., no other procedures will be performed until the completion of the replacement facility is completed. See L 000. The replacement facility is to have a full essential electrical system consistent with the requirements of NFPA 00. See also attachments 1 and 2.	8/31/16
{L 145}	Type 1 EES 3.4.2.2.2 The Type I EES is divided into the critical branch, life safety branch and the emergency system in accordance with NFPA 99. 3.4.2.2.2 This Regulation is not met as evidenced by: The ASTC Essential Electrical System is not installed as a Type I system in comformance with Licensing Requirements, NFPA 110, NFPA 99	{L 145}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING 01 - MAIN BUILDING B. WING	R 08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	5086 NORTH ELSTON AVENUE CHICAGO, IL 60630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 145}	Continued From page 25 and NFPA 70. Findings include: A. The ASTC is permitted under its License to administer anesthesia and required by IL Administrative Code 205.1780 to have an emergency generator. Section 205.115 requires compliance with NFPA 99-1999 Health Care Facilities and NFPA 70-1999 National Electric Code. NFPA 99-1999, 3-4.2.2.1 and NFPA 70-1999, 517-45(c) Essential Electrical Systems for Ambulatory Health Care Centers requires compliance with 517-30 thru 517-35. NFPA 99-1999, 3-4.2.2.1 and NFPA 70-1999, 517-30(b)2 require the generating system to be comprised of a Life Safety branch and a Critical branch. The installed system did not appear to be arranged to provide power from two separate branches because only a single "emergency" panel was observed with mixed loads required to be on either the Life Safety branch or the Critical branch in accordance with NFPA 99-1999, 3-4.2.2.2. The emergency panel did not have all circuits identified as to their functional use to comply with NFPA 70-1999, 384-13. A one-line diagram of the emergency electrical distribution system was not reviewed. UPDATE 8/21/14: Refer also to L032-A10 Update and L046-B Updates which identify locations where emergency lighting and exit lighting is required, but could not be confirmed by staff or observation whether this lighting is powered by an emergency battery powered lighting system or the generator system. Surveyor notes that if any emergency lighting or exit lighting is powered by the generator system upon loss of normal utility power, the generator is a required emergency generator system which must comply with NFPA 99 and 110. Battery powered emergency lighting logs do not indicate that exit discharge lighting,	{L 145}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7000789	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY MEDICAL SURGICAL CENTER	**5086 NORTH ELSTON AVENUE CHICAGO, IL 60630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 145}	Continued From page 26 exit signage or other emergency means of egress lighting is included as a battery powered system being maintained.	{L 145}		

ATTACHMENT NO. 1

IN THIS SURVEY A NUMBER OF DEFICIENCIES HAVE BEEN IDENTIFIED WHICH HAVE BEEN DETERMINED TO BE ARCHITECTURALLY IMPRACTICAL AND FINANCIALLY PROHIBITIVE TO CORRECT WITHIN THE EXISTING FACILITY. THEREFORE CORRECTIONS WILL BE MADE BY THE RELOCATION OF THE ASTC IN AN ADDITION TO THE EXISTING BUILDING.

AN ADJACENT STRUCTURE OF APP. 10,000 SF HAS BEEN PURCHASED AND WILL BE THE SITE REDEVELOPING THE ASTC IN RENOVATED SPACE FULLY COMPLINAT WITH ILLINOIS LICENSURE STANDARDS AND APPLICABLE CODES. RECONSTRUCTION IT IS TO CONTAIN TWO OPERATING ROOMS AND REQUIRED SUPPORT AREAS. THIS NEW DEVELOPMENT WILL BE CONNECTED TO THE EXISTING STRUCTURE. IT IS THE INTENT THAT ALL DEFICIENCIES WILL ALSO BE CORRECTED TO AREAS WITHIN THE EXSTING BUILDING THAT ARE NOT BEING REPLACED.

ALL WORK IN THE ADDITION WILL FULLY COMPLIANT WITH LICENSURE. DRAWINGS WILL BE SUBMITTED TO IDPH FOR REVIEW,THROUGHOUT THE DEVELOPMENT OF CONCEPT DRAWINGS AND THROUGH CONSTRUCTION DOCUEMENTS.

ALBANY CLINIC CONCEPT PLAN 5082 & 5086 N. Elston Chicago, IL

			Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
1	Notice to Proceed / As-builts &Concept Documents	1/15/2015	x																			
2	Complete As-Builts at 5086 and 5082 N. Elston	1/15/2015																				
3	Submit Concept Plan for IDPH Review & Comment	4/29/2015																				
4	NTP to Architect / Engineer for CD / Begin CD's	5/13/2015																				
5	Construction Documents for 5086 N. Elston	6/15/2015					x															
6	Submit Design Development Contract Documents for IDPH review	7/15/2015						x														
7	Submit 90% Contract Documents for IDPH review	8/15/2015							x													
8	Final Construction Documents Submittal to IDPH	10/1/2015									x											
9	Issue for Chicago Permit / Bidding	10/15/2015																				
10	Contractor Award begin Construction	12/15/2015																				
11	Complete Construction / IDPH on Site	7/31/2016																			x	
12	Occupancy	8/31/2016																				x

Attachment # 3

INTERIM LIFE SAFETY MEASURES SUMMARY

An Interim Life Safety Measures Plan (ILSM) is in effect and includes measures that have been developed and implemented since January, 2014. A defined chain of command identifying the individuals responsible for implementation and monitoring of the ILSP has been established. The measures included in the ILSM are:

	Measure	Frequency
1.	Ensure that the ILSM assessment and daily inspection sheet is posted.	Daily
2.	All exits are unobstructed and available	Hourly
3.	Required fire extinguishers are available, appropriately located, and in good working order.	Hourly
4.	Fire alarm is in good working order	Hourly
5.	All passageways and fire doors are unobstructed and all stairwell doors are closed.	Hourly
6.	Storage and work areas are free of trash.	Hourly
7.	All equipment and electrical devices not in use are turned off.	Hourly
8.	Signage is displayed prohibiting smoking	Quarterly
9.	One additional fire drill has been performed or is planned.	Quarterly
10.	Educate all staff that increased fire and hazard surveillance is in effect until further notice; that staff shall report any possible safety hazards to management immediately.	Quarterly
11.	Education has been conducted with appropriate staff members regarding the building's deficiencies and for compensation for structural and fire safety features.	Quarterly

Inspections of items 2 through 7 are conducted and recorded hourly during business hours.

Work order records are maintained identifying the time and date work orders to address deficient items found during the fire watch rounds.

A decision matrix designed to identify temporary measures to be implemented on a temporary basis while work orders are completed.

Increased training of staff on fire awareness and fire safety measures. Training will occur once per shift per department on a monthly basis.

Increased frequency of fire drills to heighten staff awareness of fire safety during the duration of the interim life safety measures.

The ILSM have been implemented. Logs and records are available at the facility for review and inspection.

May 12, 2015

Albany Medical Surgical Center Interim Life Safety Measures – Identification of Chain of Command

All duties and responsibilities are defined as followed.

Administrator in Charge: [redacted] **COO**

Contact Information: [redacted]

[redacted] is aware of all needed corrections and is responsible for verifying that the corrections are completed. Additionally, [redacted] will initiate all interim safety measures, including educating and training the management and maintenance staff. [redacted] will provide follow up on implementation of all interim safety measures as needed.

Fire warden: [redacted] **Facility Manager**

Contact Information: [redacted]

[redacted] has 28 years of experience working at this facility. [redacted] is the facility manager and participated in developing our Safety and Security Manual and Policies.

Additionally, [redacted] is responsible for conducting all fire and safety drills. [redacted] will participate in performing and documenting the required daily and hourly interim life safety measures.

Fire warden: [redacted] **Assistant Manager**

Contact Information: [redacted]

[redacted] has been employed with Albany Medical Surgical Center for 8 years and she participated in developing our Safety and Security Manual and Policies as well as our Interim Life Safety Measures. Additionally, [redacted] is certified in BLS.

[redacted] will participate in performing and documenting the required daily and hourly interim life safety measures.

Person Responsible to Review Fire Logs: [redacted] **Operations Manager**

Contact Information: [redacted]

[redacted] is responsible for all fire safety training. Additionally, [redacted] will participate in performing and documenting the required daily and hourly interim life safety measures.

Location of Records: Admitting office one.

Albany Medical Surgical Center Daily Interim Life Safety Measures Checklist

Date:_____ Staff Member(s) Performing the Inspection:_____

Measure	Description	Yes	No	N/A	Comments
1.	Ensure the ILSM assessment and daily inspection sheet is posted. *				
2.	Ensure all exits are available and clear. *				
3.	The required number of fire extinguishers are available, appropriately located and in good working order. *				
4.	The main fire alarm is in good working order. *				
5.	All passageways and fire doors are unobstructed and all stairwell doors are closed. *				
6.	Storage and working areas are free of trash. *				
7.	All equipment and electrical devices that are not in use are turned off. *				
8.	Signage is displayed regarding the prohibition of smoking.				
9.	One additional fire drill per quarter has been performed or has been planned.				
10.	Alert staff that increased fire and hazard surveillance is in effect until further notice, and that they should report any possible fire hazards to management immediately.				
11.	Education has been conducted with appropriate staff members regarding the building deficiencies and for compensation for structural and fire safety features.				

Note: Measures 1 through 7 must be performed hourly during regular business hours and documented below.

Documentation of hourly measure checks (attach form for additional comments if needed)

Time	7:00 AM	8:00 AM	9:00 AM	10:00 AM	11:00 AM	12:00 PM	1:00 PM	2:00 PM	3:00 PM	4:00 PM	5:00 PM	6:00 PM
Initials												
All Measures in Compliance	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No

Comments:_____

Back up Materials

1. Fire Safety Manual and Plan

See Fire Safety Manual and Plan located in the facility.

2. Fire Watch Program

A. Fire Watch Program Narrative

i. Fire watch will be performed once daily and hourly as documented.

ii. Chain of Command (see attached document)

iii. Identification of fire warden and qualifications (see attached Chain of Command)

iv. Who will review the fire logs (see attached Chain of Command)

v. Who will initiate the interim safety measures (see attached Chain of Command)

vi. Follow up on implementation of interim safety measures (see attached Chain of Command)

vii. Who will verify the execution of corrective measures (see attached Chain of Command)

viii. Identification of administrator or manager in charge (see attached Chain of Command)

ix. Definition of duties and responsibilities (see attached Chain of Command)

x. Follow up verification of correction plan.

B. Fire Watch Log/Records

i. See attached form, which is to be used for daily and hourly documentation.

4. Fire Drills

A. Fire Drill Procedures

At an unannounced, random time, the Safety and Security Officer or Management or her/his designee will call a "Code Red Drill" to a specific location in the facility.

It is each employee's responsibility to react as if the drill was a real fire. The fire emergency action plan is to be followed from start to finish evaluating our readiness for a real fire situation.

Drill Evaluation
During fire drills, staff knowledge is evaluated for the following:

- Evaluation of fire drill sheet.
- The effectiveness of fire response training according to the fire response plan will be evaluated annually at our company's Safety and Security Training.

Our Codes will include "manageable" and "unmanageable" fire.

Manageable Fire
- All staff should know locations of all fire extinguishers.

- All staff should know how to handle and properly use a fire extinguisher.
- Make sure everyone knows what type of fire it is made to extinguish.
- Have everyone pick one up and examine it. Some are heavy!
- Know who in the office is willing or unwilling to use a fire extinguisher in the case of a manageable fire.
- In the event of a manageable fire, pull pin and spray back and forth across the base of the flame from about 6-8 feet away.
- If emptying the contents of one fire extinguisher is not enough to put out the fire then it is unmanageable. Evacuate and call the fire department.
- If fire is successfully extinguished call fire department anyway. They need to come and determine the cause of the fire. If it was electrical, there may be problems elsewhere in the building that they can find that will prevent another incident.

Unmanageable Fire

- Practice communicating that there is an emergency and a need to evacuate the clinic. Do you have an intercom system or a fire alarm? How will you make sure everyone is aware of the situation?
- Have several pre-planned and practiced escape routes. The fire may not start or be set in a place where it is convenient for you to evacuate out the main door.
- If you use sedation, practice evacuations with patients who are sedated.
- Have at least two designated meeting points a safe distance from the clinic and make sure to notify all staff of which place will be used, prior to evacuating.
- Set a goal of an amount of time in which you want to complete the evacuation and work toward it.

Recordkeeping

A copy of the fire safety drill will be placed and kept in the Documentation binder.

i. Fire Drill Staff Training Manual

To provide the maximum level of safety in the event of a fire within the workplace, buildings must be properly constructed and be provided with fire protection systems that detect and suppress fires and alert occupants. Codes and standards require life safety measures in the form of construction and egress components. The human interface with the fire protection and egress components is a critical factor in the provision of an acceptable level of life safety in the event of a fire.

Building occupants must know what the evacuation alarm sounds like, where the exits are and the proper response during an emergency. Emergency plans and workplace fire drills address the human element in the protection of lives in the event of fire.

Health care facilities can find evacuation of occupants during drill unrealistic, fire drills involving staff may serve the purpose. Evacuation drills are conducted, to familiarize occupants with the means of egress in the building. Evacuation drills provide learning experiences for occupants and employee for a variety of emergency conditions including fire, hazardous materials spills, bomb threats, and building system failures.

The primary reason for conducting fire drills is to educate building occupants about the procedures to follow in the event of an emergency that requires evacuation. It is easy for building occupants to overlook the features of a building that are in place for their safety as they go about their day-to-day routine. Most people will enter and leave buildings through the same entrance. Stairways and alternative exits might not be familiar to many occupants, even those who have worked in the same building for many years. In the event of an emergency, occupants might travel past emergency exits to get to the building entrance (exit) they are familiar with. Fire drills provide an opportunity for occupants to locate and use alternative routes under nonthreatening conditions. This familiarity increases the probability of a successful evacuation during an actual emergency. Fire drills may be required by codes or regulations, local ordinances, good practice, insurance recommendations, or as a policy of the employer or building owner. For whatever reason they

are conducted, fire drills serve to educate building occupants, assist in the evaluation of emergency plans, and identify potential issues with the building's means of egress.

The code requirements for fire drills are found in a number of national standards and in the requirements of OSHA 29, *Code of Federal Regulations* 1910.38, Employee Emergency Plans and Fire Prevention Plans.

National standards with fire drill requirements include fire prevention codes such as NFPA 1, *Fire Prevention Code*, 2000 edition, and others promulgated by consensus code organizations. NFPA *101®, Life Safety Code®*, 2000 edition, also contains specific requirements for fire drills in many occupancies.

REASONS FOR CONDUCTING FIRE DRILLS CODE REQUIREMENTS

Although the *Life Safety Code* does not apply to all occupancies, the following information is very useful when a facility plans and evaluates fire drills in the workplace:

- The purpose of emergency egress and relocation drills is to educate the participants in the fire safety features of the building, the egress facilities available, and the procedures to be followed.
- Speed in emptying buildings or relocating occupants, while desirable, is not the only objective. Prior to an evaluation of the performance of an emergency egress and relocation drill, an opportunity for instruction and practice should be provided. This educational opportunity should be presented in a nonthreatening manner, with consideration to the prior knowledge, age, and ability of audience.
- The usefulness of an emergency egress and relocation drill and the extent to which it can be performed depend on the character of the occupancy.
- In buildings where the occupant load is of a changing character, such as hotels or department stores, no regularly organized emergency egress and relocation drill is possible. In such cases, the emergency egress and relocation drills are to be limited to the regular employees, who can, however, be thoroughly schooled in the proper procedure and can be trained to properly direct other occupants of the building in case of emergency evacuation or relocation. In occupancies such as hospitals, employees can rehearse the proper procedure in case of fire; such training always is advisable in all occupancies, whether or not regular emergency egress and relocation drills can be held.

The Ambulatory Surgery Center and other facilities shall receive fire evacuation drills as required by NFPA 101 Life Safety Code. All employees in all areas of the facility will participate in drills as per the fire response plan. The primary purpose of the drills is to evaluate whether the staff is knowledgeable in the implementation of the fire evacuation plan, with the goal of providing for the life safety of patients, guests, and employees during fire emergencies. In addition, drills are used as an opportunity to educate, instruct, and reinforce employees on the concepts of fire evacuation.

Drill Frequency and Locations

- Each location is responsible for conducting fire drills.
- Drills will be conducted quarterly.

Safety and Security Training

At the beginning of employment there will be a tour of the facility given to each employee. This allows for the trainer to show the emergency exits, fire extinguishers, hold up buttons, and security monitors. All employees will be shown proper videos, PowerPoint presentations, guidelines, and handbooks that will ensure the success of compliance with federal, state, local, and applicable laws.

In addition to the orientation training, given within the first week of employment, will be annual safety and security trainings maintained and presented by the Safety and Security Committee, the Safety and Security Officer, or their designee.

Training will cover the topics outlined in this manual, in addition to any new resources that may become available. In each topic of this manual, please find information regarding the training that is given to employees.

Security preparedness is an ongoing part of the work setting for employees of Family Planning Associates Medical Group and Family Planning Management. We strive to make security education and consciousness a customary practice and topic of discussion. National Abortion Federation's security alerts will be used to inform employees of potential issues with security and may be posted as they are received.

Safety and Security issues will be posted and communicated as they arise. As staff meetings are scheduled, there will be time provided to discuss safety and security information to give employees the opportunity to ask questions. As HIPAA releases changes in their guideline and regulations, these will also be posted for employees. Safety standards and regulations will be adapted by current OSHA, HIPAA, CDC, CLIA and any other available regulations and policies.

Training guidelines, outlines, PowerPoint presentations, and other materials used to provide training to employees, as well as, training and employee meeting attendance can be found in the Manager of Finance and Administration's office. All documentation of training and compliance can be found in each individual employee's personnel file.

Albany Medical Surgical Center

FIRE / SAFETY TEST

Part I

Name of Employee:_____ Date: _____ Employee Position:_____

1. P.A.S.S. stands for: _____
2. R.A.C.E stands for: _____
3. Which fire extinguishers are in our facilities: _____
4. Record where fire extinguishers are located: _____
5. In the event of an Internal Disaster, our evacuation/meeting place is: _____
6. Record the utility shut-off locations for the following:
    a. Water Supply _____
    b. Gas _____
    c. Electric _____
7. In the event of disruption in services, lighting is provided by: (Circle the correct answer)
    a. Emergency Lights
    b. Candles
    c. Flashlights
8. When operating any of the fire extinguishers, direct the nozzle at the _____ of the flame.
9. In the event of a fire, the air circulating system should be: (Circle the correct answer)
    a. Turned Off
    b. Turned On
10. What is the phrase that is announced of there intercom when there is a fire: _____

11. When removing people downward to a safe area, we should: (Circle the correct answer)
    a. Use the Elevator
    b. Use the Stairway

12. If a person is aflame in bed, you should do the following: (Circle the correct answer)
    a. Throw the contents of a water carafe onto the person with a sweeping motion
    b. Use a pillow, sheet, or a non-acrylic blanket to smother the fire
    c. Use the type of extinguisher we have in the facility to extinguish the flames on the patient
    d. Confine the fire by closing the door to the room

Albany Medical Surgical Center

FIRE / SAFETY TEST

Part II

Match the term with the appropriate definition

____ 1. Fire extinguishers, Fire Hoses, Fire Sprinklers.

____ 2. Actions necessary to control an External Disaster.

____ 3. Fire or Broken water pipe initiated within the Facility

____ 4. Those responsible for the coordination, supervision and implementation of the Internal and External Disaster Program.

____ 5. Fire Alarm Boxes and Smoke Detectors

____ 6. Information to assist in PREPLANNING for an emergency

____ 7. Persons injured during any disaster

____ 8. Information, forms and equipment available for any disaster

____ 9. Disruption or Expansion of Services initiated outside the Facility

____ 10. Corridor doors that divide the facility into sections to prevent the spread of fire and/or smoke

____ 11. The process of sorting and classifying casualties at the scene of an Emergency or wherever definitive care and treatment is given

____ 12. Areas (Primary & Secondary) designated for receiving casualties

____ 13. Actions necessary to control an Internal Disaster

____ 14. Measures taken to prevent exposure to bloodborne pathogens

____ 15. Control Center during an Internal or External Disaster

A. SAFETY COMMITTEE

B. FIRE AND DISASTER GUIDELINES

C. INTERNAL DISASTER

D. EXTERNAL DISASTER

E. FIRE PROCEDURES

F. DISASTER PROCEDURES

G. COMMUNICATION CENTER

H. CASUALTIES

I. TRIAGE

J. DISASTER KIT

K. FIRE AND/OR SMOKE BARRIER DOORS

L. UNIVERSAL PRECAUTIONS

M. FIRE ALARM DEVICES

O. FIRE FIGHTING APPLICANCES

P. TRIAGE AREA

ii. Identification of Codes

A variety of possible emergencies could take place in or outside any one of our facilities. For preparation, as well as, safe and secure measures, we do enforce drills so that as an emergency situation may occur, each employee will know their role and how to react to possible situations.

Drills are practiced no less than one a quarter for fire drills, no less than once annually for medical safety, and as often as can be practiced for all other drills. Documentation of the drills can be found in the Manager's office at each location.

The following are codes that we presently use and what they stand for:

Codes	Definition	Practice
Blue	Cardiac Arrest and/or Respiratory Failure	Medical Professionals must present at the location in which a Code Blue is called. (Please also find more defined instructions in the Back Office Guidelines.)
Red	Fire	R. A. C. E. (Please also find more defined instruction in the 'Fire Drills' section.)
Violet	Possible or Occurring Violence	Manager, supervisor, and possible further assistance to the location called. (Please review 'Workplace Violence' section for more information.)
Grey	Bomb or Bomb Threat	Manager, supervisor, and possible further assistance to the

		location called. All Staff look and address any suspicious packages or odd objects.

iii. RACE

Patient care settings offer unique challenges for fire safety. Some patients are not able to help themselves during a fire, and all of them depend on us to keep them safe.

