

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.

Sharon Morris
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.)	Docket No. ASTC 15-001
)	
ALBANY MEDICAL SURGICAL CENTER,)	
<i>License No. 7000789</i>)	
)	
Respondent.)	

**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.**

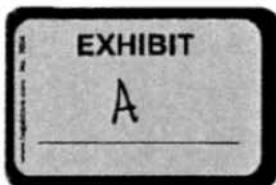


Nirav D. Shah, M.D., J.D.

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

EASTC ☐ 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	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		
Section 205.320			

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

NOTE: IF PLY, INDICATE DATE OF PRIOR SURVEY (Provider's Representative)

EASTC	<input type="checkbox"/> HHA	<input type="checkbox"/> HMO	<input type="checkbox"/> HOSPICE	<input type="checkbox"/> HOSPITAL
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LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
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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**

EASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

NAME AND ADDRESS Albany Medical Surgical Center
OF FACILITY 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)	<p>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:</p> <p>-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.</p> <p>-Pt #14 was a 24 year old female admitted to the facility on 12/20/14 for a D & E. Pt #14 was in recovery from 10:46 am - 12:51 pm.</p> <p>-Pt #15 was a 28 year old female admitted to the</p>		

DATE OF SURVEY _1/5/15_____

BY _30195_____

(Surveyor)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

(Provider's Representative)

**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)	<p>facility on 12/20/14 for a D & E. Pt #15 was in recovery from 11:43 am – 1:10 pm.</p> <p>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</p>		

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

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____ (Provider's Representative)

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

☒ EASTC ☐ 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)	<p>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.</p> <p>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.</p> <p>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</p>		

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

NOTE: IF PLY, INDICATE DATE OF PRIOR SURVEY _____

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

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NAME AND ADDRESS Albany Medical Surgical Center
OF FACILITY 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**

☒ **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	<p>Statistical Data</p> <p>(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...</p> <p>(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.</p> <p>This requirement is not met as evidenced by:</p>		

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			PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
LIST RULE VIOLATED Section 205.620 (cont'd)	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG 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**

☐ EASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

NAME AND ADDRESS OF FACILITY Albany Medical Surgical Center 5086 North Elston Ave., Chicago, IL 60630	LIST RULE VIOLATED Section 205.620 (cont'd)	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG 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.	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
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DATE OF SURVEY 1/5/15 BY 30195 (Surveyor)
 NOTE: IF P.L.V., INDICATE DATE OF PRIOR SURVEY _____ (Provider's Representative)

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.

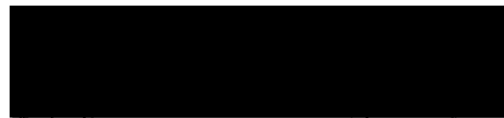
Docket No. ASTC 15-001

PROOF OF SERVICE

The undersigned certifies that she caused a true and correct copy of the attached Notice of Prehearing Conference was sent by certified mail in a sealed envelope, postage prepaid to:

John K. Hughes
Huges Socol Piers Resnick Dym, LTD
70 West Madison Street
Suite 4000
Chiago, IL 60602

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



Snigdha Acharya
Deputy General Counsel
Department of Public Health
122 S. Michigan Ave., 7th Floor
Chicago, Illinois 60603
(312) 814-6033

cc: ALJ Linda Maschek

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 PREHEARING CONFERENCE

Pursuant to Section 10b of the Ambulatory Surgical Treatment Center Act (210 ILCS 5/et seq.) and pursuant to Respondent's request for hearing, NOTICE IS HEREBY GIVEN that an administrative hearing will be conducted before a duly authorized Administrative Law Judge of the Department of Public Health to provide Respondent with an opportunity to contest the attached Notice of Violations and accompanying sanctions.

Pursuant to Section 100.11 of the Department of Public Health's Rules of Practice and Procedure in Administrative Hearings (77 Ill. Adm. Code 100) ("Practice Rules"), a **Prehearing Conference is scheduled for 10:30 a.m. on April 8, 2015. This Prehearing Conference will be held by telephone.** The Prehearing shall be conducted according to the Practice Rules.

