Notice

Northern Illinois Women's Center Final Order

Because of the increased amount of public inquiries into this matter, the Department is making the Final Order in this case available on its website. However, please note that the Department does not have the resources to post all Final Orders in all cases in the same manner.

THE DEPARTMENT OF PUBLIC HEALTH, STATE OF ILLINOIS,

Complainant,

Docket No. PTC 11-002

v.

NORTHERN ILLINOIS WOMEN'S CENTER,

Respondent.

PROOF OF SERVICE

The undersigned certifies that a true and correct copy of the attached Final Order was sent via email and certified mail in a sealed envelope, postage prepaid to:

Harold C. Hirshman SNR Denton 233 South Wacker Drive Suite 7800 Chicago, IL 60606-6404 Email: Harold.hirshman@snrdenton.com

That said document was caused to be deposited in the United States Post Office at Chicago, Illinois, on the 4th day of Qanuard, 2012.

Hva M. Byerley

Assistant General Counsel U Illinois Department of Public Health

cc: Cynthia Ramirez, A.L.J. William Bryant [Springfield Final Order File] William Bell, Assistant Deputy Director, IDPH Sheila Maxwell

THE DEPARTMENT OF PUBLIC HEALTH, STATE OF ILLINOIS,

Complainant,

v.

Docket No. PTC 11-002

NORTHERN ILLINOIS WOMEN'S CENTER,

Respondent.

FINAL ORDER

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

ILLINOIS DEPARTMENT OF PUBLIC HEALTH Dr. Kenneth Sovemi, M.D., Acting Director Date

THE DEPARTMENT OF PUBLIC HEALTH, STATE OF ILLINOIS,

Complainant,

Docket No. PTC 11-002

v.

NORTHERN ILLINOIS WOMEN'S CENTER,

Respondent.

CONSENT AGREEMENT AND REOUEST FOR FINAL ORDER

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

RECITALS

- 1. The Illinois Department of Public Health (the "Department" or "Complainant") is designated as the State Agency to license, regulate, inspect, investigate and discipline Illinois Pregnancy Termination Centers ("PTC's") pursuant to the Ambulatory Surgical Treatment Center Act, 210 ILCS 5 (the "Act"), and the Ambulatory Surgical Treatment Center Licensing Requirement Code (the "Code"), 77 Ill Admin. Code 205.
- 2. Northern Illinois Women's Center (the "Respondent") was and is, at all pertinent times, licensed by the Department to operate a facility located at 1400 Broadway Street, Suite 201, Rockford, Illinois 61104 (the "facility"). Respondent operated the facility under Ambulatory Surgical Treatment Center ("ASTC") license number 7002967, which license was issued by the Department pursuant to both the Act and the Code.
- On or about June 6 through June 8, 2011, employees of the Department conducted an investigation of Respondent's facility, which resulted in the issuance of a Statement of Deficiencies (the "June 2011 Deficiencies").
- 4. On or about September 15, 2011, employees of the Department conducted another investigation of Respondent's facility, that resulted in the issuance of a second Statement of Deficiencies (the "September 2011 Deficiencies").
- 5. On or about September 29, 2011, the Department issued to Respondent a Notice of Emergency Summary Suspension, Notice of Fine Assessment and Notice of Opportunity for Hearing ("Notice"). The Notice was based on, without limitation, the June 2011 Deficiencies and the September 2011 Deficiencies, both of which were attached as exhibits to the Notice. For reasons more fully set forth in the Notice, the Department ordered the immediate, emergency suspension of the facility's license number 7002967, as provided by Sections 5/10f and 5/10d of the Act, Section 205.840 of the Code, and Section 10-65(d) of the Illinois Administrative Procedure Act (5 ILCS 100/1-5, et seq.), incorporated into the Act at 210 ILCS 5/10(a). A true and correct copy of the Notice is

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attached hereto as Exhibit A and is incorporated as if fully set forth herein.