In a Case of a Fire

R = Rescue

- Stay calm and determine if there is immediate danger or need for rescue.
- Remove/relocate anyone who is in immediate danger.

A = Alarm

- Page "Code Red & _____" (location), three times. Alerting employees of a Code Red will:
  - ✓ Let the employees know to take action.
  - ✓ One employee from each department should report to the location of the fire.
  - ✓ Each employee that reports to the fire should bring any available fire extinguisher.

C = Confine

- The fire doors need to be shut to confine the smoke and fire.
- The ventilation system will to be turned off to reduce the spread of smoke.

E = Extinguish or Evacuate

First, we must attempt to extinguish the fire:

- A fire extinguisher will fully discharge in about 20 seconds.
- Be sure to have another co-worker to assist you; do not try to extinguish a fire alone.
- Remember that we have ABC fire extinguishers – NOT TO BE USED ON PATIENTS.
- If you do not feel safe trying to extinguish the fire, then do not attempt it.
- When using a fire extinguisher always remember: **P.A.S.S.**
  - ✓ **P**ull - Pull the pin on top of the extinguisher
  - ✓ **A**im - Aim at the base of the fire
  - ✓ **S**queeze - Squeeze the handle
  - ✓ **S**weep - Sweep from side to side at the base of the fire

If necessary, the manager will have staff, patients, and guests **evacuate**.

- Follow a safe route moving horizontally through the nearest fire door and vertically down the stairs, if necessary. **Do not use the elevators.**
- Once the evacuation decision is made, the general alarm will be pulled. The general alarm is a loud alarm sound at the Elston location, announcement on the overhead speaker at the Washington location, or by announcement at Cottage Grove. This indicates a full evacuation. You will be instructed on the safest route.
- Use good judgment. Evacuate horizontally if in danger.

iv. Frequency of Fire Drills

Protocol states that fire drills will be conducted quarterly, during the time in which interim life safety measures are in place one additional fire drill will be performed each quarter.

v. Fire Drill Forms and Debriefing

See attached form.

vi. Verification of Training

After the annual training each staff member is required to take a quiz about our safety and security training. This serves as documentation of completion and participation in our annual staff training. When a new employee is hired they receive individual training and complete a safety and security quiz prior to their first scheduled shift.

vii. Identification of person responsible for training:

Linda Rivera the Operations Manager is responsible for our annual training with our full staff and the training of new employees.

B. Facility's Fire Drill Records

A copy of the fire safety drills are kept in the Documentation binder.

Albany Medical Surgical Center Daily Interim Life Safety Measures Checklist

Date: 5-4-15 Staff Member(s) Performing the Inspection: [redacted]

Measure	Description	Yes	No	N/A	Comments
1.	Ensure the ILSM assessment and daily inspection sheet is posted. *	✓			
2.	Ensure all exits are available and clear. *	✓			
3.	The required number of fire extinguishers are available, appropriately located and in good working order. *	✓			
4.	The main fire alarm is in good working order. *	✓			
5.	All passageways and fire doors are unobstructed and all stairwell doors are closed. *	✓			
6.	Storage and working areas are free of trash. *	✓			
7.	All equipment and electrical devices that are not in use are turned off. *	✓			
8.	Signage is displayed regarding the prohibition of smoking.	✓			
9.	One additional fire drill per quarter has been performed or has been planned.	X			
10.	Alert staff that increased fire and hazard surveillance is in effect until further notice, and that they should report any possible fire hazards to management immediately.	✓			
11.	Education has been conducted with appropriate staff members regarding the building deficiencies and for compensation for structural and fire safety features.	✓			

Note: Measures 1 through 7 must be performed hourly during regular business hours and documented below.

Documentation of hourly measure checks (attach form for additional comments if needed)

Time	7:00 AM	8:00 AM	9:00 AM	10:00 AM	11:00 AM	12:00 PM	1:00 PM	2:00 PM	3:00 PM	4:00 PM	5:00 PM	6:00 PM
Initials	[redacted]											
All Measures in Compliance	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	Yes / No

Comments:

Albany Medical Surgical Center Daily Interim Life Safety Measures Checklist

Date: 5-5-15 Staff Member(s) Performing the Inspection: [redacted]

Measure	Description	Yes	No	N/A	Comments
1.	Ensure the ILSM assessment and daily inspection sheet is posted. *	✓			
2.	Ensure all exits are available and clear. *	✓			
3.	The required number of fire extinguishers are available, appropriately located and in good working order. *	✓			
4.	The main fire alarm is in good working order. *	✓			
5.	All passageways and fire doors are unobstructed and all stairwell doors are closed. *	✓			
6.	Storage and working areas are free of trash. *	✓			
7.	All equipment and electrical devices that are not in use are turned off. *	✓			
8.	Signage is displayed regarding the prohibition of smoking.	✓			
9.	One additional fire drill per quarter has been performed or has been planned.	X			
10.	Alert staff that increased fire and hazard surveillance is in effect until further notice, and that they should report any possible fire hazards to management immediately.	✓			
11.	Education has been conducted with appropriate staff members regarding the building deficiencies and for compensation for structural and fire safety features.	✓			

Note: Measures 1 through 7 must be performed hourly during regular business hours and documented below.

Documentation of hourly measure checks (attach form for additional comments if needed)

Time	7:00 AM	8:00 AM	9:00 AM	10:00 AM	11:00 AM	12:00 PM	1:00 PM	2:00 PM	3:00 PM	4:00 PM	5:00 PM	6:00 PM
Initials	[redacted]											
All Measures in Compliance	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No

Comments:

Albany Medical Surgical Center Daily Interim Life Safety Measures Checklist

Date: 5-6-15 Staff Member(s) Performing the Inspection: [redacted]

Measure	Description	Yes	No	N/A	Comments
1.	Ensure the ILSM assessment and daily inspection sheet is posted. *	✓			
2.	Ensure all exits are available and clear. *	✓			
3.	The required number of fire extinguishers are available, appropriately located and in good working order. *	✓			
4.	The main fire alarm is in good working order. *	✓			
5.	All passageways and fire doors are unobstructed and all stairwell doors are closed. *	✓			
6.	Storage and working areas are free of trash. *	✓			
7.	All equipment and electrical devices that are not in use are turned off. *	✓			
8.	Signage is displayed regarding the prohibition of smoking.	✓			
9.	One additional fire drill per quarter has been performed or has been planned.	X			
10.	Alert staff that increased fire and hazard surveillance is in effect until further notice, and that they should report any possible fire hazards to management immediately.	✓			
11.	Education has been conducted with appropriate staff members regarding the building deficiencies and for compensation for structural and fire safety features.	✓			

Note: Measures 1 through 7 must be performed hourly during regular business hours and documented below.

Documentation of hourly measure checks (attach form for additional comments if needed)

Time	7:00 AM	8:00 AM	9:00 AM	10:00 AM	11:00 AM	12:00 PM	1:00 PM	2:00 PM	3:00 PM	4:00 PM	5:00 PM	6:00 PM
Initials	[redacted]											
All Measures in Compliance	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) No	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	Yes / No

Comments:

Albany Medical Surgical Center Daily Interim Life Safety Measures Checklist

Date: 5-9-15 Staff Member(s) Performing the Inspection: [redacted]

Measure	Description	Yes	No	N/A	Comments
1.	Ensure the ILSM assessment and daily inspection sheet is posted. *	✓			
2.	Ensure all exits are available and clear. *	✓			
3.	The required number of fire extinguishers are available, appropriately located and in good working order. *	✓			
4.	The main fire alarm is in good working order. *	✓			
5.	All passageways and fire doors are unobstructed and all stairwell doors are closed. *	✓			
6.	Storage and working areas are free of trash. *	✓			
7.	All equipment and electrical devices that are not in use are turned off. *	✓			
8.	Signage is displayed regarding the prohibition of smoking.	✓			
9.	One additional fire drill per quarter has been performed or has been planned.	X			
10.	Alert staff that increased fire and hazard surveillance is in effect until further notice, and that they should report any possible fire hazards to management immediately.	✓			
11.	Education has been conducted with appropriate staff members regarding the building deficiencies and for compensation for structural and fire safety features.	✓			

Note: Measures 1 through 7 must be performed hourly during regular business hours and documented below.

Documentation of hourly measure checks (attach form for additional comments if needed)

Time	7:00 AM	8:00 AM	9:00 AM	10:00 AM	11:00 AM	12:00 PM	1:00 PM	2:00 PM	3:00 PM	4:00 PM	5:00 PM	6:00 PM
Initials	[redacted]											
All Measures in Compliance	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	Yes / No

Comments:

Albany Medical Surgical Center Daily Interim Life Safety Measures Checklist

Date: 5-8-15 Staff Member(s) Performing the Inspection: [redacted]

Measure	Description	Yes	No	N/A	Comments
1.	Ensure the ILSM assessment and daily inspection sheet is posted. *	✓			
2.	Ensure all exits are available and clear. *	✓			
3.	The required number of fire extinguishers are available, appropriately located and in good working order. *	✓			
4.	The main fire alarm is in good working order. *	✓			
5.	All passageways and fire doors are unobstructed and all stairwell doors are closed. *	✓			
6.	Storage and working areas are free of trash. *	✓			
7.	All equipment and electrical devices that are not in use are turned off. *	✓			
8.	Signage is displayed regarding the prohibition of smoking.	✓			
9.	One additional fire drill per quarter has been performed or has been planned.	X			
10.	Alert staff that increased fire and hazard surveillance is in effect until further notice, and that they should report any possible fire hazards to management immediately.	✓			
11.	Education has been conducted with appropriate staff members regarding the building deficiencies and for compensation for structural and fire safety features.	/			

Note: Measures 1 through 7 must be performed hourly during regular business hours and documented below.

Documentation of hourly measure checks (attach form for additional comments if needed)

Time	7:00 AM	8:00 AM	9:00 AM	10:00 AM	11:00 AM	12:00 PM	1:00 PM	2:00 PM	3:00 PM	4:00 PM	5:00 PM	6:00 PM
Initials	[redacted]											
All Measures in Compliance	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No

Comments: _____

Attachment # 4

FIRESTOP-814+

Intumescent Elastomeric Firestopping Sealant

Technical Data Sheet

Product Features
Tested to ASTM-E814 (UL 1479)
Tested to ASTM-E1966 (UL-2079)
UL Classified
Intumescent
Elastomeric
Up to a 3 Hour Fire Rating
CPVC Compatible
Low V.O.C. (<10 g/l)

Product Description:

Firestop-814+ Intumescent Elastomeric Firestopping Sealant is a UL Classified, intumescent firestop sealant designed to resume the integrity of 1 & 2 hour rated fire rated floors and walls when penetrated by plumbing, electrical, and other mechanical items. Firestop-814+ is red in color, applies in a smooth, consistent paste, and cures to a tough, rubbery solid.

Applications:

- Multi-family and commercial construction
- For use where up to a 3 hour fire rating is reuired
- Wood, concrete, gypsum, and fire rated gypsum floors & walls
- Electrical, plumbing, and HVAC penetrations
- Fire resistive joints

Firestop 814+ is chemically compatible with FlowGuardGold® and Corzan® pipe fittings as well as all PVC, CPVC, ABS, PEX tubing and other applicable tested penetrating items.

*Flowguard Gold, BlazeMaster, and Corzan are licensed trademarks to the Lubrizol Corporation

Standards & Specifications:

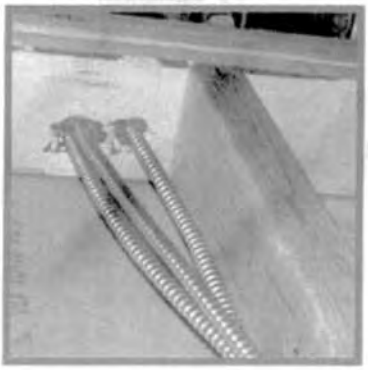
Tested to ASTM-E814 / UL-1479
Tested to ASTM-E1966 / UL-2079
Meets 51 STC Rating

EcoSeal Standards:
V.O.C. Content: **10 g/l**
LEED 2009 (EQ Credit 4.1): **1 point**
NAHB Green Guidelines: **5 G.I. Points**
Complies To: **SCAQMD Rule #1168**
OTC-Ozone Trans. Comm.
CARB
BAAQMD

Physical Properties:

Chemistry	Acrylic Latex
Cure Type	Water-Based
Color	Coral Red
Physical Uncured State	Glossy Paste
Physical Cured State	Rubbery Solid
Shelf Life	18 Months
Tack Free Time	30 Minutes at 75°F
Cure Time	3-4 Weeks at 75°F
Flame Spread	0
Smoke Development	0
Freeze - Thaw Stability	Excellent - 5 Cycles
STC Rating	51*
Volume Coverage (½" x ¼" diameter bead)	10.3 Oz. Tube = 16 ft. 20 Oz. Tube = 31.5 ft. 28 Oz. Tube = 45 ft. 5 Gallon Pail = 896 ft.
V.O.C. Level	10 grams / liter

*Tested in a UL-411 wall assembly/section to ASTM-E90



EverKem Diversified Products
5180 Indiana Avenue Winston Salem, 27106
PH: 1.800.638.3160 / FX: 1.336.661.7969
www.everkemproducts.com

FIRESTOP-814+

Intumescent Elastomeric Firestopping Sealant

Technical Data Sheet

Application Procedures:

1. Refer to the manufacturer's UL specified application procedures to ensure proper application of the firestop sealant.
2. Clean area to be protected so that is clean of wood shavings, dust particles, and debris.
3. Fill the annular space or void with Firestop-814+ to the required depth.
4. When encountering multiple wires or cables through a single penetration, be sure to apply caulking between and around the wires to ensure complete contact of filling material with the wire substrates and annular space surface.
5. There should be no visible passage upon completion of firestopping application.

Clean Up Procedures:

Excess caulk should be cleaned off tools and nonporous surfaces while it is in the uncured state using a dry cloth or paper towels. Excessive amounts may require the use of a solvent such as acetone or mineral spirits. Cured compound should be cut away.

Packaging Options:

Part #	Product Description	Color	Case Quantity
FS-814+	Firestop-814+ 10.3 Fl. Oz Tube	Coral Red	12 tubes/case
FS-814+20	Firestop-814+20 20 Fl. Oz. Sausage Tube	Coral Red	20 tubes/case
FS-814+28	Firestop-814+28 28 Fl. Oz. Tube	Coral Red	12 tubes/case
FS-814+5	Firestop-814+5 5 Gallon Pail	Coral Red	Each

Caution:

Read all directions before using this product. Avoid prolonged contact with skin and eyes as severe irritation may occur. Do not take internally. Keep container tightly closed when not in use. For additional information call 1-800-638-3160.

KEEP OUT OF REACH OF CHILDREN

Scan this QR Code to be directed to our online product page, where you can view additional information including Safety Data Sheets and Applicable Testing Documentation

Disclaimer:

Recommendations for use of this product are based on tests we believe to be reliable. Manufacturer and seller are not responsible for results where this product is used under conditions beyond our control. If when applied as directed, this material peels, cracks or separates, it will be replaced without charge upon presentation of proof of purchase and used cartridge. This limited warranty only applies to residential use and damages including consequential damage and other remedies are excluded. No other warranties apply, including fitness for a particular purpose.

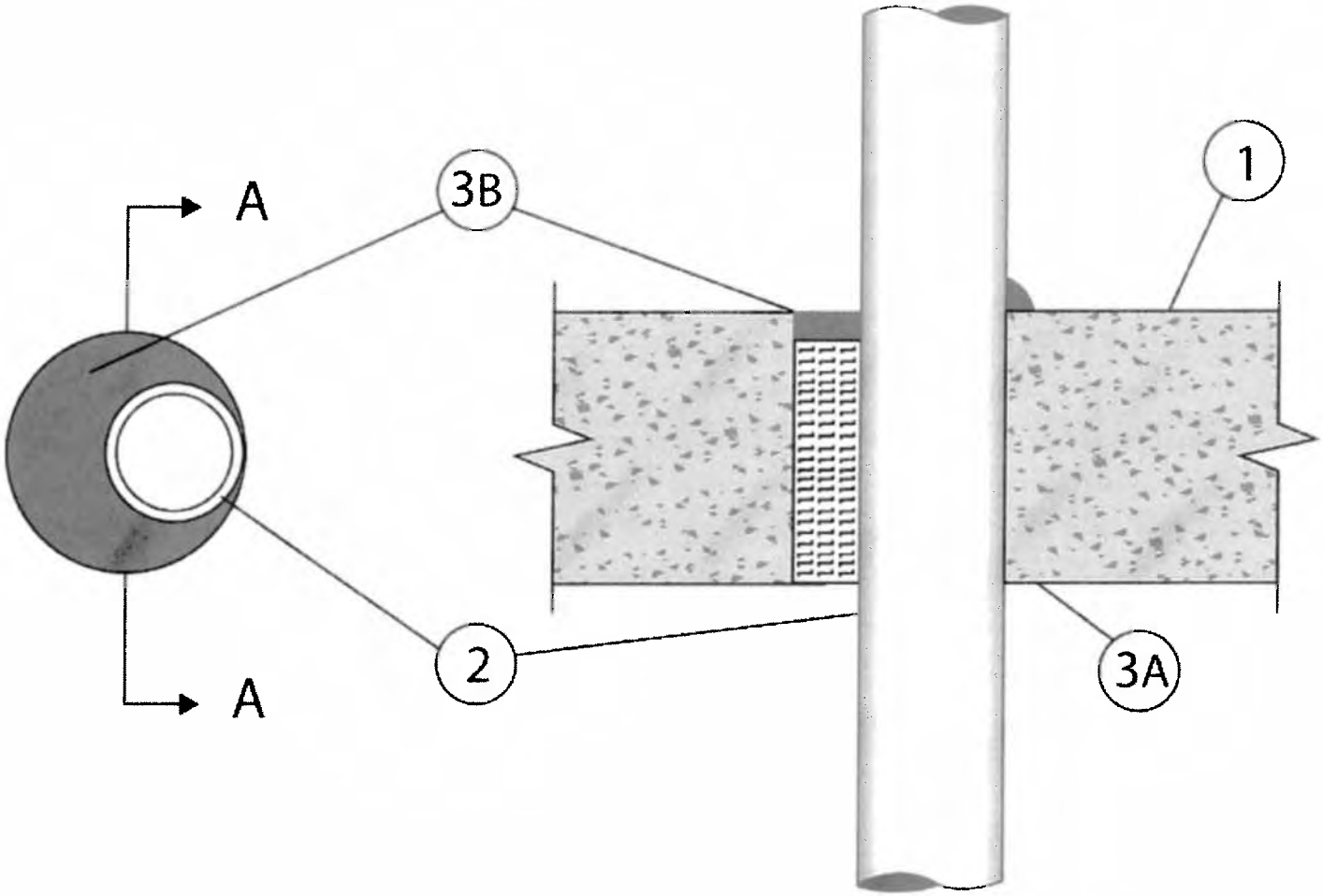
EverKem Diversified Products
5180 Indiana Avenue Winston Salem, 27106
PH: 1.800.638.3160 / FX: 1.336.661.7969

System No. C-AJ-2590

April 18, 2007

F Rating — 2 Hr

T Rating — 2 Hr



SECTION A-A

1. Floor or Wall Assembly — Min 4-1/2 in. thick reinforced lightweight or normal weight (100-150 pcf) concrete floor or min 5 in. thick reinforced lightweight or normal weight concrete wall. Wall may also be constructed of any UL Classified Concrete Blocks*. Max diam of opening is 4 in.

See Concrete Blocks (CAZT) category in the Fire Resistance Directory for names of manufacturers.

2. Through Penetrating Product* — One non-metallic pipe, installed either concentrically or eccentrically within firestop system. The annular space between the pipe and periphery of opening shall be min 0 (point contact) to max 1-5/8 in. Pipe to be rigidly supported on both sides of floor or

wall assembly. The following types and sizes of non-metallic pipes may be used:

A. Polyvinyl Chloride (PVC) Pipe — Nom 2 in. diam (or smaller) Schedule 40 solid core or cellular core PVC pipe for use in closed (process or supply) or vented (drain, waste or vent) piping systems.

B. Chlorinated Polyvinyl Chloride (CPVC) Pipe — Nom 2 in. diam (or smaller) SDR 13.5 CPVC pipe for use in closed (process or supply) piping systems.

C. Acrylonitrile Butadiene Styrene (ABS) Pipe — Nom 2 in. diam (or smaller) Schedule 40 solid core or cellular core ABS pipe for use in closed (process or supply) or vented (drain, waste or vent) piping systems.

3. Firestop System — The firestop system shall consist of the following:

A. Packing Material — Min 4 in. thickness of min 4 pcf mineral wool batt insulation firmly packed into opening as a permanent form. Packing material to be recessed from top surface of floor or from both surfaces of wall as required to accommodate the required thickness of fill material.

B. Fill, Void or Cavity Material* - Caulk — Min 1/2 in. thickness of fill material applied within the annulus, flush with top surface of floor or with both surfaces of wall assembly. At point contact location, ½ in. diam bead of caulk applied at interface of pipe and periphery of opening on top surface of floor or both surface of wall. For PVC pipe installed with an annular space of 0 (point contact) to 5/8 in., sealant depth may be reduced to ¼ in.