Linda Maschek, Attorney at Law, 122 S. Michigan Ave., 7th Floor, Chicago, IL 60603, or other Administrative Law Judge sitting in her stead, will preside at the administrative hearing. The written Answer and any correspondence regarding these proceedings shall be addressed to the Administrative Law Judge with a copy being sent to **Snigdha Acharya**, 122 S. Michigan Ave., 7th Floor, Chicago, IL 60603, Telephone: (312) 814-6033.

**FAILURE TO APPEAR ON THE ABOVE-REFERENCED DATE
MAY RESULT IN AN ORDER OF DEFAULT BEING ENTERED AGAINST YOU.**


Snigdha Acharya
Deputy General Counsel
Department of Public Health
122 S. Michigan Ave., 7th Floor
Chicago, Illinois 60603
(312) 814-6033

Dated this 18th day of March, 2015.

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH

DEPARTMENT OF PUBLIC HEALTH,
STATE OF ILLINOIS,

Complainant,

v.

ALBANY MEDICAL SURGICAL CENTER,
License No. 7000789

Respondent.

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) Docket No. ASTC 15-001
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REQUEST FOR HEARING

The Respondent, Albany Medical Surgical Center, License No. 7000789, by its attorneys, John K. Hughes of Hughes, Socol Piers Resnick & Dym, Ltd. and Richard M. Kates, requests a hearing to contest the Notice of Violations and Notice of Fine Assessment received by Respondent on February 19, 2015.

By

Attorney for Respondent
John K. Hughes
Hughes Socol Piers Resnick & Dym, Ltd.
70 West Madison Street, Suite 4000
Chicago, Illinois 60602
312-604-2602 Direct
312-604-2603 Direct Fax
Email jhughes@hsplegal.com

By

Attorney for Respondent
Richard M. Kates
111 West Washington Street
Suite 1900
Chicago, IL 60602
312-236-0267 Office
312-807-4858 Fax

NOTICE OF MAILING

The undersigned certifies that this Request for hearing was deposited in the U.S. Mail, addressed to Snigdha Acharya, Deputy General Counsel, Illinois Department of Public Health, 122 South Michigan Avenue, 7th Floor, Chicago, IL 60603, on February 27, 2015.

John K. Hughes

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH

DEPARTMENT OF PUBLIC HEALTH,
STATE OF ILLINOIS,

Complainant,

v.

ALBANY MEDICAL SURGICAL CENTER,
License No. 7000789


Respondent.

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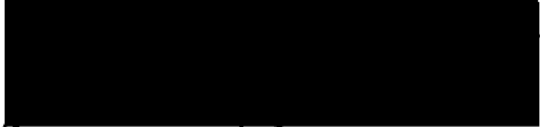
APPEARANCE

The undersigned, attorneys licensed to practice in the State of Illinois, enter their Appearance on behalf of Respondent, Albany Medical Surgical Center, License No. 7000789.

By


Attorney for Respondent
John K. Hughes
Hughes Socol Piers Resnick & Dym, Ltd.
70 West Madison Street, Suite 4000
Chicago, Illinois 60602
312-604-2602 Direct
312-604-2603 Direct Fax
Email jhughes@hspolegal.com

By


Attorney for Respondent
Richard M. Kates
111 West Washington Street
Suite 1900
Chicago, IL 60602
312-236-0267 Office
312-807-4858 Fax

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH

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

ANSWER TO ALLEGATIONS OF NONCOMPLIANCE

Respondent, Albany Medical Surgical Center, License No. 7000789, by its attorneys, John K. Hughes and Richard M. Kates, makes the following Answer to the Allegations of Noncompliance.

The Respondent denies that any conditions at the Facility at any time threatened the public interest, health, safety or welfare. It further denies substantial or continued failure to comply with the Act or rules promulgated thereunder.

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

ANSWER: Admitted.

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.

ANSWER: The Respondent admits that the Department alleges a substantial failure to comply as stated. However, Respondent denies "substantial" failure and affirmatively alleges that in the single instance the Department found, medical necessity and the standard of care required the physician leave in the ambulance with the subject patient before any "on-call" physician could arrive, that the three patients in recovery were at all times monitored by competent medical professionals with the ability to communicate with the physician immediately and that no harm was suffered by any of the three patients.