FLAME TECH INC — Firestop-814+

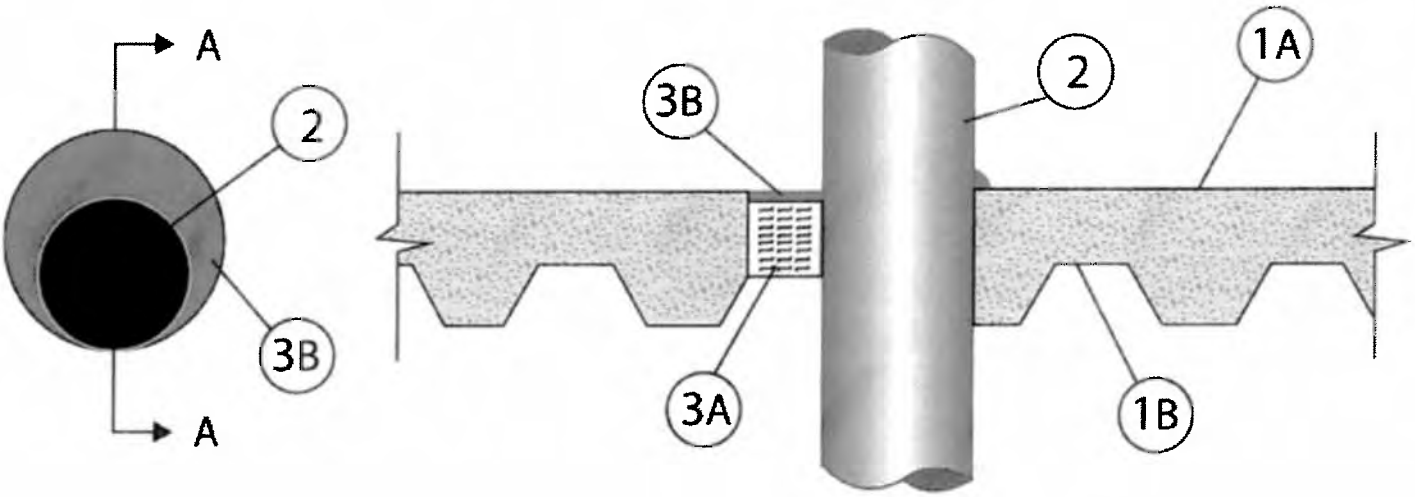
*Bearing the UL Classification Mark

System No. F-A-1096

April 18, 2007

F Rating — 2 Hr

T Rating — 0 Hr



SECTION A-A

1. Floor Assembly — The fire-rated unprotected concrete and steel floor assembly shall be constructed of the materials and in the manner specified in the individual D900 Series designs in the UL Fire Resistance Directory and as summarized below:

A. Concrete — Min 2-1/2 in. thick reinforced lightweight or normal weight (100-150 pcf) concrete.

B. Steel Floor and Form Units* — Composite or non-composite max 3 in. deep galv fluted units as specified in the individual Floor -Ceiling Design. Max diam of opening is 11 in.

2. Through Penetrant — One metallic pipe, conduit or tubing installed either concentrically or eccentrically within the firestop system. The annular space between penetrant and periphery of opening shall be min of 0 in. (point contact) to max 1-7/8 in. Penetrant to be rigidly supported on both sides of floor assembly. The following types and sizes of metallic pipes, conduits or tubing may be used:

A. Steel Pipe — Nom 8 in. diam (or smaller) Schedule 10 (or heavier) steel pipe.

B. Iron Pipe — Nom 8 in. diam (or smaller) cast or ductile iron pipe.

C. Conduit — Nom 6 in. diam (or smaller) steel conduit or nom 4 in. diam (or smaller) steel electrical metallic tubing.

D. Copper Tubing — Nom 4 in. diam (or smaller) Type M (or heavier) copper tubing.

E. Copper Pipe — Nom 4 in. diam (or smaller) Regular (or heavier) copper pipe.

3. Firestop System — The firestop system shall consist of the following:

A. Packing Material — Min 2-1/4 in. thickness of min 4 pcf mineral wool batt insulation firmly packed into opening as a permanent form. Packing material to be recessed from top surface of floor as required to accommodate the required thickness of fill material.

B. Fill Void or Cavity Materials* - Sealant — Min 1/4 in. thickness of sealant applied within the annulus, flush with top surface of floor. Min 1/2 in. diam bead of sealant applied at penetrant/concrete interface at point contact location on top surface of floor.

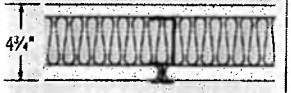
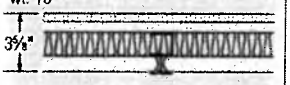
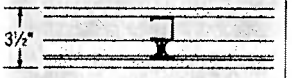
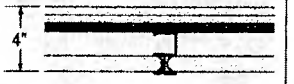
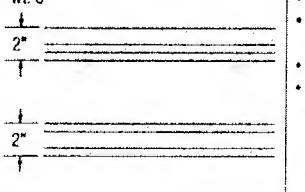
FLAME TECH INC — Firestop-814+

*Bearing the UL Classification Mark

Attachment # 5

Performance Selector

All details, specifications, and data contained in this literature are intended as a general guide. These products must not be used in a design or construction of any given structure without complete and detailed evaluation by a qualified structural engineer or architect to verify suitability of a particular product for use in the structure.

1-Hour Fire-rated Construction Construction Detail	Non-loadbearing Description	Test Number	Acoustical Performance STC	Test Number	Reference ARL	Index
wt. 8  3⅛"	• 5/8" Sheetrock Firecode Core gypsum panels, joints finished • 2-1/2" USG C-H Studs 25 gauge 24" o.c. • 1" Sheetrock gypsum liner panels	UL Des U415, System A or U469	39	USG-040901 Based on 4" C-H studs 25 gauge	SA926	1
2-Hour Fire-rated Construction						
wt. 9  3½"	• 1/2" Sheetrock Firecode C Core gypsum panels, face layer joints finished • 2-1/2" USG C-H Studs 25 gauge 24" o.c. • 1" Sheetrock gypsum liner panels	UL Des U415, System B or U438	38 43 48 50	USG-040917 USG-040912 Based on 4" C-H studs 25 gauge RAL-OT-04-022 Based on 1" sound batts in cavity RAL-OT-04-019 Based on 4" C-H studs 25 gauge with 3" mineral fiber insulation	SA926	2
wt. 8  4¼"	• 3/4" Sheetrock Ultracode Core gypsum panels, joints finished • 4" USG C-H studs 25 gauge 24" o.c. • 3" Thermafiber SAFB • 1" Sheetrock gypsum liner panels	UL Des U415, System C	51	RAL-OT-04-020 Based on 4" C-H studs with 3" Thermafiber SAFB insulation	SA926	3
wt. 10  3⅝"	• 1/2" Duracock cement board, joints finished • 5/8" Sheetrock Firecode Core gypsum panels • 2-1/2" USG C-H studs 20 gauge 24" o.c. • 1-1/2" Thermafiber SAFB • 1" Sheetrock gypsum liner panels • Duracock cement board, screw attached and laminated to gypsum panel with 4 vertical strip ceramic tile mastic centered between studs	UL Des U415, System D			SA926	4
wt. 9  3½"	• 1/2" Sheetrock Firecode C Core gypsum panels • 2-1/2" USG C-H Studs 25 gauge 24" o.c. • 1" Sheetrock gypsum liner panels • joints finished both sides	UL Des U415, System E or U467	44	USG-040911 Based on 4" C-H studs 25 gauge	SA926	5
wt. 10  4"	• 1/2" Sheetrock Firecode C Core gypsum panels applied vertically, face layer joints finished • RC-1 resilient channel or equivalent 24" o.c. • 2-1/2" USG C-H Studs 25 gauge 24" o.c. • 1" Sheetrock gypsum liner panels	UL Des U415, System F	53 58	USG-040909 Based on 4" C-H studs 25 gauge with 3" mineral fiber insulation USG-040910 Based on 4" C-H studs 25 gauge with additional layer on liner panel side and 3" mineral fiber insulation	SA926	6
wt. 8  2" 2"	• 1" x 2" perimeter angles 25 gauge • 1" Sheetrock gypsum liner panel fastened to angles • 1/2" Sheetrock Firecode C Core gypsum panels • 1/2" Sheetrock Firecode C Core gypsum panels joints finished	UL Des U529			SA926	7

Components

USG shaft wall systems have been comprehensively tested for fire resistance ratings only when all of the system components are used together. Substitutions of any of the components are not recommended and are not supported by USG. Refer to the appropriate product material safety data sheet for complete health and safety information.

Gypsum Liner Panels

SHEETROCK® Brand Gypsum Liner Panels

- High-performance panels have a noncombustible core encased in a water-resistant 100% recycled green face and back paper
- Underwriters Laboratories (UL)/Underwriters Laboratories Canada (ULC) Classified for fire resistance
- Panels are 1" thick and 24" wide with beveled edges
- Refer to product submittal sheet WB2278 for more information

SHEETROCK® Brand MOLD TOUGH™ Gypsum Liner Panels

- High-performance panels have a noncombustible and moisture- and mold-resistant gypsum core enclosed in a moisture- and mold-resistant, 100% recycled blue face and back paper
- UL/ULC Classified as to fire resistance
- Panels are 1" thick and 24" wide with beveled edges
- Refer to product submittal sheet WB2389 for more information

SHEETROCK® Brand Glass-Mat Liner Panels

- High-performance panels have a noncombustible and moisture- and mold-resistant gypsum core enclosed in a moisture- and mold-resistant glass mat on both sides
- Can be left exposed for up to 12 months
- UL/ULC classified as to fire resistance
- Panels are 1" thick and 24" wide with beveled edges
- Refer to product submittal sheet WB2483 for more information

Gypsum Panels and Cement Board

SHEETROCK® Brand FIRECODE® Core Gypsum Panels

- All of the advantages of regular panels with additional resistance to fire
- Available in 5/8" thickness, 4' width
- Refer to product submittal sheet WB1473 for more information

SHEETROCK® Brand FIRECODE® C Core Gypsum Panels

- Provide improved fire resistance over standard FIRECODE panels because of additives that enhance integrity of the core under fire exposure
- Available in 5/8" and 1/2" thicknesses, 4' width
- Refer to product submittal sheet WB1473 for more information

Wall Systems – Limiting Heights Table

Intermittent Air Pressure Load (wind load)–psf[a]

Stud Type and Size	Designation	Allowable deflection	Fire-rated system B, D, F, G, H, I 5	7.5	10	15	Fire-rated system E[b] 5	7.5	10	15
2-1/2" C-H Studs 	212CH-18	L/120	12'4"	10'10"	9'10"	8'7"	12'2"	10'8"	9'8"	8'5"
		L/240	11'4"	9'11"	8'12"	7'10"	11'2"	9'9"	8'10"	7'9"
		L/360	10'4"	9'1"	8'3"	7'2"	9'10"	8'7"	7'10"	6'10"
	212CH-34	L/120	14'3"	12'5"	11'4"	9'11"	14'2"	12'5"	11'3"	9'10"
		L/240	12'10"	11'3"	10'2"	8'11"	13'0"	11'5"	10'4"	9'1"
		L/360	11'7"	10'1"	9'2"	8'0"	11'6"	10'0"	9'1"	7'12"
4" C-H Studs 	400CH-18	L/120	17'9"	14'6"	12'7"	10'3"	16'4"	14'3"	12'11"	10'7"
		L/240	15'7"	13'8"	12'5"	10'3"	15'2"	13'3"	12'0"	10'6"
		L/360	13'11"	12'2"	11'1"	9'8"	13'4"	11'8"	10'7"	9'3"
	400CH-34	L/120	19'11"	17'4"	15'9"	13'10"	19'6"	17'1"	15'6"	13'7"
		L/240	18'1"	15'9"	14'4"	12'6"	17'11"	15'8"	14'3"	12'5"
		L/360	16'2"	14'1"	12'10"	11'3"	15'10"	13'10"	12'7"	11'0"
6" C-H Studs	600CH-34	L/120	25'4"	22'2"	19'8"	16'1"	28'0"	25'1"	21'9"	17'9"
		L/240	21'9"	19'0"	17'4"	15'1"	24'10"	21'9"	19'9"	17'3"
		L/360	20'0"	17'6"	15'11"	13'11"	21'11"	19'2"	17'5"	15'2"

Stud type and Size	Designation	Allowable deflection	Fire-rated system C[c] 5	7.5	10	15	Fire-rated system A[c] 5	7.5	10	15
2-1/2" C-H Studs 	212CH-18	L/120	—	—	—	—	11'5"	10'0"	9'1"	7'11"
		L/240	—	—	—	—	10'7"	9'3"	8'4"	7'4"
		L/360	—	—	—	—	9'4"	8'2"	7'5"	6'6"
	212CH-34	L/120	—	—	—	—	13'5"	11'8"	10'8"	9'3"
		L/240	—	—	—	—	12'3"	10'9"	9'9"	8'6"
		L/360	—	—	—	—	10'10"	9'6"	8'7"	7'6"
4" C-H Studs 	400CH-18	L/120	15'2"	12'5"	10'9"	8'9"	15'2"	12'5"	10'9"	8'9"
		L/240	14'5"	12'5"	10'9"	8'9"	14'5"	12'5"	10'9"	8'9"
		L/360	12'9"	11'2"	10'1"	8'9"	12'9"	11'2"	10'1"	8'9"
	400CH-34	L/120	20'5"	17'10"	16'2"	13'4"	20'5"	17'10"	16'2"	13'4"
		L/240	17'6"	15'3"	13'10"	12'1"	17'6"	15'3"	13'10"	12'1"
		L/360	15'3"	13'4"	12'1"	10'7"	15'3"	13'4"	12'1"	10'7"
6" C-H Studs	600CH-34	L/120	26'3"	21'5"	18'7"	15'2"	26'3"	21'5"	18'7"	15'2"
		L/240	24'0"	20'12"	18'7"	15'2"	24'0"	20'12"	18'7"	15'2"
		L/360	21'1"	18'5"	16'9"	14'8"	21'1"	18'5"	16'9"	14'8"

For more information consult Progressive Engineering Report AER-09038 at p-e-i.com

Notes

Runner fasteners should withstand 193-lb single shear and 200-lb bearing force; attachment spacing should not exceed 24" o.c. See the Performance Selector for system references and rated assembly details. L/180 data available upon request from USG. Limiting criteria: f—bending stress, d—deflection, v—end reaction shear c—practical limitation. [a] Stud spacing of 24" for all values. [b] For assembly with single-layer board both sides of studs. [c] For assembly with single-layer board attached to studs. [d] Attachment of USG steel double 6" E-stud for USG shaft wall systems. The studs are to be attached back-to-back (web to web) with pairs 1/2" of type S-12 pan head screws installed in two rows, spaced as widely apart as possible. The first and last pairs of fasteners shall start within 6" of each end of the studs. They shall then be spaced at a maximum of 12" on center throughout the body of the entire stud. [e] Use JR20 runner for this height.

Performance Selector

Wall Systems – Limiting Heights

Unlined Shafts

Gypsum shaft walls have been used for many years for vent and air shafts. Their fire-resistant features and economical dry construction make them ideal for this use. To function properly, vent and air shaft systems should be designed with the following performance provisions:

1. Gypsum board surface temperature does not exceed 125 °F.
2. Separate approved liners should be installed in areas subject to continuous moisture overspray, condensation or air stream temperature over 125 °F.
3. Air stream dew point temperatures are maintained below gypsum board surface temperature.
4. The assembly is constructed to withstand sustained design uniform air pressure loads not exceeding 10 psf. Startup surge loads should not be greater than 1-1/2 times the design static load. (See table below for limiting heights.)
5. To ensure airtight construction, select appropriate sealants and apply where required.

Sustained pressure load–psf

				2-hr. fire-rated system		1-hr. fire-rated system	
Stud Type and Size	**Designation**	**Stud Spacing**	**Allowable deflection**	**5**	**10**	**5**	**10**
2-1/2" C-H Studs	212CH-18	24"	L/120	10'10"	8'7"	10'0"	7'11"
			L/240	9'11"	7'10"	9'3"	7'4"
			L/360	9'1"	7'2"	8'2"	6'6"
	212CH-34	24"	L/120	12'5"	9'11"	11'8"	9'3"
			L/240	11'3"	8'11"	10'9"	8'6"
			L/360	10'1"	8'0"	9'6"	7'6"
4" C-H Studs	400CH-18	24"	L/120	14'6"	10'3"	12'5"	8'9"
			L/240	13'8"	10'3"	12'5"	8'9"
			L/360	12'2"	9'8"	11'2"	8'9"
	400CH-34	24"	L/120	17'4"	13'10"	17'10"	13'4"
			L/240	15'9"	12'6"	15'3"	12'1"
			L/360	14'1"	11'3"	13'4"	10'7"
6" C-H Studs	600CH-34	24"	L/120	22'2"	16'1"	21'5"	15'2"
			L/240	19'0"	15'11"	20'1"	15'2"
			L/360	17'6"	13'11"	18'5"	14'8"

For more information consult Progressive Engineering Report AER-09038 at p-e-i.com

Notes
Runner fasteners should withstand 193-lb. single shear and 200 lb. bearing force; attachment spacing should not exceed 24" o.c. for Use L/360 runner for this height.

Larsen's

Call us Today! 1-800-527-7367

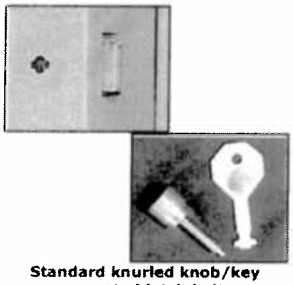
www.larsensmfg.com

Flush Fire-Rated Access Panels

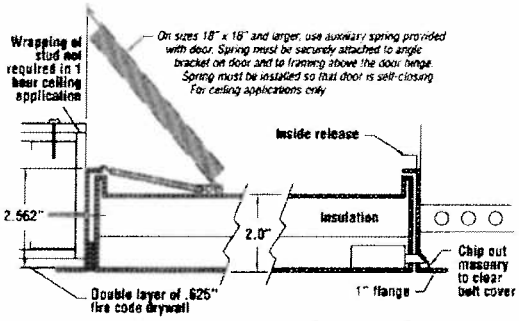
Larsen's has a fire-rated access panel for any wall or ceiling application. The 1" wide flange frame **(L-FRAP)** is standard. Stainless steel units are available in 304 with #4 finish **(L-FRAPSS)**. For concealment, Larsen's offers drywall corner bead or plaster bead frames. These will allow finish material to be applied, leaving only the panel exposed (**please contact Larsen's for sizing and availability**).

L-FRAP

Fire-rated, flush access panel for all applications



Standard knurled knob/key operated latch bolt



UL Listed "B" Label for 1.5 hrs in walls (maximum temperature rise to 250°F in .5 hrs)

Warnock-Hersey listed for 3 hrs in ceilings

Fire-Rated access panels are available with an optional mortise preparation for 1.125" cylinder.

Warnock Hersey

c UL us

L-FRAP	L-FRAPSS	Part	Description
X		Door	20 ga. cold rolled steel
	X	Door	304 Stainless steel
X	X	Frame	16 ga. with 1" flange
X	X	Hinge	Concealed continuous piano hinge
X	X	Latch	Knurled knob/key operated latch bolt
X		Finish	Phosphate dipped and prime coated
	X	Finish	#4
X	X	Insulation	2" fire-rated mineral fiber

Width x Height mm	Width x Height inches	Latches
203 x 203	08 x 08	1
254 x 254	10 x 10	1
305 x 305	12 x 12	1
305 x 610	12 x 24	1
356 x 356	14 x 14	1
406 x 406	16 x 16	1
457 x 457	18 x 18	1
508 x 762	20 x 30	1
559 x 559	22 x 22	1
559 x 762	22 x 30	1
559 x 914	22 x 36	2
610 x 610	24 x 24	1
610 x 762	24 x 30	1
610 x 914	24 x 36	2
610 x 1219	24 x 48*	2
762 x 762	30 x 30*	1
813 x 813	32 x 32*	1
914 x 914	36 x 36*	2

Rough Opening = Panel Size + .25"

*L-FRAP is available in 304 stainless steel with #4 finish **(L-FRAPSS)***

All access panels are hinged on the second dimension (height).

*Exceeds maximum size to carry a Warnock-Hersey label in ceilings

CALL 1-800-LARSENS (527-7367) / FAX (763) 571-6900

Contact Larsen's Mfg. - Request More Info

If you would like us to contact you or provide more information please use the online form below. Please note we respect your privacy and will not sell your information including email address to anyone else. Thank you!

Name

E-mail

Phone (required)

More information about Please select one

How did you find us? Please select one

Additional comments or specific questions

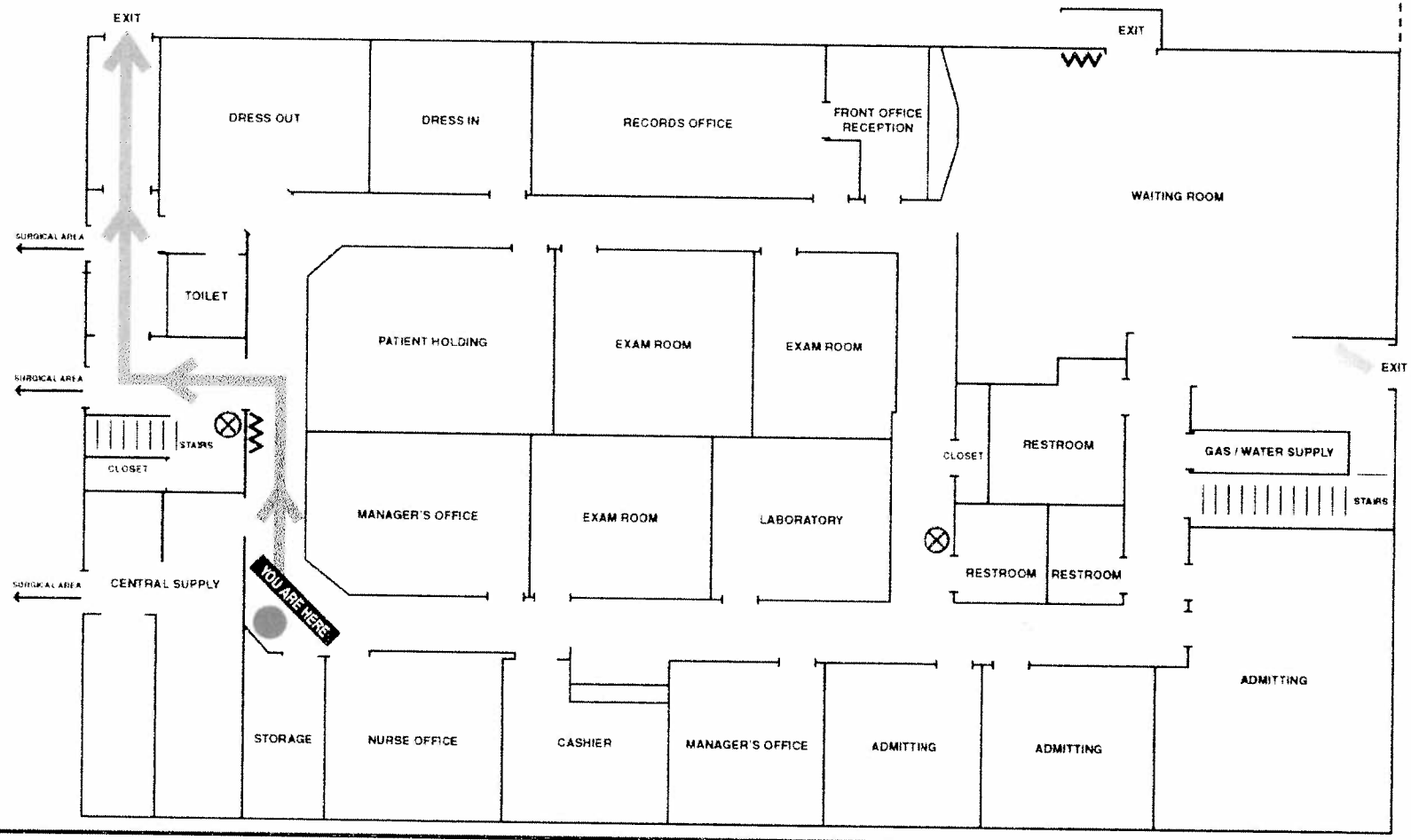
Request Info from Larsen's Manufacturing

Minneapolis Division
7421 Commerce Lane N.E., Minneapolis, MN 55432
Phone (763) 571-1181 Toll Free 1-800-527-7367
Fax (763) 571-6900

Florida Division
3130 N.W. 17th St. Ft. Lauderdale, FL 33311
Phone (954) 486-3325 Toll Free 1-800-262-3473
Fax (954) 486-3352

EMERGENCY EXIT PLAN

ATTACHMENT # 6



Location of where you are standing

Fire Extinguisher

Manual Fire Pull Station

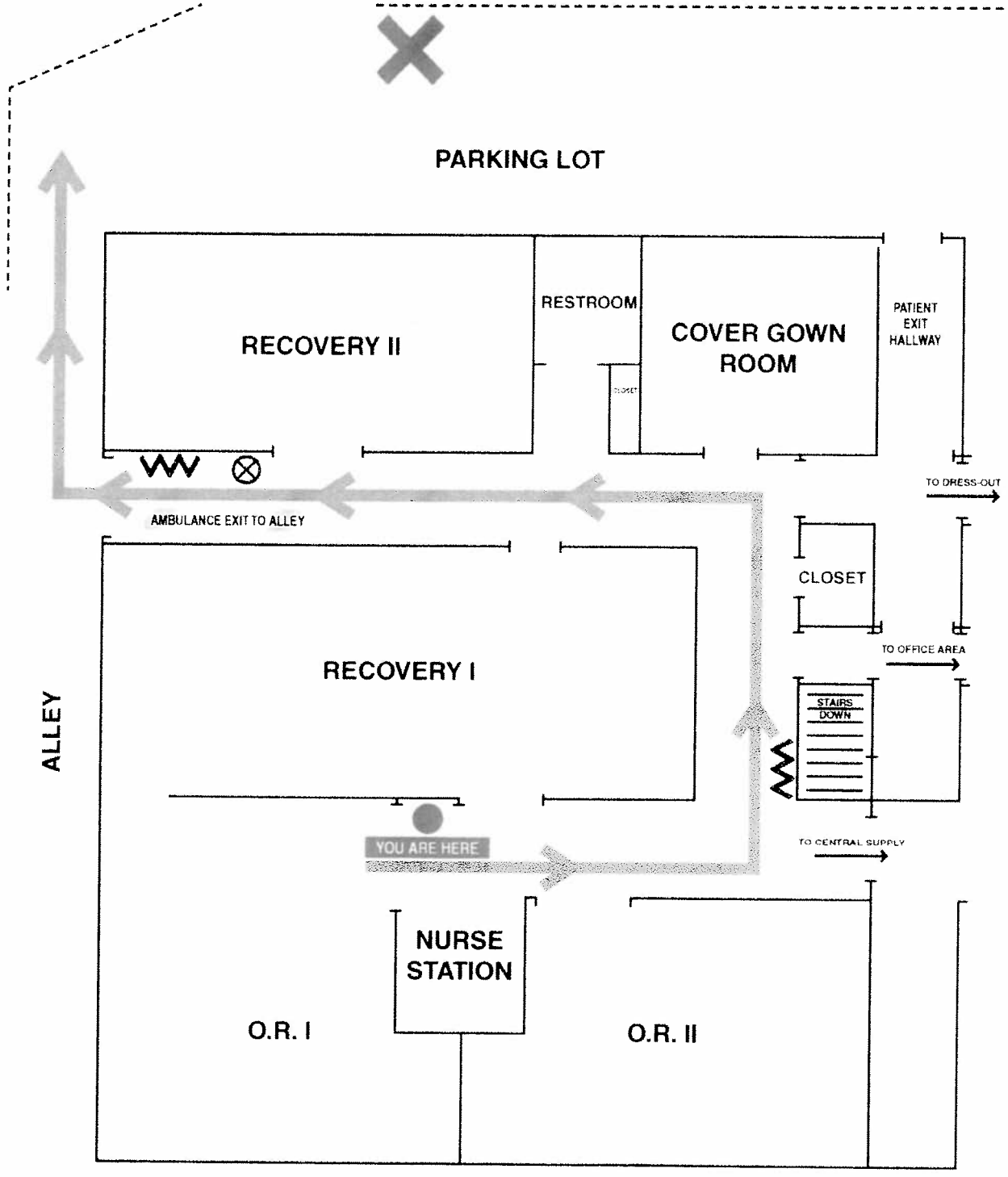
Fence

Primary Exit (Green)

Secondary Exit (Yellow)

SAFE Meeting Point

EMERGENCY EXIT PLAN



Location of where you are standing

Fire Extinguisher

Manual Fire Pull Station

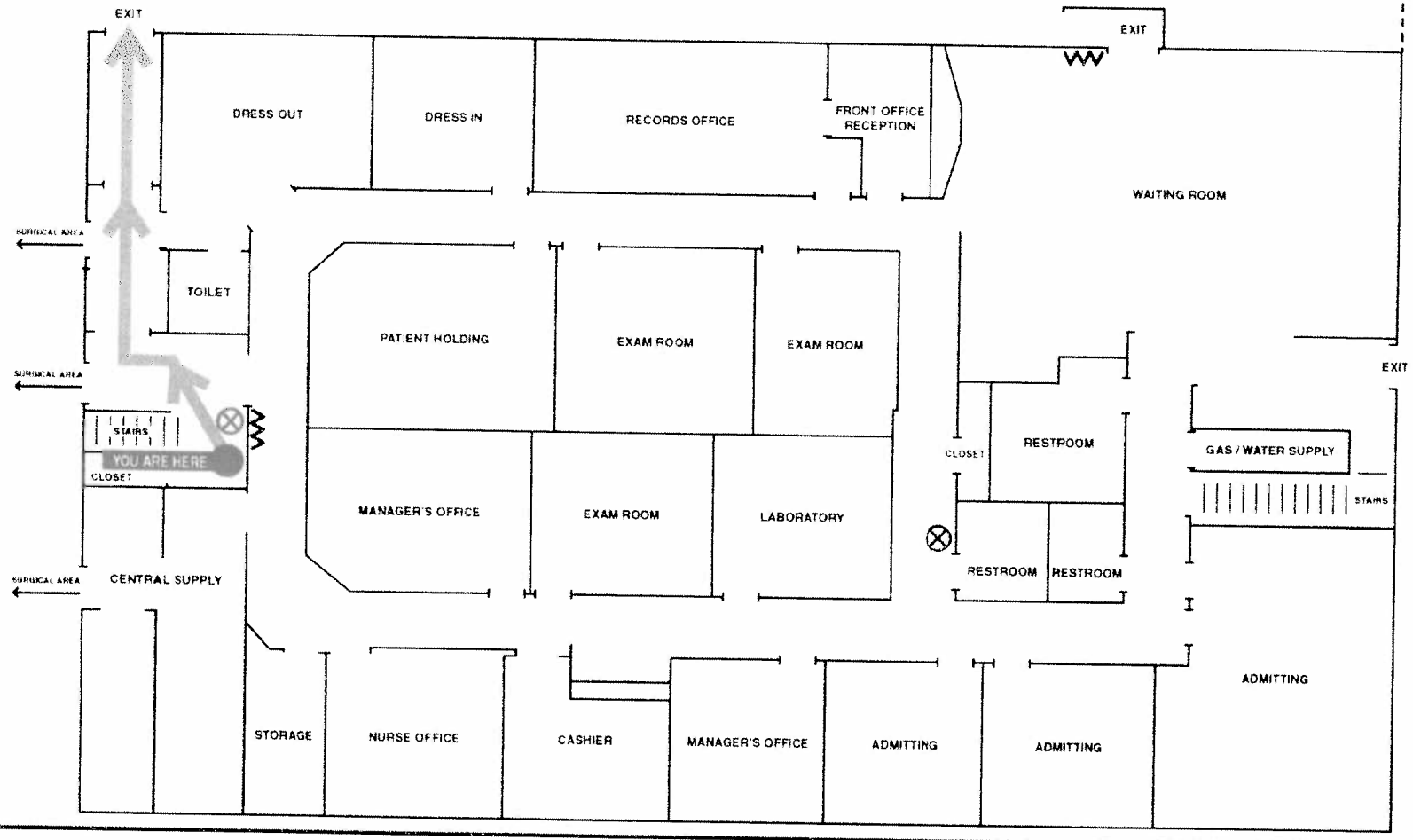
Fence

SAFE Meeting Point

Primary Exit (Green)

Secondary Exit (Yellow)

EMERGENCY EXIT PLAN



Location of where you are standing

Fire Extinguisher

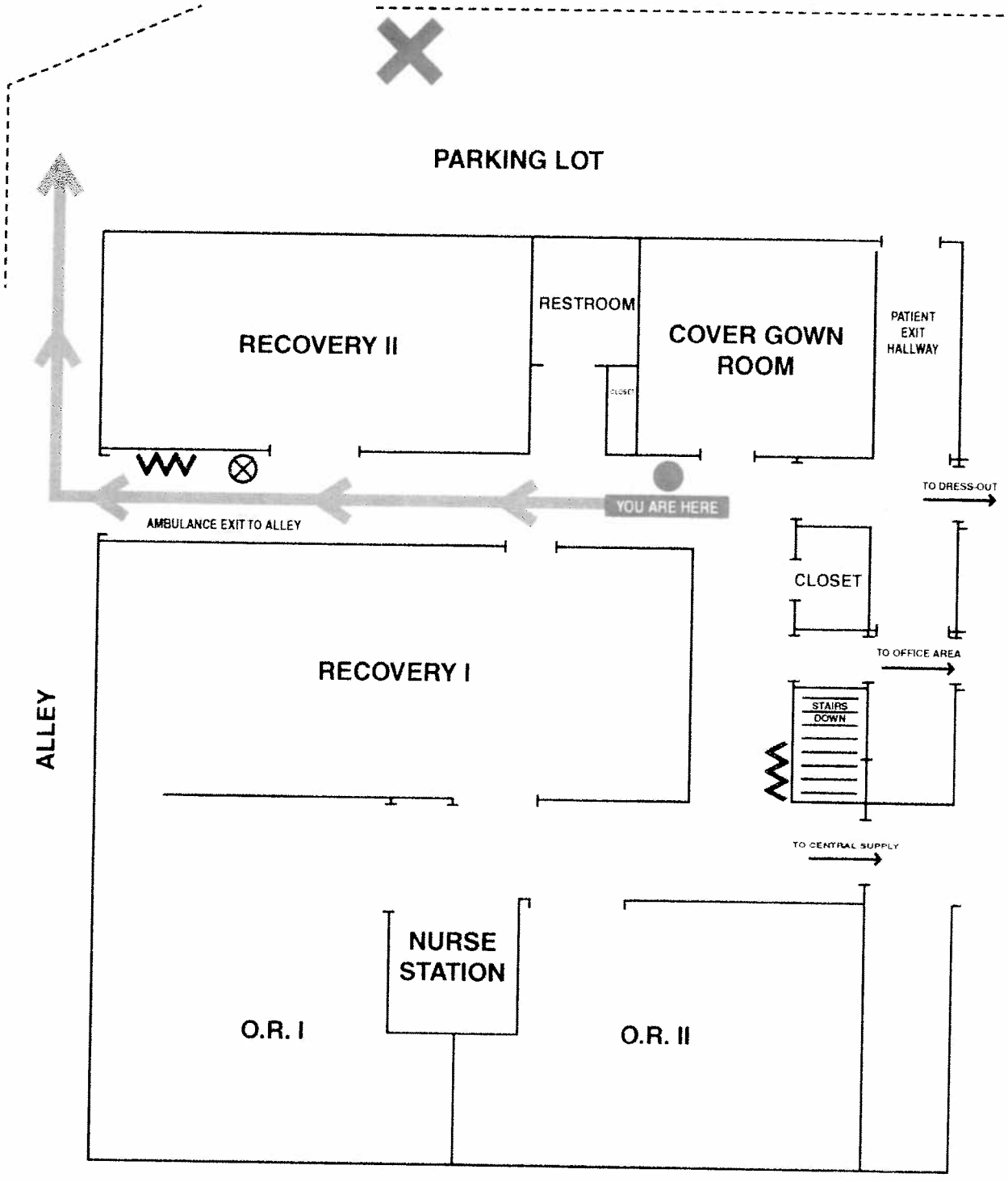
Manual Fire Pull Station

Fence

Primary Exit (Green)

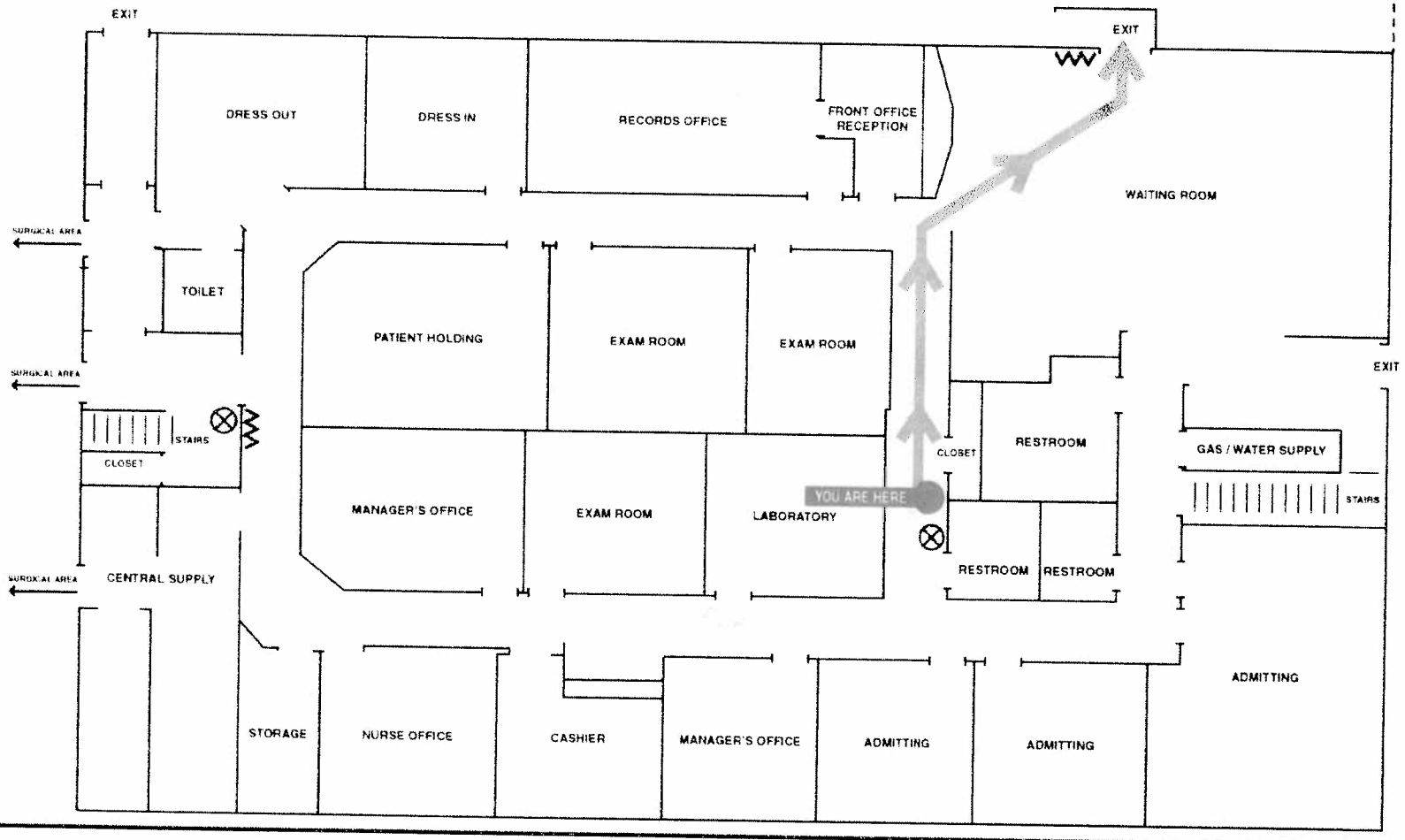
SAFE Meeting Point

EMERGENCY EXIT PLAN

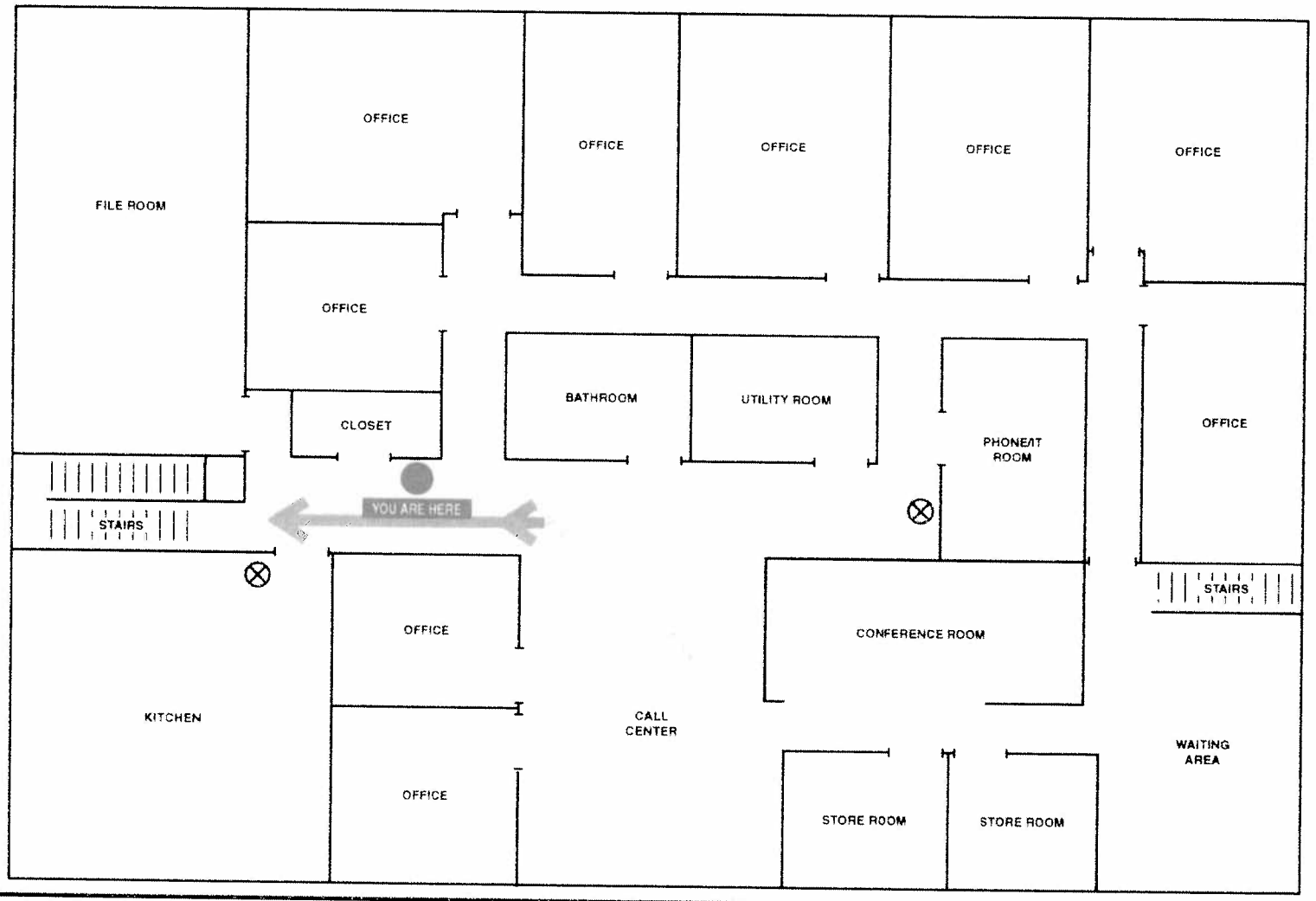


- Location of where you are standing
- Fire Extinguisher
- Manual Fire Pull Station
- ------ Fence
- SAFE Meeting Point
- Primary Exit (Green)
- Secondary Exit (Yellow)