3. Consequent to the Survey, the Department determined that Respondent substantially failed to comply with the Act and Code Section 305.620, 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.

ANSWER: Respondent denies "substantially" failing to comply with the alleged Code Section and denies a failure to comply with Subparagraph 1 – 3 and 5 – 6 of Paragraph 3. Respondent admits failures to comply in the past with Subparagraph 4 but affirmatively pleading states that Respondent complied with all subparagraphs in its reporting for the fourth quarter of 2014 and will comply with all subparagraphs in the future.

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.

ANSWER: The Respondent admits there is a Statement of Deficiencies attached as Exhibit A containing items the Department asserts are further descriptions of the alleged deficiencies.

By


One of the Attorneys for Respondent

John K. Hughes
Hughes Socol Piers Resnick & Dym, Ltd.
70 West Madison Street, Suite 4000
Chicago, Illinois 60602
312-604-2602 Direct
312-604-2603 Direct Fax
Email jhughes@hsplegal.com

Richard M. Kates
111 West Washington Street, Suite 1900
Chicago, Illinois 60602
312-236-0267 Office
312-807-4858 Fax


AFFIDAVIT OF SERVICE VIA MAIL

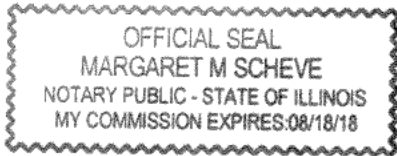
The undersigned, a non-attorney, on oath states that she served true and correct copies of the foregoing documents by mailing the same to counsel of record listed below from Three First National Plaza, 70 West Madison Street, Chicago, Illinois 60602 before 5:00 p.m. on March 11, 2015:

Snigdha Acharya
Deputy General Counsel
Illinois Department of Public Health
122 South Michigan Avenue, 7th Floor
Chicago, IL 60603



SUBSCRIBED AND SWORN TO
before me this 11th day of
March, 2015.


Notary Public



Docket No. ASTC 15-001

cc: ALJ Linda Maschek

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


COMPLAINANT'S REPLY TO RESPONDENT'S ANSWER

NOW COMES the Illinois Department of Public Health (hereinafter "Complainant") through its attorney, Snigdha Acharya, pursuant to Section 100.7 of the Department's Rules of Practice and Procedure in Administrative Hearings (77 Ill. Adm. Code 100) and Section 2-610 of the Code of Civil Procedure (735 ILCS 5/1-101 *et seq.*) and in Reply to Respondent's Answer states the following:

1. **Respondent's First Affirmative Defense:** Objection. Respondent failed to set forth a proper or legally recognizable affirmative defense through the averments set forth in Paragraph 2 of Respondent's Answer. In the alternative, Complainant denies the averments set forth in Paragraph 2 of Respondent's Answer.
2. **Respondent's Second Affirmative Defense:** Objection. Respondent failed to set forth a proper or legally recognizable affirmative defense through the averments set forth in Paragraph 3 of Respondent's Answer. In the alternative, Complainant denies the averments set forth in Paragraph 3 of Respondent's Answer.

Wherefore, Complainant prays that the Administrative Law Judge deny Respondent's Affirmative Defenses.

Respectfully submitted,


Snigdha Acharya
Deputy General Counsel
Department of Public Health
122 S. Michigan Ave., 7th Floor
Chicago, Illinois 60603
(312) 814-6033

Dated this 1st day of April, 2015.

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

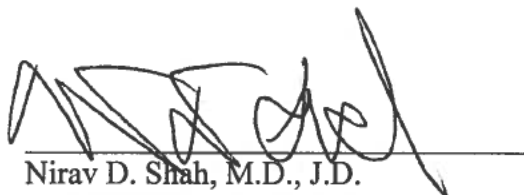
The licensee has a right to a hearing to contest these actions pursuant to, without limitation, Section(s) 5/10b, 5/10c, 5/10d, 5/10f, and 5/10g of the Act and Section 205.860 of the Code. **A written request for hearing must be sent within ten days of receipt of this Notice.** Such request for a hearing 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.**

A handwritten signature in black ink, appearing to read 'Nirav D. Shah', is written over a horizontal line.