EMERGENCY EXIT PLAN



EMERGENCY EXIT PLAN



Location of where you are standing

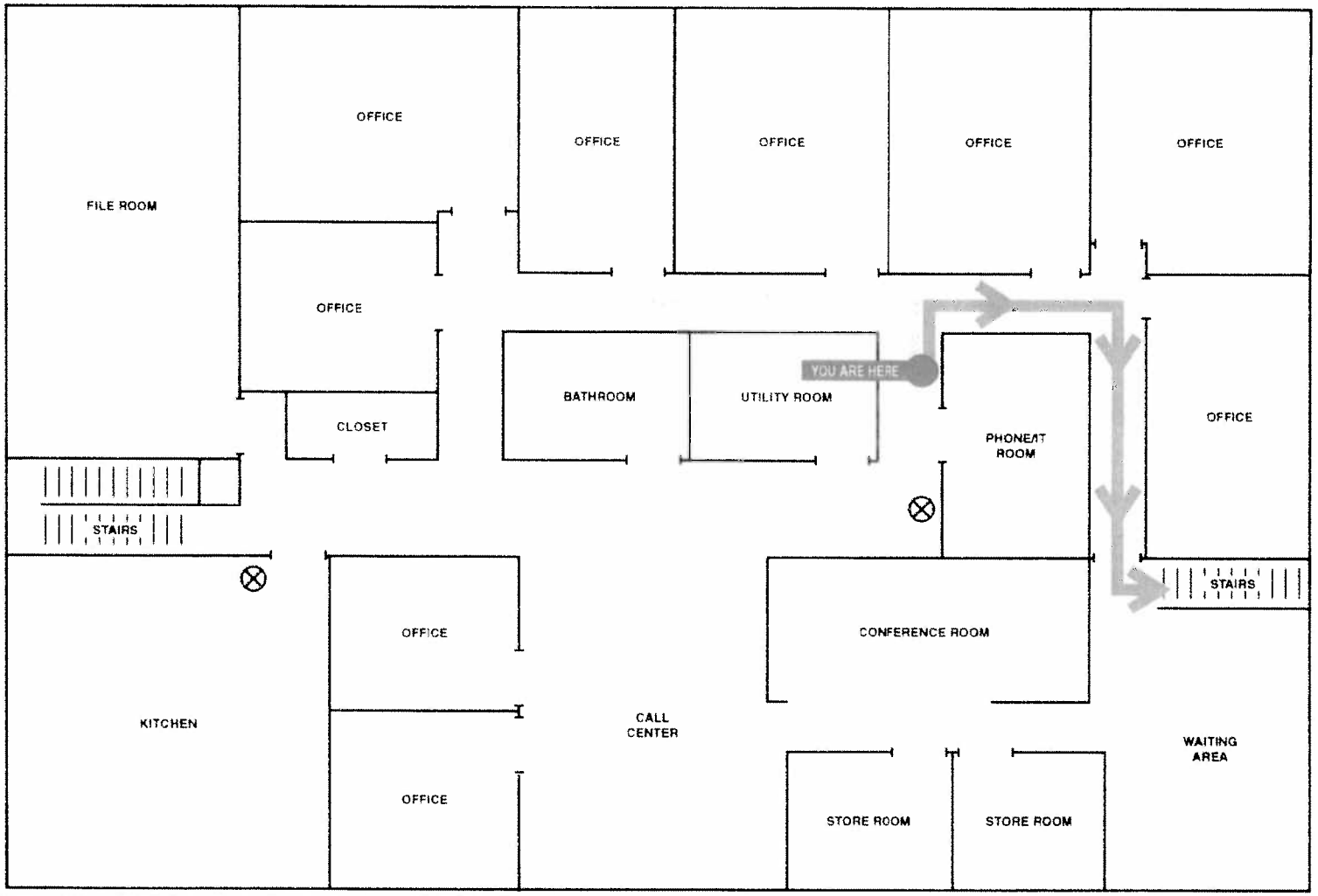
Fire Extinguisher

Manual Fire Pull Station

Primary Exit (Green)

Secondary Exit (Yellow)

EMERGENCY EXIT PLAN



Location of where you are standing

Fire Extinguisher

Manual Fire Pull Station

Primary Exit (Green)

Secondary Exit (Yellow)

ATTACHMENT No. 7

Topic: Fire Safety	Page: 1 of 1	Policy Number: 7.2
Title: Fire Response Plan	Revised/Reviewed 10/22/2014	Effective Date: 10/22/2014
		Removal Date:

General
Evacuation for the Ambulatory Surgery Center will mean removal of patients, personnel, and guests to the outside. Evacuation route drawings are posted in prominent locations throughout the facility.

Upon Discovery of a Fire or a Suspected Fire – Follow R.A.C.E. Procedures

- ✓ **R** – Rescue immediately endangered persons
- ✓ **A** – Activate the Alarm
- ✓ **C** – Confine fire by closing door
- ✓ **E** – Extinguish/Evacuate

After the fire alarm has been activated, the code phrase "Code Red", followed by the employee's location shall be used when an employee discovers a fire or suspects a fire. When all employees hear "Code Red" to a location all employees are expected, and required, to start the emergency action plan (EAP) for fire.

Fire Alarm Notification System
When a fire is discovered or suspected the fire alarm must be pulled immediately to activate the alarm.
A fire alarm can be activated by the following mechanisms:

- ✓ Manual pull station
- ✓ Heat and/or smoke detection devices

All alarms are automatically transmitted to the local fire department.
A horn sounding along with flashing strobe lights indicates that the facility is evacuating.

Operating Room/Recovery Room Employee Procedures

- ➢ No case will be started after the fire alarm has sounded. Surgeons and Anesthesia Care Providers with cases in progress will be informed of the situation and advised to complete procedures as quickly as possible and report the minimum length of time before evacuation of the patients can take place.
- ➢ The surgical team will stay with their patient in the room until the patient is stabilized and evacuation becomes possible.
- ➢ For fires in the OR, the patient will be stabilized surgically and evacuated as quickly as possible. Please note that monitoring equipment can be moved with the patient as it is battery powered.
- ➢ For fires in Recovery, patients should be stabilized and moved as quickly as possible to the designated evacuation place. Please note that monitoring equipment can be moved with the patient as it is battery powered.
- ➢ All OR and Recovery Room employees are responsible for evacuating the ambulatory patients first, then the non-ambulatory patients as they will need more assistance. The gurneys located in the recovery room can be utilized to evacuate patients who are unable to walk. All employees and patients will meet at the evacuation place. The Recovery Room nurse or her/his designee is also responsible for evacuating with the disaster box to sustain the patients until further emergency personnel arrive.
- ➢ The decision to shut off oxygen flow to the affected OR will depend on the circumstances of the fire. Once it is determined if this measure is necessary the manager or designated staff member will immediately shut off the supply valve.

Review History:
Reviewed October 22, 2014, by [redacted]

Topic: Fire Safety	Page: 1 of 4	Policy Number: 7.1
Title: Employee Emergency and Fire Prevention Plan	Revised/Reviewed 02/25/2015	Effective Date: 02/25/2015 Removal Date:

FIRE PREVENTION PLAN

1.0 POLICY

It is the policy of Family Planning Associates Medical Group (FPA) and Albany Medical-Surgical Center (AMSC) to provide to employees the safest practical workplace free from areas where potential fire hazards exist. The primary goal of this fire protection program is to reduce or eliminate fire in the workplace by heightening the fire safety awareness of all employees. Another goal if this plan is to provide all employees with the information necessary to recognize hazardous conditions and take appropriate action before such conditions result in a fire emergency.

This plan details the basic steps necessary to minimize the potential for fire occurring in the workplace. Prevention of fires in the workplace is the responsibility of everyone employed by the company but must be monitored by each supervisor overseeing any work activity that involves a major fire hazard. Every effort will be made by the company to identify those hazards that might cause fires and establish a means for controlling them.

The fire prevention plan will compile a list of all major workplace fire hazards, the names or job titles of personnel responsible for fire control and prevention equipment maintenance, names or job titles of personnel responsible for control of fuel source hazards and locations of all fire extinguishers in the workplace. The plan administrator, or safety officer, must also be familiar with the behavior of employees that may create fire hazards as well as periods of the day, month, and year in which the workplace could be more vulnerable to fire. This fire prevention plan will be reviewed and updated as needed to maintain compliance with applicable regulations and standards and remain up-to-date with the state of the art in fire protection. Workplace inspection reports and fire incident reports will be maintained and used to provide corrections and improvements to the plan.

This plan will be available for employee review at any time during all normal working hours.

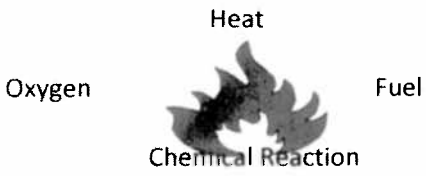
2.0 SCOPE AND APPLICATION

As required by OSHA the following Fire Prevention Plan has been developed to prevent or minimize the possibility of a fire emergency.

3.0 ELEMENTS

3.1 Classification

Fire is a chemical reaction involving the rapid oxidation or burning of a fuel. It needs four elements to occur as illustrated below:



3.2 Types of Fires

Fires are classified into four groups according to sources of fuel: Class A, B, C, and D based on the type of fuel source.

Class A	Ordinary combustible materials such as paper, wood, cloth and some rubber and plastic materials.
Class B	Flammable or combustible liquids, flammable gases, greases and similar materials, and some rubber and plastic materials.
Class C	Energized electrical equipment and power supply circuits and related materials.
Class D	Combustible metals such as magnesium, titanium, zirconium, sodium, lithium and potassium.

3.3 Major Workplace Fire Hazards

The following is a list of a potential fire hazard within the facility and their proper handling and storage procedures.

Formalin – Follow manufactures' recommendations for handling and storage.
Electric Circuits – Keep equipment, moister, paper, and any chemical clear.
Hot Water Heater – Keep equipment, moister, paper, and any chemical clear.
Medical Equipment – Follow manufactures' recommendations for handling and storage.

It is every employee's responsibility to let their supervisor know if one of the above is not in compliance. Fire extinguishers are located throughout the facility. The alarm system is connected with the fire department.

3.4 Personnel Responsible for Maintenance of Fire and Emergency Equipment

Tim Fitch, Maintenance Engineer

3.5 Personnel Responsible for Control of Fuel Source Hazards

Tim Fitch, Maintenance Engineer, is responsible for the control of fuel source hazards. Regular inspections are performed by him or an outside service of his designation.

4.0 STORAGE AND HANDLING PROCEDURES

The storage of material shall be arranged such that adequate clearance is maintained away from heating surfaces, air ducts, heaters, and lighting fixtures. All storage containers or areas shall prominently display signs to identify the material stored within. Storage of chemicals shall be separated from other materials in storage, from handling operations, and from incompatible materials. All individual containers shall be identified as to their contents.

Only containers designed, constructed, and tested in accordance with the U. S. Department of Transportation specifications and regulations are used for storage of compressed or liquefied gases. The gas cylinders shall be secured in place and stored away from any heat or ignition source, primarily compressed oxygen in our facility. Pressurized gas cylinders shall never be used without pressure regulators.

4.1 Flammable Materials

4.1.1 Bulk quantities of flammable materials shall be stored outdoors and away from buildings.
4.1.2 Flammable materials shall be stored away from sources that can produce sparks.
4.1.3 Flammable materials shall be separated from materials and conditions that present exposure hazards to and from each other.
4.1.4 Storage locations shall be well protected, dry, well ventilated, and separate from combustible materials.

4.2 Potential Ignition Sources

4.2.1 Don't misuse fuses. Never install a fuse rated higher than specified for the circuit.

4.2.2 Investigate any appliance or equipment that smells strange. Microwave ovens, autoclaves, surgical equipment, coffee makers and other small appliances shall be rigidly regulated and closely monitored.

5.0 HOUSEKEEPING

General housekeeping is an everyday duty. Cleanliness is stressed to all employees! The Housekeeping Personnel from the maintenance department have as part of their duties, the responsibility for maintaining and cleaning equipment.

5.1 Housekeeping Preventative Techniques

5.1.1 Keep storage and working areas free of trash.

5.1.2 Dispose of materials in noncombustible containers that are emptied daily.

5.1.3 Follow provided storage and handling procedures.

5.1.4 Ensure combustible materials are present only in areas in quantities required for the work operation.

5.1.5 Clean up any spill of flammable liquids immediately.

5.1.6 Report any hazardous condition, such as old wiring, worn insulation and broken electrical equipment, to a supervisor immediately.

5.1.7 Don't overload electrical outlets.

5.1.8 Ensure all electrical equipment is turned off at the end of the work day.

5.1.9 Maintain the right type of fire extinguisher available for use.

5.1.10 Use the safest cleaning solvents (nonflammable and nontoxic) when cleaning electrical equipment.

5.1.11 Ensure that all passageways and fire doors are unobstructed.

5.1.12 Stairwell doors shall never be propped open, and materials shall not be stored in stairwells.

5.1.13 Don't allow material of any kind to block or to be piled around fire extinguisher locations.

6.0 FIRE PROTECTION EQUIPMENT

Every building will be equipped with an electrically managed, manually operated fire alarm system. When activated, the system will sound alarms that can be heard above the ambient noise levels throughout the workplace. The fire alarm will also automatically transmit a message to the fire department when activated. Any fire suppression or fire detection system will automatically actuate the building alarm system.

Portable fire extinguishers are placed in our facility. Fire extinguishers must be kept fully charged and stored in their designated places. The extinguishers will not be obstructed or obscured from view. **A map indicating the locations of all fire extinguishers for this building are posted in prominent locations throughout the facility.** The fire extinguishers will also be inspected by the manager or maintenance engineer, at least monthly, to make sure that they are in their designated places, have not been tampered with or actuated, and are not corroded or otherwise impaired. Attached inspection tags shall be initialed and dated each month after the inspection is completed.

7.0 TRAINING

7.1 Employee Training for Fire Hazards of the Materials and Processes

Employees are trained immediately upon being hired and then annually. The fire safety training sessions will coincide with a review of material safety procedures and the material safety data sheets. Fire drills will be scheduled and performed quarterly, throughout the year at various times throughout the day. The facility is not open 24 hours a day and therefore we do not operate multiple sifts a day, however if this changes at any point a fire drill will be scheduled quarterly on each shift. The fire drill will be unannounced to employees prior to its occurrence.

7.2 New Employee Training for Fire Hazards of the Materials and Processes

New employee training of fire hazards of the materials and processes must be completed with each new employee prior to the employee beginning her or his duties with in the facility. Under no circumstances should a new employee be allowed to begin work without training for fire hazards of the materials and processes.

Review History:
Reviewed February 25, 2015, by [redacted]

Topic: Fire Safety	Page: 1 of 2	Policy Number: 7.3
Title: Fire Extinguishers	Revised/Reviewed 02/25/2015	Effective Date: 02/25/2015
		Removal Date:

Types of Fire Extinguishers

Family Planning Associates Medical Group (FPA) and Albany Medical-Surgical Center, has only ABC fire extinguishers in our facilities. ABC fire extinguishers are filled with a fine yellow powder of dry chemicals. The greatest portion of this powder is composed of monoammonium phosphate. Nitrogen is used to pressurize the extinguishers. The abbreviation "**ABC**" indicates that they are designed to extinguish class A, B, and C fires.

Dry chemical extinguishers put out fire by coating the fuel with a thin layer of dust, separating the fuel from the oxygen in the air. The powder also works to interrupt the chemical reaction of fire, so **these extinguishers are extremely effective at putting out fire.**

These extinguishers will be found in the upstairs hallway, break room, stairway, patient bathroom, recovery hallway, and the basement.

Classification of Fuels

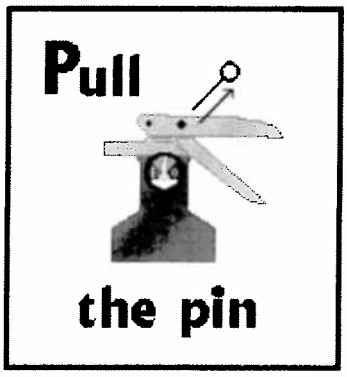
Class A - Wood, paper, cloth, trash, plastics
Solid combustible materials that are not metals. (Class **A** fires generally leave an **A**sh.)

Class B - Flammable liquids: gasoline, oil, grease, acetone
Any non-metal in a liquid state, on fire. This classification also includes flammable gases. (Class **B** fires generally involve materials that **B**oil or **B**ubble.)

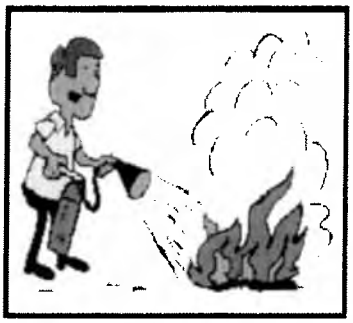
Class C - Electrical: energized electrical equipment
As long as it's "plugged in," it would be considered a class C fire. (Class **C** fires generally deal with electrical **C**urrent.)

Class D - Metals: potassium, sodium, aluminum, magnesium
Unless you work in a laboratory or in an industry that uses these materials, it is unlikely you'll have to deal with a Class D fire. It takes special extinguishing agents (Metal-X, foam) to fight such a fire.

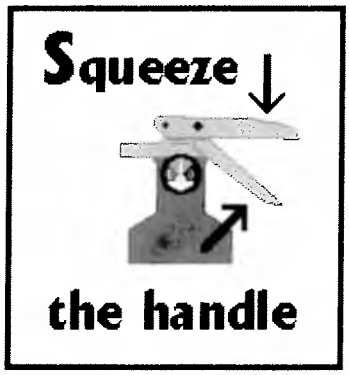
How to Use a Fire Extinguisher
It's easy to remember how to use a fire extinguisher if you can remember the acronym **PASS**, which stands for **P**ull, **A**im, **S**queeze, and **S**weep.



Pull the pin.
This will allow you to discharge the extinguisher.



Aim at the base of the fire.
If you aim at the flames (which is frequently the temptation), the extinguishing agent will fly right through and do no good. You want to hit the fuel.



Squeeze the top handle or lever.
This depresses a button that releases the pressurized extinguishing agent in the extinguisher.

Sweep from side to side
until the fire is completely out. Start using the extinguisher from a safe distance away, then move forward. Once the fire is out, keep an eye on the area in case it re-ignites.

Theory is great, but there is no substitute for hands-on experience. Employees are trained regarding the use of fire extinguishers immediately upon being hired and then annually thereafter.

Review History:
Reviewed February 25, 2015, by [redacted]

Topic: Emergency Preparedness & Disaster	Page: 1 of 4	Policy Number: 6.1
Title: Emergency Action Plan (29 CFR 1910.38)	Revised/Reviewed: 02/10/2014	Effective Date: 02/10/2014 Removal Date:

Emergencies will occur. The effect of the emergency must be controlled by means of a proper pre-emergency plan. In order to respond to this need, our company has developed the following plan which all employees are expected to follow in preventing or responding to emergency situations that we reasonably expect in our workplace.

1.0 SCOPE AND APPLICATION

As required by OSHA, the following Emergency Action Plan has been developed to ensure employee safety from fire or other emergencies.

2.0 CONTACT INFORMATION

EMERGENCY PHONE NUMBERS

Emergency	**911**
Local Police Station – 16th District	**312-742-4480**
FBI Contact – [redacted]	**312-421-6700**
Poison Control	**1-800-222-1222**

EMERGENCY PLAN COORDINATORS

FACILITY	NAME	TITLE
Cottage Grove	[redacted]	Assistant Manager
Elston		Clinic Manager
Elston		Assistant Manager
Washington		Operations Manager
All Locations		Chief Operating Officer
All Location		Maintenance Engineer

AFTER HOURS EMERGENCY CONTACTS

FACILITY	NAME	CONTACT PHONE NUMBER
Elston	[redacted]	[redacted]
Washington		
All Locations		
All Location		

3.0 ELEMENTS

3.1 Emergency Escape Procedures

Escape route assignments are posted throughout the facility. A layout of the facility clearly marked with escape routes is posted in each department. If the alarm sounds or if a supervisor orders the evacuation of the building, remain calm, walk to the nearest exit and leave the building immediately. **After leaving the building, proceed to the parking lot adjacent to the building and meet near garbage dumpsters**. Do not leave the area. Do not return into the building. Follow your supervisor's instructions. In addition to the escape routes, the locations of fire extinguisher and safety stations are indicated by color coded labels. Fire extinguisher locations are indicated by yellow labels. Safety stations are indicated by green labels.

3.2 Employees Who Remain to Operate Critical Operations Prior to Evacuation

As there are no processes which would require continued operation during an emergency, all employees are expected to leave the facility immediately when an evacuation order is announced. No provisions are made for employees who remain within the facility to perform rescue, medical or fire fighting duties (see section 3.5 below for additional information).

3.3 Accounting of All Employees After an Emergency Evacuation

The supervisor is responsible for taking attendance of the employees and patients upon evacuation. The attendance sheet should remain with the supervisor at all times. In the event of an evacuation, all employees are instructed to leave the facility, **proceed to the evacuation meeting place**. The daily attendance sheets will be used to account for the employees. In the event that an employee is absent, the supervisor may at her/his own discretion, sweep the area for the missing employee. Employees must not leave the area until instructed to do so by the supervisor.

3.4 Building Re-entry

Once evacuated, no one shall re-enter the building. Once the Fire Department or other responsible agency has notified us that the building is safe to re-enter, then personnel shall return to their work areas.

3.5 Rescue and Medical Duties for Employees

Employees are not expected to perform any rescue or medical duties, unless they are medical staff appointed to support our patient. Therefore, there are no provisions for training employees in these tasks. Municipal emergency medical and fire facilities are used for emergency medical treatment. Emergency phone numbers are posted at each phone. At no time should an employee be directed to perform emergency duties which may endanger his/her life.

3.6 Preferred Means of Reporting Fires and Other Emergencies

Emergency phone numbers are posted at each phone. In the case of telephone failure, the authorities will be notified of a fire or emergency when the alarm is activated or pulled.

3.7 Persons to Contact for Further Information

Safety and Security Officer, Managers, and Supervisors.

4.0 ALARM SYSTEM

4.1 Employee Notification of an Emergency

Notification of an emergency is communicated when the alarm is pulled and the siren is activated. Directions for the use of the intercom system are as follows: Press the Page button; announce "Code Red and _____(the location)" three times. Speak slowly and clearly.

Immediate Evacuation

When the alarm is sounded, this is a signal for immediate evacuation.

5.0 EVACUATION FOR VARIOUS EMERGENCIES

5.1 Emergency Action Plan for Fire or Chemical Release

In the event of a fire or a chemical emergency, our policy is to immediately evacuate all employees from the section of the building directly affected. Additional evacuation of the building, whether partial or complete, is left to the discretion of the manager or the supervisor. Evacuated employees must report to the evacuation meeting place. The supervisor must take attendance to account for all personnel involved.

5.2 Emergency Action Plan for Electrical Outage

In the event of an electrical outage, emergency lighting should illuminate the facility. All employees should expect further direction from the manager/supervisor.

5.3 TRAINING OF PERSONNEL

In order to ensure the safe and orderly emergency evacuation of employees, all employees will be given provided a training as a new hire, and annually thereafter. The following personnel should be trained as leaders for an emergency procedure: Doctor, CRNA, RN, PA-C/NP, Manager, Supervisor, Maintenance.

6.1 Periodic Review of Emergency Plans with Employees

A review of the emergency plans must be completed when the plan is first developed; whenever the employee's responsibilities or designated actions under the plan change; and whenever the plan is revised.

6.2 Review of Emergency Plans with Employees

A review of the emergency plans must be complete with each new employee prior to the employee beginning her/his duties within the facility. The Manager of Finance and Administration, or her/his designee, is responsible for performing the review with all new employees. Under no circumstances should a new employee be allowed to begin work without safety and evacuation training. A copy of the Emergency Plans will be located all Department Manuals, as well as, on the FPA File Share, Safety with the intent that it will be available to all employees who wish to review it.

6.3 Subjects to be covered in Training:

a. Emergency escape procedures/routes
b. Fire extinguisher locations and proper use
c. Head count procedures
d. Major facility fire hazards
e. Fire prevention practices
f. Means of reporting fires/emergencies (use of alarm systems)
g. Names/titles of Coordinators
h. Availability of the plan to employees
i. Housekeeping practices
j. No smoking areas
k. Hazardous weather procedures
l. Special duties as assigned to Coordinators and those listed above.

Written records shall be maintained of all Emergency Action Plan training.

Review History:

Reviewed February 10, 2014, by [redacted]

Topic: Fire Safety	Page: 1 of 5	Policy Number: 7.1.1
Title: Universal Fire Safety Information	Revised/reviewed 05/12/2015	Effective Date: 12/04/2014
		Removal Date:

Information Regarding OSHA Fire Safety Regulations

The Occupational Safety and Health Administration (OSHA) is part of the United States Department of Labor. OSHA is the main federal agency charged with the enforcement of safety and health regulation. With the Occupational Safety and Health Act of 1970, congress created the Occupational Safety and Health Administration (OSHA) working conditions for working men and women by setting and enforcing standards and providing training, outreach, education and assistance. Fire in the workplace is one of the most significant hazards to employee's lives and health. It is a hazard which can potentially strike any workplace. The effects of workplace fires are devastating to employees and to employers. Historically, workplace fires have been one of the leading causes of worker deaths and injury, exacting a toll of emotional trauma and financial hardship on families. Fires also destroy productive buildings and equipment, disrupt operations and so damage the financial viability of businesses. In our complex, interconnected market economy the losses, disruptions and costs of workplace fires spread beyond the physical site of the fire and continue long after the flames are extinguished. The public interest in preventing workplace fires and in reducing the damaging effects of fires that do occur is clear and has given rise to an integrated structure of fire safety institutions and regulations by local, state and federal government agencies.

OSHA fire safety standards are an important element of the total complex of public policies affecting fire safety. As the federal government agency responsible for setting the national standards for worker safety and health, OSHA has established standards addressing each of the three key elements of fire safety: (1) fire prevention, (2) safe evacuation of the workplace in the event of fire, and (3) protection of workers who fight fires or who work around fire suppression equipment. These issues are addressed by a variety of detailed OSHA rules applicable to general industry in 29CFR1910. The OSHA Fire Safety Advisor has been designed to help businesses better understand and comply with these rules by identifying and organizing the rules according to the specific circumstances and needs of the user. OSHA standards establish minimum requirements for fire prevention, for workplace evacuation in the event of fire, and for protection of workers who may become involved in fire fighting in the workplace. Other agencies (federal, state or local) may impose more stringent standards which are therefore controlling. Where other standards are less stringent, then the OSHA standards are controlling. Employers may never provide less protection to workers than required by OSHA standards.

Basics of Fire Prevention

Fire Prevention involves elimination or control of conditions or substances that could ignite or fuel a fire. Maintenance of a clean and orderly workplace is an essential element of fire prevention. Every employer should routinely inspect the workplace to identify fire ignition and fuel hazards and then take appropriate steps to eliminate them. Fire ignition hazards include open flames, some chemical agents, sparks, and heat producing equipment or materials. Electrical systems and equipment, including wiring and switches, are major sources of fire ignition sparks or heating hazards. Overloaded, damaged or flawed electrical circuits generate heat in wiring that can reach a temperature sufficient ignite adjacent materials. Welding, cutting and grinding operations can produce sparks that can ignite materials, gases or flammable liquids in the work area. Certain materials generate heat from inherent chemical decomposition processes and if accumulated to critical mass can generate enough internal heat to spontaneously combust. Special care is needed to avoid or control such hazards. Open containers of

flammable liquids can generate evaporative gases that flow through or accumulate in enclosed areas to reach a flame or spark that can cause explosive ignition leading back to the flammable liquid source. Uncontrolled smoking and careless disposal of tobacco smoking wastes is a major hazard and the ignition source for many workplace fires.

Every Employer's Duty

A general duty to identify and control potential fire hazards is applied to all employers under the requirements of Section 5(a)(1) of the Occupational Safety and Health Act of 1970: "Each employer shall furnish to each of his employees employment and a place of employment which are free from recognized hazards which are causing or likely to cause death or serious physical harm to his employees." OSHA standards further specify this duty in 29CFR1910.22(a)(1): "All places of employment, passageways, storerooms, and service rooms shall be kept clean and orderly and in a sanitary condition." and in 29CFR1910.36(b)(2): "Every building or structure shall be so constructed, arranged, equipped, maintained and operated as to avoid undue danger to the lives and safety of its occupants from fire, smoke, fumes, or resulting panic during the period of time reasonably necessary for escape from the building or structure in case of fire or other emergency."

Elements of Effective Fire Prevention

Effective fire prevention requires vigilance, action and cooperation. Vigilance involves regular inspection of the workplace to identify fire hazards. Action is necessary to correct hazardous situations by cleaning up debris, by installing effective storage and ventilation systems for hazardous materials that could ignite or fuel a fire, by establishing and enforcing work rules and maintenance policies that prevent hazardous situations from arising, by shielding or ventilating heat sources, and by repairing or replacing faulty equipment or electrical systems. Cooperation between employers and employees is necessary to ensure understanding of your common interests in fire prevention and to ensure maximum effort by all concerned to see and correct fire hazards.

Experience has shown that certain types of workplaces or the presence of certain materials or processes in workplaces significantly increase the likelihood of fire or of serious harm in the event of fire. For these circumstances, OSHA standards include specific requirements for emergency action and fire prevention planning, work procedures, maintenance, hazard communication and training.

Fire Fighting

Despite the best efforts of fire prevention, fires do occur. It is important, therefore, to include in workplace fire safety planning considerations for fire suppression or extinguishment and for evacuation of persons in the event of a fire emergency. Automatic fire suppression systems (such as sprinkler systems), structural design including barriers to prevent fire spread throughout an establishment, and manual fire extinguishment systems such as portable fire extinguishers or hose and standpipe installations are useful means of checking a fire at the incipient stage and preventing more widespread danger to people and property. Clearly marked, safe and accessible evacuation routes (passageways, stairwells and exit doors to the outside) are essential to ensure that workers and other occupants can escape quickly in the event of fire. Alarm systems to signal the need for evacuation are

essential and fire detection systems and communication systems to summon firefighters are useful means of reducing the harm to people and property in the event of fire.

OSHA standards require that every workplace have an alarm or signal system to alert employees of the outbreak of fire and the need to evacuate. To ensure safe evacuation, OSHA standards include minimum requirements for location, design, marking and maintaining exits and ways of access to exits.

Fight or Flee

A critical decision for every employer is whether or not to involve employees in fire fighting efforts. Fire fighting is an inherently dangerous activity and should only be undertaken by properly trained and equipped persons. Protection of life is the paramount consideration. In most circumstances immediate evacuation may be the best policy, especially if professional fire fighting services are available to respond quickly. There may be situations where employee fire fighting is warranted as a means of affording other workers time to escape or of preventing danger to others by spread of a fire. Some employers choose a policy of evacuation and do not allow employees to fight fires; some employers allow any employee to fight incipient fires with available portable fire extinguishers or hose/standpipe systems; some employers designate only certain employees to fight fires and direct that all others evacuate; some employers (usually large industrial complexes) establish an internal fire fighting brigade. Each of these employer policy options carries with it specific requirements for compliance with OSHA fire safety standards.

OSHA DOES NOT REQUIRE ANY EMPLOYER TO ASSIGN FIRE FIGHTING DUTIES TO AN EMPLOYEE. THE EMPLOYER HAS THE OPTION TO ADOPT A POLICY REQUIRING COMPLETE AND IMMEDIATE EVACUATION IN THE EVENT OF FIRE.

In that case the fire extinguisher requirements of 29CFR1910.157 do not apply, provided that the policy is implemented by adopting comprehensive emergency action and fire prevention plans that meet OSHA criteria.

In situations where fire extinguishers are provided for general employee use, OSHA standards specify requirements for their distribution, placement, design, testing, and maintenance and for employee training in their use. In situations where designated employees are authorized to use fire extinguishers, OSHA standards specify requirements for their design, testing, and maintenance and for employee training in their use.

Various OSHA standards require the provision of fire suppression or extinguishment equipment (e.g., automatic sprinklers or portable fire extinguishers) in certain workplaces where the fire hazard has been found to be particularly significant.

Equipment Safety

Portable fire extinguishers, hose/standpipe systems, and automatic fire suppression systems can cause injury or death during a fire emergency or at other times if they are not properly designed, installed, tested, maintained, and operated. For example, pressurized extinguishers can burst and injure nearby workers with canister fragments or extinguisher contents; contents of dry chemical or gaseous agent fire suppression systems can cause chemical burns or asphyxiation. Specific OSHA standards for worker protection apply to such systems whether they are installed in response to an OSHA requirement or for some other reason.

OSHA's general industry standards for fire safety and emergency evacuation are found in two subparts of the OSHA regulations at 29CFR1910. Separate OSHA regulations apply to workers in construction, shipbuilding/maritime industries, and agriculture. All other employers are covered by 29CFR1910, OSHA's general industry standards.

Subpart E, 29CFR1910.36, 37 and 38, describes requirements for emergency exits (means of egress), fundamental fire safety, and emergency action and fire prevention plans. All employers covered by 29CFR1910 (general industry) are required to comply with the fundamental fire safety and means of egress requirements of sections 36 and 37. These requirements address issues including number of exits, alarm systems, visibility and signage for emergency exits, construction specifications for means of egress and maintenance of emergency exit components.

Section 38 (29CFR1910.38) describes requirements for an employer's emergency action plan and fire prevention plan. The requirements of Section 38 apply only if another OSHA regulation requires an emergency action or fire prevention plan. A number of regulations regarding workplaces that deal with chemicals, explosives, flammable materials or hazardous wastes specify that an emergency action plan be produced and implemented. In addition 29CFR1910.157, which specifies requirements for providing portable fire extinguishers for employee use in the workplace, requires that the employer produce emergency action and fire prevention plans if the employer wants to be exempt from certain of the requirements of that Section. Many employers in office, retail and manufacturing establishments are subject to the emergency action plan and fire prevention plan requirements because of the link to portable fire extinguisher standard exceptions.

Safety Plans

An emergency action plan is a simple policy statement that describes evacuation procedures and routes, describes procedures for shut-down of critical operations, describes procedures for making sure that everyone is safely out, identifies (if applicable) rescue and medical emergency personnel, describes how emergencies should be reported, and identifies who is responsible for answering employee questions about emergency procedures.

A fire prevention plan identifies special fire hazards in the workplace and specifies procedures for their safe handling and storage and procedures for controlling fire hazards through work practices and maintenance.

Synopsis of OSHA Standards

Section 157 (29CFR1910.157), which addresses portable fire extinguishers, affects all employers. This section describes requirements for providing, maintaining, and testing portable fire extinguishers and for training employees in their use. The section provides four options: (1) employers who have a policy requiring complete and immediate evacuation of all employees in the event of fire are exempt from the requirement to install and maintain portable fire extinguishers, (2) employers who have fire extinguishers but designate them as not for employee use are required only to meet the maintenance and inspection requirements, (3) employers who designate only certain employees as authorized fire extinguisher users are exempt from the spatial distribution requirements. (4) Employers who provide fire extinguishers for use by all employees are subject to all requirements of 29CFR1910.157. In each of these three cases employers must produce and maintain emergency action plans conforming to OSHA standards. A fire safety plan meeting OSHA specifications is also required under the provisions for a complete and immediate evacuation policy.

SPECIFIC GUIDANCE FOR OUR FACILITY

OSHA standards 29CFR1910.36 and 29CFR1910.37 are applicable to our workplace. These standards require that all workplaces have exits sufficient to allow safe evacuation in the event of an emergency, that alarms to signal emergency evacuation orders be provided and used, that signs identify emergency routes and exits, and that the workplace be maintained so that exits are not obstructed, locked, or confused with non-exit areas in the event of fire or other emergency. These rules include detailed minimum specifications for the design and maintenance of exits and other means of egress components.

We are required to have an alarm system to signal employees to evacuate in the event of fire (29CFR1910.36(b)(7) applies). The alarm system must be installed and maintained to conform to the requirements of 29CFR1910.165. Per NFPA 72-199.7-3.2.1, testing of the detectors is done on alternate years, the last was done in 2014. The next scheduled test is 2016. We are required per NFPA 7.9 and 21.2.2.9.2 to have a yearly emergency lights test for a minimum of 90 minutes, along with a monthly emergency lights test for a minimum of 30 seconds and to keep a log of the testing.

Our establishment is required to have an Emergency Action Plan that meets the requirements of (29CFR1910.38(a)). An Emergency Action Plan is a policy statement that instructs employees how to report fire and other emergencies, how to evacuate, and who is responsible for certain duties during emergencies. The Emergency Action Plan is located in Chapter 6: Emergency Preparedness and Disaster in section 6.1 which is entitled: Emergency Action Plan.

Because we provide portable fire extinguishers for all employees to use, 29CFR1910.157 applies in its entirety. Portable fire extinguishers must be available for all employees to use. This section specifies requirements for selection, distribution, testing, inspection and training for portable fire extinguisher use by employees. For more detailed information, see Chapter 7, section 3— of the Safety and Security Manual: 7.3 Fire Extinguishers.

Review History:
Reviewed May 12, 2015, by [redacted]

ATTACHMENT N0. 8

Activities For Account L21641 (9/3/2014 00:00 ~ 9/4/2014 24:00)

FAMILY PLANNING ASSOCIATES MEDICAL GROUP
5086 N. ELSTON AVENUE
CHICAGO, IL 60630-0000
(773)725-0200

Sig	Date/Time	Condition (A/M Account)	Description	Service/Comments	Entity Called	Operator
*	09/03/14 06:37:04(C)	B? - OPENING SIGNAL	OPENING	logOnly signal Event B	(n/a)	25
*	09/03/14 09:31:07(C)	TE - COMM.CHANNEL FAIL	Al.Co. Name	RD PetReport Reached	CUSTOM SECURITY ELEC	25
	09/03/14 17:00:03(C)	XX - TEST AUTHORIZED BY (in test)	EXP. 09/03/14 17:15:42(C)	TIM	659	G4
*	09/03/14 17:06:19(C)	01 - FIRE ALARM	FIRE	testing call Event 01	(n/a)	25
	09/03/14 17:07:42(C)	XX - ALL CONDITIONS		removed from test	(n/a)	C0
*	09/03/14 20:12:38(C)	C? - CLOSING SIGNAL	CLOSING	logOnly signal Event C	(n/a)	25
*	09/04/14 06:35:23(C)	B? - OPENING SIGNAL	OPENING	logOnly signal Event B	(n/a)	25
*	09/04/14 09:31:12(C)	TE - COMM.CHANNEL FAIL	Al.Co. Name	RD PetReport Reached	CUSTOM SECURITY ELEC	25

ATTACHMENT # 9

CUSTOM SECURITY ELECTRONICS, INC.

1511 Industrial Drive • Itasca, IL 60143-1849 • PHONE: 630/775-1100 • 630/775-9010 - F

December 8, 2014

[redacted]
Family Planning Associates Medical Group
5086 N. Elston Avenue
Chicago, IL 60630-2427

Dear [redacted]:

The following is the fire alarm system testing report for the address listed above. The test was performed on April 4, 2014 and the sensitivity readings were taken on October 1, 2014.

All smoke detectors were functionally tested using the SDI, Inc. smoke detector tester, model Solo 330. All rate of rise heat detectors were functionally tested using the SDI, Inc. heat detector tester, model Solo 461. All fixed temperature heat detectors were tested by shorting the terminals on the back of the product until the panel activated. The pull stations were checked by manually pulling the station. All indicating devices were tested by individual visual and audible inspections. All relays were tripped when an appropriate initiating device was activated. All of the testing completed on the fire alarm system was in accordance with the manufacturer's installation instructions and NFPA 72, 2010 Edition. This inspection was an operational functionality test of the devices listed below.

INITIATING DEVICE TEST RESULTS

Basement

LOCATION	DESCRIPTION	SENSITIVITY	ZONE	TEST
Main area	smoke detector	.65VDC	2	PASS
Main area	heat detector		2	PASS

First Floor

Waiting room	smoke detector	.65VDC	1	PASS
Reception hallway	smoke detector	.64VDC	1	PASS
Exam room 1 & 2 hallway	smoke detector	.85VDC	1	PASS
Exam room 3 hallway	smoke detector	.86VDC	1	PASS
Rear hallway	smoke detector	.68VDC	1	PASS
Recovery hallway	smoke detector	2.6%	2	PASS
Recovery room 1	smoke detector	.92VDC	2	PASS
Recovery room 2	smoke detector	2.6%	2	PASS

-continued-

OR 1	smoke detector	.90VDC	2	PASS
OR 2	smoke detector	.95VDC	2	PASS
OR hallway	smoke detector	2.4%	2	PASS
OR supply area	smoke detector	.70VDC	2	PASS
OR central supply area	smoke detector	.85VDC	2	PASS
Front lobby waiting room	pull station		3	PASS
Rear exam hallway	pull station		3	PASS
Recovery room II	pull station		3	PASS
Rear alley exit	pull station		3	PASS

Second Floor

LOCATION	DESCRIPTION		ZONE	TEST
Office	smoke detector	2.4%	2	PASS
Hallway	smoke detector	2.4%	2	PASS
Front stairway landing	smoke detector	2.4%	2	PASS

INDICATING DEVICE TEST RESULTS

First Floor

LOCATION	DESCRIPTION	TEST
Front lobby waiting room	horn	PASS
Rear exam hallway	horn	PASS
Rear alley exit door	horn	PASS
Recovery room II	horn	PASS

Fire Alarm Control Panel (Second floor - Phone/IT Room)

	DESCRIPTION	TEST
Honeywell Vista-32FB		
Digital communicator	(all conditions)	PASS
Cellular communicator	(all conditions)	PASS
Panel voltages	Main power supply	PASS
	AC voltage	PASS
	Battery charger	PASS
Panel battery (1)	Static	PASS
	Dynamic	PASS
Keypad	Display	PASS
	Audible	PASS

END OF TEST

-continued-

NOTE: Sensitivity readings for the old smoke detectors should be between .35 and 1.00VDC (volts direct current) and the new smoke detectors are a percent per foot of obscuration measurement.