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: 7000789	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING B. WING: _____	(X3) DATE SURVEY COMPLETED 08/28/2013
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NAME OF PROVIDER OR SUPPLIER ALBANY MEDICAL SURGICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5086 NORTH ELSTON AVENUE CHICAGO, IL 60630
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(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	<p>Initial Comments</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>	L 000		

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Illinois Department of Public Health

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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		

Illinois Department of Public Health

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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		

Illinois Department of Public Health

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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		

Illinois Department of Public Health

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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		

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L 032	<p>Continued From page 5</p> <p>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.</p> <p>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).</p> <p>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.</p> <p>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.</p> <p>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.</p>	L 032		

Illinois Department of Public Health

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L 032	<p>Continued From page 6</p> <p>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.</p> <p>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.</p> <p>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).</p> <p>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.</p> <p>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.</p>	L 032		

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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		

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L 032	<p>Continued From page 8</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>1. The door and path thereto is obstructed by chairs in non-compliance with 7.1.10.2.1.</p> <p>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.</p> <p>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.</p>	L 032			

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L 046	<p>20.2.9.1/21.2.9.1 Emergency Illumination</p> <p>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:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>B. Illumination of the means of egress is not provided in accordance with 21.2.8 and 7.8. The</p>	L 046		

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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		

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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		

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L 051	Continued From page 12	L 051		
L 051	<p>20.3.4/21.3.2 FIRE ALARM SYSTEM</p> <p>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</p> <p>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.</p> <p>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.</p>	L 051		
L 075	<p>Waste Receptacles 20.7.5.3, 21.7.5.5</p> <p>Soiled linen or trash collection receptacles do not exceed 32 gallons (121L) in capacity.</p> <p>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</p> <p>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:</p> <p>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</p>	L 075		

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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		

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L 106	<p>Continued From page 14</p> <p>line-operated, patient-care-related electrical appliances.</p> <p>1. The generator is not provided with a remote manual stop to comply with NFPA 110-1999, 3-5.5.6.</p> <p>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.</p> <p>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:</p> <ul style="list-style-type: none"> 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 <p>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 existence of a separate Emergency Power Supply shut-off valve.</p>	L 106		

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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		

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L 130	<p>Continued From page 16</p> <p>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:</p> <p>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.</p> <p>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.</p> <p>C. The ASTC Locker rooms located in the</p>	L 130		

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L 130	<p>Continued From page 17</p> <p>basement which are accessed through the storage room area are not provided in accordance with IL Administrative Code 205.1370(k).</p> <p>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.</p> <p>2. A lounge for the exclusive use of the personnel working within the surgical area does not appear to be provided.</p> <p>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.</p> <p>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.</p> <p>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.</p>	L 130		

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L 130	<p>Continued From page 18</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>	L 130		

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NAME OF PROVIDER OR SUPPLIER ALBANY MEDICAL SURGICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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		

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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 conformance 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		

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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		

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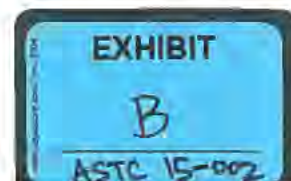
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{L 000}	<p>Initial Comments</p> <p>On August 21, 2014 a Life Safety Code Follow-up survey to the Ambulatory Surgical Treatment Center Annual Licensure Survey was conducted at the above facility by Surveyor 13755. He was accompanied during the survey 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.</p> <p>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.</p> <p>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.</p> <p>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</p>	{L 000}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



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{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}		

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{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 completed02/20/15 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}		

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{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}		

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{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}		

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{L 032}	Continued From page 5	{L 032}		
{L 032}	<p>20.2.4/21.2.4 TWO REMOTE EXITS</p> <p>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</p> <p>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:</p> <p>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.</p> <p>1. Corrected 8/21/14.</p> <p>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.</p> <p>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.</p> <p>3. Corrected 8/21/14. 4. Corrected 8/21/14. 5. Corrected 8/21/14. 6. Corrected 8/21/14.</p>	{L 032}		