Please call me directly if you have any questions or if more information is necessary.

Sincerely,

[redacted]

Digitally signed by Michael W. Chelberg
DN: cn=Michael W. Chelberg, o=Custom Security Electronics, Inc., ou=Custom Security Electronics, Inc., email=mike@customse.com, c=US
Date: 2014.12.08 09:44:44 -06'00'

State of Illinois license #124-001255
State of Illinois agency license #127-001008 (Custom Security Electronics, Inc.)

MWC:klc

INSTALLATION AND MAINTENANCE INSTRUCTIONS

i3 Series

SENS-RDR Sensitivity Reader

SYSTEM SENSOR®
3825 Ohio Avenue, St. Charles, Illinois 60174
1-800-SENSOR2, FAX: 630-377-6495
www.systemsensor.com

I56-1801-003

Environmental Specifications

Operating Temperature Range:	32 to 120°F (0 to 49°C)
Storage Temperature Range (without batteries):	5 to 140°F (–15 to 60°C)
Operating Humidity Range:	10 to 90% RH non-condensing

Before Using

The SENS-RDR sensitivity reader is a tool to measure the sensitivity of i3 smoke detectors as well as 100 series conventional smoke detectors (only models 2151 and 2151T manufactured after April 2006). It CANNOT be used on the 200, 300, 400, 500, or 800 Series detectors.

NOTICE: This manual shall be left with the owner/user of this equipment.

IMPORTANT: Use of the SENS-RDR is designed to "...assure that each smoke detector is within its listed and marked sensitivity range..." per NFPA 72. The SENS-RDR CANNOT, however, initiate a detector/sensor alarm. Sensitivity testing shall not be used as a substitute for smoke entry testing.

General Description

This battery-powered device is equipped with an infrared optical interface for reading data automatically sent by the smoke detector every ten seconds. The SENS-RDR decodes the sensitivity and status data, and displays the information on its LCD display.

The SENS-RDR may be used either as a hand-held device, or with a standard threaded extension pole.

SENS-RDR Operation

1. Turn the reader on by pressing and holding the button for approximately 2 seconds until the reader sounds. The LCD will display the word "READY". The "READY" status indicates that the SENS-RDR is ready for accepting data from an i3 Series smoke detector.
2. Place the reader by the smoke detector being tested. Position the reader at an angle on the oval area or at the chamber opening by the word "PAINT" (See Figures 1 and 2). A ledge and an anti-skid tip is provided on the reader to maintain the reader in place while it reads the sensitivity.
3. Hold the reader in this position up to 10 seconds until the reader sounds and the reader's red LED illuminates. **NOTE:** If the reader does not sound after 10 seconds, verify that the reader is properly positioned, and the LCD displays "READY".
4. The LED and sounder indicate a valid reading is received. The reader will automatically display two results. The first is a percent per foot obscuration measurement, which is displayed for approximately 3 seconds, followed by a textual status indication (See Table 1). The reader will continue to display both results for up to 30 minutes, or until the reader is reset.

Figure 1: Reader location on compatible System Sensor smoke detectors

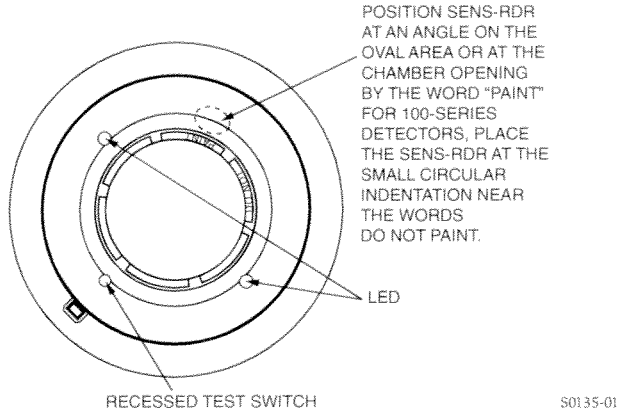
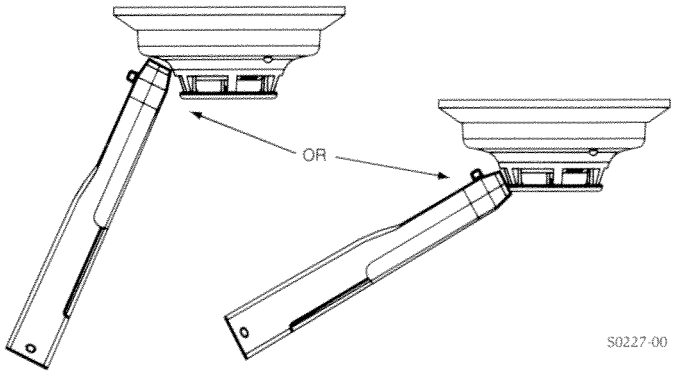


Figure 2: Position Reader on compatible System Sensor smoke detectors



NOTE: No further readings may be taken until the reader is reset.

5. To measure the sensitivity of the next detector, reset the reader by momentarily pressing the button. The LCD will again display the word "READY". Repeat steps 2 through 4, as necessary.
6. When finished, turn off the reader by pressing and holding the button for approximately 2 seconds until the reader sounds.

Table 1. SENS-RDR Status Indications:

Status Indication	Action
GOOD	The detector is within its sensitivity range. No action is necessary at this time.
SERVICE	The smoke detector's sensing chamber requires cleaning for continued reliable operation. Refer to the i³ Series installation manual for proper maintenance procedures.
REPLACE	The smoke detector is failing and should be replaced immediately.

SENS-RDR Batteries and Battery Life

The SENS-RDR operates with two AA alkaline batteries only. Other battery types may result in improper function of the reader.

NOTE: When the batteries in the SENS-RDR get low, the LCD display will read "LOW BATT". Once the low battery condition is reached, the reader will no longer function. Replace batteries to restore operation to the SENS-RDR.

The SENS-RDR automatically turns off when not used after 30 minutes. To conserve the battery life of the SENS-RDR, it is recommended that the reader be turned off when not in use. To turn off the reader, press and hold the button for approximately 2 seconds until the reader sounds.

⚠WARNING

The Limitations of the SENS-RDR

The SENS-RDR is designed to "... assure that each smoke detector is within its listed and marked sensitivity range ..." per NFPA 72.

Slight fluctuations in readings may be experienced on any device at any given time and do not indicate a defect or sensitivity shift, provided the reading is within the specified range. These fluctuations are to be expected.

The SENS-RDR and its associated smoke detectors/sensors contain electronic parts and, though they are designed to last over 10 years, any of these components can fail at any time. Therefore, it is recommended to test your smoke detectors/sensors per NFPA 72 at least annually. Regular cleaning and testing of your fire detection system will measurably reduce your product liability risks and minimize nuisance alarms.

Three-Year Limited Warranty

System Sensor warrants its enclosed product to be free from defects in materials and workmanship under normal use and service for a period of three years from date of manufacture. System Sensor makes no other express warranty for the enclosed product. No agent, representative, dealer, or employee of the Company has the authority to increase or alter the obligations or limitations of this Warranty. The Company's obligation of this Warranty shall be limited to the replacement of any part of the product which is found to be defective in materials or workmanship under normal use and service during the three year period commencing with the date of manufacture. After phoning System Sensor's toll free number 800-SENSOR2 (736-7672) for a Return Authorization number, send defective units postage prepaid to: System Sensor, Returns Department, RA #_____, 3825 Ohio Avenue, St. Charles, IL 60174. Please include a note describing the malfunction and suspected cause of failure. The Company shall not be obligated to replace units which are found to be defective because of damage, unreasonable use, modifications, or alterations occurring after the date of manufacture. In no case shall the Company be liable for any consequential or incidental damages for breach of this or any other Warranty, expressed or implied whatsoever, even if the loss or damage is caused by the Company's negligence or fault. Some states do not allow the exclusion or limitation of incidental or consequential damages, so the above limitation or exclusion may not apply to you. This Warranty gives you specific legal rights, and you may also have other rights which vary from state to state.

FCC Statement

This device complies with part 15 of the FCC Rules. Operation is subject to the following two conditions: (1) This device may not cause harmful interference, and (2) this device must accept any interference received, including interference that may cause undesired operation.

Note: This equipment has been tested and found to comply with the limits for a Class B digital device, pursuant to Part 15 of the FCC Rules. These limits are designed to provide reasonable protection against harmful interference in a residential installation. This equipment generates, uses and can radiate radio frequency energy and, if not installed and used in accordance with the instructions, may cause harmful interference to radio communications. However, there is no guarantee that interference will not occur in a particular installation. If this equipment does cause harmful interference to radio or television reception, which can be determined by turning the equipment off and on, the user is encouraged to try to correct the interference by one or more of the following measures:

- Reorient or relocate the receiving antenna.
- Increase the separation between the equipment and receiver.
- Connect the equipment into an outlet on a circuit different from that to which the receiver is connected.
- Consult the dealer or an experienced radio/TV technician for help.

Attachment #10

Albany Medical Surgical Center Daily Interim Life Safety Measures Checklist

Date: 5-4-15 Staff Member(s) Performing the Inspection: [redacted]

Measure	Description	Yes	No	N/A	Comments
1.	Ensure the ILSM assessment and daily inspection sheet is posted. *	✓			
2.	Ensure all exits are available and clear. *	✓			
3.	The required number of fire extinguishers are available, appropriately located and in good working order. *	✓			
4.	The main fire alarm is in good working order. *	✓			
5.	All passageways and fire doors are unobstructed and all stairwell doors are closed. *	✓			
6.	Storage and working areas are free of trash. *	✓			
7.	All equipment and electrical devices that are not in use are turned off. *	✓			
8.	Signage is displayed regarding the prohibition of smoking.	✓			
9.	One additional fire drill per quarter has been performed or has been planned.	X			
10.	Alert staff that increased fire and hazard surveillance is in effect until further notice, and that they should report any possible fire hazards to management immediately.	✓			
11.	Education has been conducted with appropriate staff members regarding the building deficiencies and for compensation for structural and fire safety features.	✓			

Note: Measures 1 through 7 must be performed hourly during regular business hours and documented below.

Documentation of hourly measure checks (attach form for additional comments if needed)

Time	7:00 AM	8:00 AM	9:00 AM	10:00 AM	11:00 AM	12:00 PM	1:00 PM	2:00 PM	3:00 PM	4:00 PM	5:00 PM	6:00 PM
Initials	[redacted]											
All Measures in Compliance	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No

Comments:

Albany Medical Surgical Center Daily Interim Life Safety Measures Checklist

Date: 5-5-15 Staff Member(s) Performing the Inspection: [redacted]

Measure	Description	Yes	No	N/A	Comments
1.	Ensure the ILSM assessment and daily inspection sheet is posted. *	✓			
2.	Ensure all exits are available and clear. *	✓			
3.	The required number of fire extinguishers are available, appropriately located and in good working order. *	✓			
4.	The main fire alarm is in good working order. *	✓			
5.	All passageways and fire doors are unobstructed and all stairwell doors are closed. *	✓			
6.	Storage and working areas are free of trash. *	✓			
7.	All equipment and electrical devices that are not in use are turned off. *	✓			
8.	Signage is displayed regarding the prohibition of smoking.	✓			
9.	One additional fire drill per quarter has been performed or has been planned.	X			
10.	Alert staff that increased fire and hazard surveillance is in effect until further notice, and that they should report any possible fire hazards to management immediately.	✓			
11.	Education has been conducted with appropriate staff members regarding the building deficiencies and for compensation for structural and fire safety features.	✓			

Note: Measures 1 through 7 must be performed hourly during regular business hours and documented below.

Documentation of hourly measure checks (attach form for additional comments if needed)

Time	7:00 AM	8:00 AM	9:00 AM	10:00 AM	11:00 AM	12:00 PM	1:00 PM	2:00 PM	3:00 PM	4:00 PM	5:00 PM	6:00 PM
Initials	[redacted]											
All Measures in Compliance	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No

Comments:

Albany Medical Surgical Center Daily Interim Life Safety Measures Checklist

Date: 5-6-15 Staff Member(s) Performing the Inspection: [redacted]

Measure	Description	Yes	No	N/A	Comments
1.	Ensure the ILSM assessment and daily inspection sheet is posted. *	✓			
2.	Ensure all exits are available and clear. *	✓			
3.	The required number of fire extinguishers are available, appropriately located and in good working order. *	✓			
4.	The main fire alarm is in good working order. *	✓			
5.	All passageways and fire doors are unobstructed and all stairwell doors are closed. *	✓			
6.	Storage and working areas are free of trash. *	✓			
7.	All equipment and electrical devices that are not in use are turned off. *	✓			
8.	Signage is displayed regarding the prohibition of smoking.	✓			
9.	One additional fire drill per quarter has been performed or has been planned.	X			
10.	Alert staff that increased fire and hazard surveillance is in effect until further notice, and that they should report any possible fire hazards to management immediately.	✓			
11.	Education has been conducted with appropriate staff members regarding the building deficiencies and for compensation for structural and fire safety features.	✓			

Note: Measures 1 through 7 must be performed hourly during regular business hours and documented below.

Documentation of hourly measure checks (attach form for additional comments if needed)

Time	7:00 AM	8:00 AM	9:00 AM	10:00 AM	11:00 AM	12:00 PM	1:00 PM	2:00 PM	3:00 PM	4:00 PM	5:00 PM	6:00 PM
Initials	[redacted]											
All Measures in Compliance	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	Yes / No

Comments:

Albany Medical Surgical Center Daily Interim Life Safety Measures Checklist

Date: 5-9-15 Staff Member(s) Performing the Inspection: [redacted]

Measure	Description	Yes	No	N/A	Comments
1.	Ensure the ILSM assessment and daily inspection sheet is posted. *	✓			
2.	Ensure all exits are available and clear. *	✓			
3.	The required number of fire extinguishers are available, appropriately located and in good working order. *	✓			
4.	The main fire alarm is in good working order. *	✓			
5.	All passageways and fire doors are unobstructed and all stairwell doors are closed. *	✓			
6.	Storage and working areas are free of trash. *	✓			
7.	All equipment and electrical devices that are not in use are turned off. *	✓			
8.	Signage is displayed regarding the prohibition of smoking.	✓			
9.	One additional fire drill per quarter has been performed or has been planned.	X			
10.	Alert staff that increased fire and hazard surveillance is in effect until further notice, and that they should report any possible fire hazards to management immediately.	✓			
11.	Education has been conducted with appropriate staff members regarding the building deficiencies and for compensation for structural and fire safety features.	✓			

Note: Measures 1 through 7 must be performed hourly during regular business hours and documented below.

Documentation of hourly measure checks (attach form for additional comments if needed)

Time	7:00 AM	8:00 AM	9:00 AM	10:00 AM	11:00 AM	12:00 PM	1:00 PM	2:00 PM	3:00 PM	4:00 PM	5:00 PM	6:00 PM
Initials	[redacted]											
All Measures in Compliance	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	(Yes) / No	Yes / No

Comments: _____

Albany Medical Surgical Center Daily Interim Life Safety Measures Checklist

Date: 5-8-15 Staff Member(s) Performing the Inspection: [redacted]

Measure	Description	Yes	No	N/A	Comments
1.	Ensure the ILSM assessment and daily inspection sheet is posted. *	✓			
2.	Ensure all exits are available and clear. *	✓			
3.	The required number of fire extinguishers are available, appropriately located and in good working order. *	✓			
4.	The main fire alarm is in good working order. *	✓			
5.	All passageways and fire doors are unobstructed and all stairwell doors are closed. *	✓			
6.	Storage and working areas are free of trash. *	✓			
7.	All equipment and electrical devices that are not in use are turned off. *	✓			
8.	Signage is displayed regarding the prohibition of smoking.	✓			
9.	One additional fire drill per quarter has been performed or has been planned.	X			
10.	Alert staff that increased fire and hazard surveillance is in effect until further notice, and that they should report any possible fire hazards to management immediately.	✓			
11.	Education has been conducted with appropriate staff members regarding the building deficiencies and for compensation for structural and fire safety features.	✓			

Note: Measures 1 through 7 must be performed hourly during regular business hours and documented below.

Documentation of hourly measure checks (attach form for additional comments if needed)

Time	7:00 AM	8:00 AM	9:00 AM	10:00 AM	11:00 AM	12:00 PM	1:00 PM	2:00 PM	3:00 PM	4:00 PM	5:00 PM	6:00 PM
Initials	[redacted]											
All Measures in Compliance	~~Yes~~ / No	~~Yes~~ / No	~~Yes~~ / No	Yes / No	~~Yes~~ / No	Yes / No	Yes / No	~~Yes~~ / No	Yes / No	Yes / No	Yes / No	Yes / No

Comments:

PRAXAIR
HEALTHCARE SERVICES

Attachment #11

Praxair Healthcare Services
7000 High Grove Boulevard
Burr Ridge, IL 60527-7595

Family Planning Management Inc.
5086 N Elston Ave
Chicago, IL 60630

Family Planning Management Inc.,

This letter is confirming that Praxair Distribution Inc. supplies Medical Grade Oxygen in a "K" size cylinder to Family Planning Management of Chicago, IL on a scheduled delivery made every other week.

If you have any questions or need any further information, please feel free to contact me.

[redacted]
Inside Sales/Territory Manager
630-320-4431

Attachment # 12

[redacted] MD, MPH
Medical Director
Albany Medical-Surgical Center
5086 North Elston Avenue
Chicago, Illinois 60630

February 24, 2014

State of Illinois
Division of Life Safety and Construction
Office of Healthcare Regulations
Illinois Department of Public Health [IDPH]

RE: Emergency preparedness and anesthesia practices/protocols at the Albany Medical-Surgical Center, 5086 North Elston Avenue, Chicago, Illinois 60630

Dear Administrator:

1. Since 1985 I have been a practicing, board-certified obstetrician-gynecologist.
2. I am licensed in the State of Illinois and since 1988 I have been the medical director of the Albany Medical-Surgical Center (located at 5086 North Elston Avenue, Chicago, Illinois 60630) and the medical director of Family Planning Associates Medical Group, Limited (FPAMG, Ltd.), an Illinois-registered for-profit corporate medical enterprise operating from that address with an additional medical office in downtown Chicago (located at 659 West Washington Boulevard in downtown Chicago).
3. In my role as the medical director of the Albany Medical-Surgical Center for the last 26 years, I exercise ultimate control over the medical policies at this surgicenter.
4. We undergo regular medical inspections by federal (CLIA), state and local regulatory agencies. During my tenure, until the recent citations by state healthcare architect [redacted] of the State of Illinois Division of Life Safety and Construction in the Office of Healthcare Regulations (Illinois Department of Public Health [IDPH]) pursuant to his inspection on August 28, 2013, we have never been cited for any serious infractions.
5. No patients are admitted to the Albany Medical-Surgical Center by any physicians other than those on the medical staff of FPAMG, Ltd. No physicians who are not on the medical staff of FPAMG, Ltd. can admit patients to the Albany Medical-Surgical Center.
6. We perform no surgical procedures at the Albany Medical-Surgical Center except pregnancy terminations.
7. In the surgicenter, we have two treatment rooms where the pregnancy terminations are performed, but since we staff each treatment session with only one certified registered nurse anesthetist (CRNA) and only one physician, we do not conduct more than one operative procedure at any one time.

8. Pregnancy termination procedures are normally completed within 10 minutes from the start of the procedure.
9. Many of our patients receive sleep anesthesia, which is administered solely by a CRNA. We do not intubate our patients. The vast number of our patients is completely healthy (ASA Class I).
10. For general (sleep) anesthesia we use intravenous propofol, a rapid-acting, short duration anesthetic, which is augmented by a small parenteral dose of the analgesic ketorolac (Toradol), which is given for postoperative pain.
11. Following general anesthesia, we convey patients via gurney transport to the recovery room, which lies a few feet adjacent to both treatment rooms.
12. Because propofol is a short-acting induction agent, patients normally awaken within 5 minutes of entry into the recovery room, which is monitored at all times by a registered nurse.
13. For emergency preparation and in accordance with regulations governing surgicenters in Illinois we conduct regular emergency drills in case of electrical outages, fires or other catastrophes.
14. Our staff is trained and drilled to evacuate the surgicenter within less than 5 minutes, including transport of a non-awake patient on a gurney into our parking lot, which is secured by a fence from unwarranted intrusion.
15. We maintain close contact with police and fire departments in our area as a general precaution given the nature of the controversial medical services we provide.
16. All of our monitoring devices are located in both treatment rooms and in the recovery room (for example, pulse oximetry, electrocardiography, and blood pressure/pulse). This is also true for all our treatment devices such as emergency defibrillators and nasal and oral suction machines. All of the devices mentioned above for monitoring and treatment operate with emergency back-up batteries and they therefore all remain functional in case of sudden electrical failure.
17. In addition, we can oxygenate our patients without electricity using readily available Ambu bags and oxygen tanks (which are on hand in the both treatment rooms and the recovery room).
18. In the treatment rooms and recovery room we also stock reversing drugs for all the medications we use that are reversible, thereby giving us the means to hasten the awakening of any asleep patient in the case of a building-wide emergency requiring transport and evacuation of all occupants.