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{L 032}	<p>Continued From page 6</p> <p>7. Corrected 8/21/14.</p> <p>8. Corrected 8/21/14.</p> <p>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).</p> <p>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.</p> <p>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.</p> <p>B. The Business occupancy means of egress Stair from the second floor level is not in</p>	{L 032}		

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{L 032}	<p>Continued From page 7</p> <p>accordance with 7.2.2.5 relative to enclosure and 7.1.3.2.1 relative to separation.</p> <p>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.</p> <p>2. Corrected 8/21/14.</p> <p>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).</p> <p>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.</p>	{L 032}		

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{L 032}	<p>Continued From page 8</p> <p>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.</p> <p>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.</p> <p>1. The door and path thereto is obstructed by chairs in non-compliance with 7.1.10.2.1.</p> <p>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.</p> <p>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.</p> <p>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</p>	{L 032}		

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{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}		

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{L 046}	<p>Continued From page 10</p> <p>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.</p> <p>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.</p> <p>3. Corrected 8/21/14.</p> <p>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.</p> <p>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.</p> <p>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.</p>	{L 046}			

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{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}		

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{L 048}	<p>Continued From page 12</p> <p>Procedures for the facility are not in accordance with 21.7.1.1. Findings include:</p> <p>A. Corrected 8/21/14.</p> <p>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:</p> <ol style="list-style-type: none"> 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}			

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{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}		

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{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}		

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{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}			

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{L 106}	<p>Continued From page 16</p> <p>Findings include:</p> <p>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.</p> <p>1. The generator is not provided with a remote manual stop to comply with NFPA 110-1999, 3-5.5.6.</p> <p>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.</p> <p>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:</p> <p>a. Overcrank (fail to start)</p>	{L 106}		

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{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 existence 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 I 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}		

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{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}		

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{L 130}	<p>Continued From page 19</p> <p>in the interim life safety measures to remain in place as work toward the completion of its PoC progresses.</p> <p>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.</p> <p>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.</p> <p>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).</p> <p>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.</p> <p>2. A lounge for the exclusive use of the personnel working within the surgical area does not appear to be provided.</p>	{L 130}		

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{L 130}	<p>Continued From page 20</p> <p>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.</p> <p>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".</p> <p>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.</p> <p>UPDATE 8/21/14: The clear width of the corridor measured in the hall leading to the exterior door is 59".</p>	{L 130}		

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{L 130}	<p>Continued From page 21</p> <p>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.</p> <p>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".</p> <p>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.</p> <p>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.</p> <p>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.</p>	{L 130}		

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{L 130}	<p>Continued From page 22</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>J. A control station located to permit visual surveillance of all traffic that enters the</p>	{L 130}		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7000789	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED R 08/21/2014
NAME OF PROVIDER OR SUPPLIER ALBANY MEDICAL SURGICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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}		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7000789	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED R 08/21/2014
NAME OF PROVIDER OR SUPPLIER ALBANY MEDICAL SURGICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 conformance with Licensing Requirements, NFPA 110, NFPA 99	{L 145}			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7000789	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED R 08/21/2014
NAME OF PROVIDER OR SUPPLIER ALBANY MEDICAL SURGICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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}	<p>Continued From page 25</p> <p>and NFPA 70. Findings include:</p> <p>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.</p> <p>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,</p>	{L 145}		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7000789	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED R 08/21/2014
NAME OF PROVIDER OR SUPPLIER ALBANY MEDICAL SURGICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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**

EASTC ☐ 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	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		
Section 205.320			

DATE OF SURVEY 1/5/15 BY 30195 (Surveyor)
NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY (Provider's Representative)



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

EASTC ☐ 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)	<p>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 extension 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.</p>		

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
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EASTC ☐ HHHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

NAME AND ADDRESS Albany Medical Surgical Center
OF FACILITY 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)	<p>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:</p> <p>-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.</p> <p>-Pt #14 was a 24 year old female admitted to the facility on 12/20/14 for a D & E. Pt #14 was in recovery from 10:46 am - 12:51 pm.</p> <p>-Pt #15 was a 28 year old female admitted to the</p>		