For the foregoing reasons, we have an unparalleled safety record and are confident of our ability to maintain essential medical services in case of a sudden electrical outage using the generator presently in our building. In addition, we are also fully confident that we can evacuate the building very rapidly—including the transport of any asleep patient—within 5 minutes of an alert.

Should you have need for any further details about our anesthesia practices, protocols or preparedness, please feel free to contact me c/o our chief operating office, [redacted] or our assistant manager, [redacted] both at [redacted]

I have included my current curriculum vitae for your review.

Respectfully yours,

[redacted], MD, MPH
Associate Professor of Clinical OB-GYN
Northwestern University Feinberg School of Medicine
Medical Director, Albany Medical-Surgical Center
Medical Director, Family Planning Associates Medical Group, Limited
Chicago, Illinois

ATTACHMENT No. 13

FAMILY PLANNING MANAGEMENT, INC

Yearly Ninety Minute Emergency Lights Test

FACILITY: Family Planning Assoc. DATE: Aug. 31, 2014 TIME: 1:00 - 2:40 pm

ADDRESS: 5086 N Elston

Procedure for testing: Testing will begin with a manual termination of power to the building. Emergency lights will then power up with use of the battery backup and will be monitored for a minimum of ninety minutes.

Operating Room #1:	✓ Functional	__ Needs Repair	
Operating Room #2:	✓ Functional	__ Needs Repair	
Recovery Room #1:	✓ Functional	__ Needs Repair	
Recovery Room #2:	✓ Functional	__ Needs Repair	
Recovery Hallway:	✓ Functional	__ Needs Repair	
Stairway Hallway:	✓ Functional	__ Needs Repair	
Dress Out Hallway (Patient Exit):	✓ Functional	__ Needs Repair	
Lab Hallway:	✓ Functional	__ Needs Repair	
ont Lobby:	✓ Functional	__ Needs Repair	
Exterior Light at Alley Doorway:	__ Functional	__ Needs Repair	N/A See Comments
Exterior Light at Parking Lot Exit Doorway:	__ Functional	__ Needs Repair	N/A See Comments

Comments/Corrective Action taken:

Battery Back UP Fixture will be provided ON Exterior lights as Per construction documents

FAMILY PLANNING MANAGEMENT, INC

Monthly Emergency Lights Test

FACILITY: Family Planning Assoc DATE: Sept. 2. 2014 TIME: 10:00 AM

ADDRESS: 5086 N. Elston

Procedure for testing: Testing will be performed by holding the test button for a minimum of thirty seconds.

Operating Room #1:	✓ Functional	__ Needs Repair
Operating Room #2:	✓ Functional	__ Needs Repair
Recovery Room #1:	✓ Functional	__ Needs Repair
Recovery Room #2:	✓ Functional	__ Needs Repair
Recovery Hallway:	✓ Functional	__ Needs Repair
Stairway Hallway:	✓ Functional	__ Needs Repair
Dress Out Hallway (Patient Exit):	✓ Functional	__ Needs Repair
Lab Hallway:	✓ Functional	__ Needs Repair
Front Lobby:	✓ Functional	__ Needs Repair
Exterior Light at Alley Doorway:	__ Functional	__ Needs Repair N/A See Comments
Exterior Light at Parking Lot Exit Doorway:	__ Functional	__ Needs Repair N/A See Comments

Comments/Corrective Action taken:

Battery back up fixtures will be provided on Exterior lights as per construction documents

FAMILY PLANNING MANAGEMENT, INC

Monthly Emergency Lights Test

FACILITY: Family Plan Assoc. DATE: 10-10-14 TIME: 10:30 AM

ADDRESS: 5086 N Elston

Procedure for testing: Testing will be performed by holding the test button for a minimum of thirty seconds.

Operating Room #1:	✓ Functional	__ Needs Repair
Operating Room #2:	✓ Functional	__ Needs Repair
Recovery Room #1:	✓ Functional	__ Needs Repair
Recovery Room #2:	✓ Functional	__ Needs Repair
Recovery Hallway:	✓ Functional	__ Needs Repair
Stairway Hallway:	✓ Functional	__ Needs Repair
Dress Out Hallway (Patient Exit):	✓ Functional	__ Needs Repair
Lab Hallway:	✓ Functional	__ Needs Repair
Front Lobby:	✓ Functional	__ Needs Repair
Exterior Light at Alley Doorway:	✓ Functional	X Needs Repair
Exterior Light at Parking Lot Exit Doorway:	__ Functional	X Needs Repair N/A see comments

Comments/Corrective Action taken:

Battery Back up Fixture will be provided on Exterior Lights as per construction documents

FAMILY PLANNING MANAGEMENT, INC

Monthly Emergency Lights Test

FACILITY: Family Planning Assoc. DATE: 11-12-14 TIME: 10:00

ADDRESS: 5086 N Elston

Procedure for testing: Testing will be performed by holding the test button for a minimum of thirty seconds.

Operating Room #1:	✓ Functional	__ Needs Repair
Operating Room #2:	✓ Functional	__ Needs Repair
Recovery Room #1:	✓ Functional	__ Needs Repair
Recovery Room #2:	✓ Functional	__ Needs Repair
Recovery Hallway:	✓ Functional	__ Needs Repair
Stairway Hallway:	✓ Functional	__ Needs Repair
Dress Out Hallway (Patient Exit):	✓ Functional	__ Needs Repair
Lab Hallway:	✓ Functional	__ Needs Repair
Front Lobby:	✓ Functional	__ Needs Repair
Exterior Light at Alley Doorway:	__ Functional	X Needs Repair → N/A See comments
Exterior Light at Parking Lot Exit Doorway:	__ Functional	X Needs Repair

Comments/Corrective Action taken:

Battery Backup Fixture will be Provided on exterior Lights as per construction documents

FAMILY PLANNING MANAGEMENT, INC

Monthly Emergency Lights Test

FACILITY: Elston DATE: 12-11-14 TIME: 10.00 AM

ADDRESS: 5086 N Elston

Procedure for testing: Testing will be performed by holding the test button for a minimum of thirty seconds.

Operating Room #1:	✓ Functional	__ Needs Repair
Operating Room #2:	✓ Functional	__ Needs Repair
Recovery Room #1:	✓ Functional	__ Needs Repair
Recovery Room #2:	✓ Functional	__ Needs Repair
Recovery Hallway:	✓ Functional	__ Needs Repair
Stairway Hallway:	✓ Functional	__ Needs Repair
Dress Out Hallway (Patient Exit):	✓ Functional	__ Needs Repair
Lab Hallway:	✓ Functional	__ Needs Repair
Front Lobby:	✓ Functional	__ Needs Repair
Exterior Light at Alley Doorway:	__ Functional	__ Needs Repair
Exterior Light at Parking Lot Exit Doorway:	__ Functional	__ Needs Repair

→ See ATTACHMENT

Comments/Corrective Action taken:

Battery back up fixtures to be installed as per construction documents.

FAMILY PLANNING MANAGEMENT, INC

Monthly Emergency Lights Test

FACILITY: Elston DATE: 1-19-15 TIME: 10:00

ADDRESS: 5086 N Elston

Procedure for testing: Testing will be performed by holding the test button for a minimum of thirty seconds.

Operating Room #1:	✓ Functional	__ Needs Repair
Operating Room #2:	✓ Functional	__ Needs Repair
Recovery Room #1:	✓ Functional	__ Needs Repair
Recovery Room #2:	✓ Functional	__ Needs Repair
Recovery Hallway:	✓ Functional	__ Needs Repair
Stairway Hallway:	✓ Functional	__ Needs Repair
Dress Out Hallway (Patient Exit):	✓ Functional	__ Needs Repair
Lab Hallway:	✓ Functional	__ Needs Repair
Front Lobby:	✓ Functional	__ Needs Repair
Exterior Light at Alley Doorway:	✓ Functional	__ Needs Repair
Exterior Light at Parking Lot Exit Doorway:	✓ Functional	__ Needs Repair

Comments/Corrective Action taken:

Exterior lights now compliant with Battery Back

FAMILY PLANNING MANAGEMENT, INC

Monthly Emergency Lights Test

FACILITY: Elston DATE: 2-18-15 TIME: 10:30

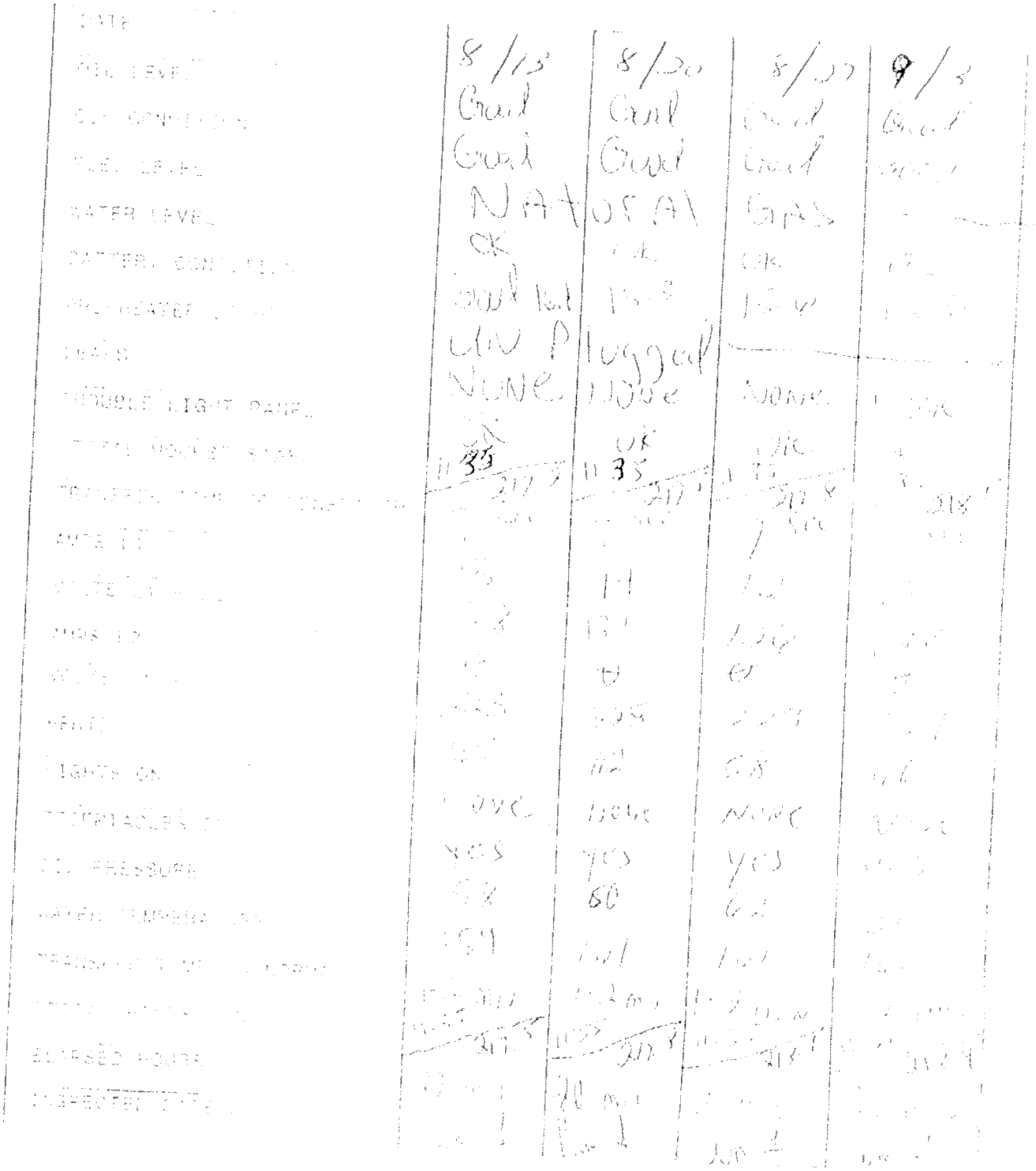
ADDRESS: 5086 N Elston

Procedure for testing: Testing will be performed by holding the test button for a minimum of thirty seconds.

Operating Room #1:	✓ Functional	__ Needs Repair
Operating Room #2:	✓ Functional	__ Needs Repair
Recovery Room #1:	✓ Functional	__ Needs Repair
Recovery Room #2:	✓ Functional	__ Needs Repair
Recovery Hallway:	✓ Functional	__ Needs Repair
Stairway Hallway:	✓ Functional	__ Needs Repair
Dress Out Hallway (Patient Exit):	✓ Functional	__ Needs Repair
Lab Hallway:	✓ Functional	__ Needs Repair
Front Lobby:	✓ Functional	__ Needs Repair
Exterior Light at Alley Doorway:	✓ Functional	__ Needs Repair
Exterior Light at Parking Lot Exit Doorway:	✓ Functional	__ Needs Repair

Comments/Corrective Action taken:

ATTACHMENT No. 14



2014

GENERATOR INSPECTION LOG

DATE	9/10	9/17	9/24	10/1
OIL LEVEL	Good	Good	Good	Good
OIL CONDITION	Good	Good	Good	Good
FUEL LEVEL	— Natural	Gas		
WATER LEVEL	Ok	Ok	Ok	Ok
BATTERY CONDITION	15.3	15.6	16.1	15.9
PRE-HEATER LIGHT	— Plugged	in		
LEAKS	NONE	NONE	NONE	NONE
TROUBLE LIGHT PANEL	OK	OK	OK	OK
"TOTAL HOURS" START	11:35 218.4	11:35 218.7	11:35 219.0	11:35 219.3
TRANSFER TIME TO GENERATOR	7 sec	7 sec	7 sec	7 sec
AMPS L1	14	14	12	13
VOLTS L1 - L2	130	128	128	126
AMPS L2	0	0	0	0
VOLTS L1 - L2	223	225	224	225
HERTZ	60	62	58	60
LIGHTS ON	NONE	NONE	NONE	NONE
RECEPTACLES ON	Yes	yes	Yes	Yes
OIL PRESSURE	60	58	61	58
WATER TEMPERATURE	158	155	161	160
TRANSFER TIME TO NORMAL	1-2 min	1-2 min	1-2 min	1-2 min
"TOTAL HOURS" END	11:55 218.7	11:55 219.0	11:55 219.3	11:55 219.6
ELAPSED HOURS	20 min	20 min	20 min	20 min
INSPECTED DATE/BY	[redacted]			

2014

GENERATOR INSPECTION LOG

DATE	10/8	10/15	10/22	10/29
OIL LEVEL	Good	Good	Good	Good
OIL CONDITION	Good	Good	Good	Good
FUEL LEVEL	NATURAL GAS			
WATER LEVEL	OK	OK	OK	OK
BATTERY CONDITION	15.9	16.1	16.1	15.8
PRE-HEATER LIGHT		Plugged in		
LEAKS	None	None	None	None
TROUBLE LIGHT PANEL	OK	OK	OK	OK
"TOTAL HOURS" START	11:35 / 219.6	11:35 / 219.9	11:35 / 220.2	11:35 / 220.5
TRANSFER TIME TO GENERATOR	7 sec	7 sec	7 sec	7 sec
AMPS L1	13	14	13	12
VOLTS L1 - L2	126	128	30	126
AMPS L2	0	0	0	0
VOLTS L1 - L2	223	224	223	225
HERTZ	60	60	62	58
LIGHTS ON	None	None	None	None
RECEPTACLES ON	yes	yes	yes	yes
OIL PRESSURE	58	60	61	58
WATER TEMPERATURE	160	161	158	158
TRANSFER TIME TO NORMAL	1-2 min	1-2 min	1-2 min	1-2 min
"TOTAL HOURS" END	11:55 / 219.9	11:55 / 220.2	11:55 / 220.5	11:55 / 220.8
ELAPSED HOURS	20 min	20 min	20 min	20 min
INSPECTED DATE/BY	[redacted]			

GENERATOR INSPECTION LOG

DATE	11/5	11/12	11/19	11/26
OIL LEVEL	Good	Good	Good	Good
OIL CONDITION	Good	Good	Good	Good
FUEL LEVEL	—	NATURAL GAS		—
WATER LEVEL	OK	OK	OK	OK
BATTERY CONDITION	15.9	16.1	15.8	15.5
PRE-HEATER LIGHT	—	Plugged in		—
LEAKS	None	None	None	None
TROUBLE LIGHT PANEL	OK	OK	OK	OK
"TOTAL HOURS" START	10:55 / 220.8	10:55 / 221.1	10:55 / 221.4	10:55 / 221.7
TRANSFER TIME TO GENERATOR	7 sec	7 sec	7 sec	7 sec
AMPS L1	14	12	14	13
VOLTS L1 - L2	128	130	120	128
AMPS L2	0	0	0	0
VOLTS L1 - L2	225	224	225	223
HERTZ	60	62	60	61
LIGHTS ON	None	None	None	None
RECEPTACLES ON	yes	yes	yes	yes
OIL PRESSURE	60	58	61	60
WATER TEMPERATURE	158	158	161	159
TRANSFER TIME TO NORMAL	1-2 min	1-2 min	1-2 min	1-2 min
"TOTAL HOURS" END	10:55 / 221.1	10:55 / 221.4	10:55 / 221.7	10:55 / 222.0
ELAPSED HOURS	20 min	20 min	20 min	20 min
INSPECTED DATE/BY	[redacted]			

2014

GENERATOR INSPECTION LOG

DATE	12-3-14	12-10-14	12-17	12-24
OIL LEVEL	Good	Good	Good	
OIL CONDITION	Good	Good	Good	
FUEL LEVEL	—	NATURAL GAS		
WATER LEVEL	OK	OK	OK	
BATTERY CONDITION	15.9	15.7	16.1	
PRE-HEATER LIGHT	—	Plugged in		
LEAKS	NONE	None	NONE	
TROUBLE LIGHT PANEL	OK	OK	OK	
"TOTAL HOURS" START	10:35 222.0	10:35 222.3	10:35 222.5	223
TRANSFER TIME TO GENERATOR	7 sec	7 sec	7 sec	
AMPS L1	13	13	14	
VOLTS L1 - L2	126	125	123	
AMPS L2	0	0	0	
VOLTS L1 - L2	225	226	225	
HERTZ	60	60.1	59.5	
LIGHTS ON	None	None	NONE	
RECEPTACLES ON	Yes	yes	Yes	
OIL PRESSURE	58	60	58	
WATER TEMPERATURE	160	158	160	
TRANSFER TIME TO NORMAL	1-2 min	1-2 min	1-2 min	
"TOTAL HOURS" END	10:35 222.3	10:35 222.1	10:35 222.8	223.1
ELAPSED HOURS	20 min	20 min	20 min	
INSPECTED DATE/BY	[redacted]			

2015

GENERATOR INSPECTION LOG

DATE	12-31-14	1-7-15	1-14-15	1-21-15
OIL LEVEL	C	Good	Good	Good
OIL CONDITION		Good	Good	Good
FUEL LEVEL	NATURAL GAS			
WATER LEVEL		OK	OK	OK
BATTERY CONDITION		16	15.8	15.9
PRE-HEATER LIGHT	OPlugged in			
LEAKS		None	None	None
TROUBLE LIGHT PANEL	S	OK	OK	OK
"TOTAL HOURS" START	223.1	10.35 / 225.1	10:35 / 228.1	10.35 / 224.5
TRANSFER TIME TO GENERATOR		7 sec	7 sec	7 sec
AMPS L1	T	14	14	13
VOLTS L1 - L2		123	124	123
AMPS L2		0	0	0
VOLTS L1 - L2		225	223	226
HERTZ		59.8	60.1	60.5
LIGHTS ON		None	None	None
RECEPTACLES ON		Yes	Yes	Yes
OIL PRESSURE		58	60	59
WATER TEMPERATURE		160	158	159
TRANSFER TIME TO NORMAL		1-2 min	1-2 min	1-2 min
"TOTAL HOURS" END	223.1	10:55 / 225.1	10:55 / 224.0	10:55 / 224.3
ELAPSED HOURS		20 min	20 min	20 min
INSPECTED DATE/BY				[redacted]

GENERATOR INSPECTION LOG

DATE	1-28-15	2-4-15	2-11-15	2-18-15
OIL LEVEL	Good	Good	Good	Good
OIL CONDITION	Good	Good	Good	Good
FUEL LEVEL	Natural	GAS		
WATER LEVEL	OK	OK	OK	OK
BATTERY CONDITION	15.8	16.0	15.8	16.1
PRE-HEATER LIGHT	Plugged IN			
LEAKS	NONE	NONE	NONE	NONE
TROUBLE LIGHT PANEL	OK	OK	OK	OK
"TOTAL HOURS" START	10:35 / 224.3	10:35 / 224.6	10:35 / 224.9	10:35 / 225.2
TRANSFER TIME TO GENERATOR	7 sec	7 sec	7 sec.	7 sec.
AMPS L1	13	14	14	13
VOLTS L1 - L2	124	124	123	124
AMPS L2	0	0	0	0
VOLTS L1 - L2	224	223	224	223
HERTZ	60.1	60.0	60.1	59.2
LIGHTS ON	None	None	NONE	NONE
RECEPTACLES ON	Yes	Yes	Yes	Yes
OIL PRESSURE	60	58	62	58
WATER TEMPERATURE	160	159	159	161
TRANSFER TIME TO NORMAL	1-2 min	1-2 min	1-2 min	1-2 min
"TOTAL HOURS" END	10:55 / 224.6	10:55 / 224.9	10:55 / 225.2	10:55 / 225.5
ELAPSED HOURS	20 min	20 min	20 min	20 min
INSPECTED DATE/BY	[redacted]			