DATE OF SURVEY _1/5/15_____

BY _30195_____

(Surveyor)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

(Provider's Representative)

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

☒ EASTC
 ☐ HHA
 ☐ HMO
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NAME AND ADDRESS Albany Medical Surgical Center
OF FACILITY 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)	<p>facility on 12/20/14 for a D & E. Pt #15 was in recovery from 11:43 am – 1:10 pm.</p> <p>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</p>		

DATE OF SURVEY _1/5/15_____ BY _30195_____

(Surveyor)

(Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

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DIVISION OF HEALTH FACILITIES STANDARDS
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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)	<p>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.</p> <p>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.</p> <p>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</p>		

DATE OF SURVEY 1/5/15

BY 30195
(Surveyor)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

(Provider's Representative)

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

☒ ASTC
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NAME AND ADDRESS Albany Medical Surgical Center
OF FACILITY 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
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NAME AND ADDRESS Albany Medical Surgical Center
OF FACILITY 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	<p>Statistical Data</p> <p>(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...</p> <p>(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.</p> <p>This requirement is not met as evidenced by:</p>		

DATE OF SURVEY _1/5/15_ BY _30195_ (Surveyor)

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**ILLINOIS DEPARTMENT OF PUBLIC HEALTH
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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)	<p>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.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 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)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY (Provider's Representative)

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

<p>Section 205.620 (cont'd)</p>	<p>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.</p>				
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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.

Sharon Morris
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 15-001

**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

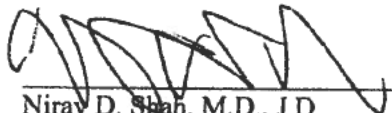
Respondent has a right to a hearing to contest these actions pursuant to, without limitation, Section(s) 5/10b, 5/10c, 5/10d, and 5/10g of the Act and Section 205.860 of the Code. **A written request for hearing must be sent within ten days of receipt of this Notice to the Department.** Such request 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.**

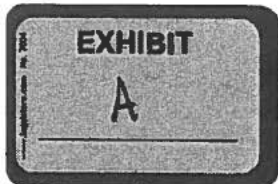
ANSWER BY RESPONDENT

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

EASTC ☐ 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	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		
Section 205.320			

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

NOTE: IF PLY, INDICATE DATE OF PRIOR SURVEY (Provider's Representative)

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

EASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

NAME AND ADDRESS OF FACILITY Albany Medical Surgical Center 5086 North Elston Ave, Chicago, IL 60630			
LIST RULE VIOLATED Section 205.320 (cont'd)	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG 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 extension 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.	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE

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

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

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DIVISION OF HEALTH FACILITIES STANDARDS
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NAME AND ADDRESS OF FACILITY Albany Medical Surgical Center 5086 North Elston Ave., Chicago, IL 60630	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 #14 was 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)

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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)	<p>facility on 12/20/14 for a D & E. Pt #15 was in recovery from 11:43 am - 1:10 pm.</p> <p>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</p>		

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

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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)	<p>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.</p> <p>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.</p> <p>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</p>		

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

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NAME AND ADDRESS OF FACILITY Albany Medical Surgical Center 5086 North Elston Ave., Chicago, IL 60630			
LIST RULE VIOLATED Section 205.320 (cont'd)	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG 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.	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE

DATE OF SURVEY 1/5/15 BY 30195 (Surveyor) _____ (Provider's Representative) _____
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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	<p align="center">Statistical Data</p> <p>(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...</p> <p>(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.</p> <p>This requirement is not met as evidenced by:</p>		

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

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NAME AND ADDRESS OF FACILITY Albany Medical Surgical Center 5086 North Elston Ave., Chicago, IL 60630			
LIST RULE VIOLATED Section 205.620 (cont'd)	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG 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	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE

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

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NAME AND ADDRESS OF FACILITY 5086 North Edison 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) _____
 NOTE: IF P.L.V. INDICATE DATE OF PRIOR SURVEY _____ (Provider's Representative) _____