- 6. Respondent timely requested a hearing to contest the Department's allegations, determinations and notices set forth in paragraph 5 above.
- 7. The Department and Respondent have agreed, in order to resolve this matter, that Respondent be permitted to enter into this Consent Agreement and Request for Final Order ("Consent Agreement") with the Department, providing for the imposition of certain provisions that are consistent with the best interests of the People of the State of Illinois, subject to the entering of a Final Order dismissing this matter.
- 8. This Consent Agreement is a compromise and settlement of the issues alleged in Docket Number PTC 11-002. This Consent Agreement shall not be used in determining liability in any action brought by a third party not a signatory to this Consent Agreement against Respondent. Nothing herein shall be considered an admission of fault of any kind by Respondent as to any future action brought by a third party, nor shall anything herein be considered a reflection of any weakness of proof by the Department. The parties agree that this Consent Agreement is entered into solely for the purpose of settlement and does not constitute an admission of any liability or wrongdoing by the Respondent, its parent, subsidiaries or other related entities, or each of its directors, officers, employees, agents, successors, assigns and attorneys. However, nothing in this paragraph shall limit the Department's power pursuant to Section 5/10d and/or 5/10f of the Act.

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

ARTICLE I Respondent's Consideration

- 1.1 Respondent hereby withdraws its request for a hearing in this matter, thereby expressly waiving its right to contest the Notice of Emergency Summary Suspension, Notice of Fine Assessment and Notice of Opportunity for Hearing as described in paragraph 5 of the Recitals.
- 1.2 The Respondent agrees not to contest the summary suspension of its license or the findings of noncompliance as described in the Notice in the present matter or contest the summary suspension of its license or the findings of noncompliance as described in the Notice in any other matter before the Department, including but not limited to, any future license denial, license revocation, license nonrenewal, or license suspension proceeding pursuant to Section 5/10d and/or 5/10f of the Act. Therefore, the summary suspension and the findings of noncompliance as described in the Notice are imposed against the Respondent and the Respondent agrees to pay the agreed fine amount pursuant to the terms set forth in paragraph 1.4 below (of if applicable, the Reduced Fine Amount pursuant to paragraph 3.2 below).
- 1.3 The Respondent has agreed to correct the deficiencies identified by the Department

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during the September 2011 survey identified in paragraph 4 of the Recitals above and has represented that the deficiencies have been corrected. The Respondent has provided the Department documentary evidence that the deficiencies have been corrected as further detailed in paragraph 2.3 below. The Respondent shall continue to follow the Plan of Correction which is attached here-to as Exhibit B. In the event that Respondent does not reopen the facility and agrees to relinquish is license to the Department pursuant to Paragraph 3.3 below, Respondent's obligations pursuant to this paragraph 1.3 are waived.

- 1.4 On the 15th day of the month following the execution of the Department's Final Order in this matter, Respondent shall deliver to the Department checks in twelve (12) equal monthly installments, due the 15th of each month, which total the amount of Nine Thousand Seven Hundred and Fifty dollars (\$9,750.00) ("agreed fine amount"). Each of the twelve (12) checks totaling Nine Thousand Seven Hundred and Fifty dollars (\$9,750.00) shall be made out to the Illinois Department of Public Health, and delivered to the Illinois Department of Public Health P.O. Box 4263, Springfield, Illinois 62708.
- 1.5 The agreed fine amount will be in full satisfaction of all matters in controversy for which this action was brought by the Department against Respondent in this matter. Should the payments described in paragraph 1.4 above not be made on a timely basis, the Department shall re-institute this action against Respondent, regardless of whether Respondent still exists as a legal entity. The Department shall also institute collection proceedings against Respondent should Respondent fail to make payments in accordance with paragraph 1.4.
- 1.6 Remondent agrees that a reneat violation of Code Sections 205.530(a), 205.330a(a), 205.230(a)(4) and 205.359(b), as further described in the Sentember 2011 Deficiencies referred to in Paragraph 4 of the recitals above, within one (1) calendar year of the execution of this Consent Agreement will result in the immediate forfeiture of Respondent's ASTC License, license number 7002967, without the right to an administrative hearing before the Department. Respondent further agrees that this does not limit the Department's ability to impose violations for unrelated deficiencies, nor will it limit Respondent's right to contest those same, unrelated deficiencies.

ARTICLE II Department's Consideration

- 2.1 The Department hereby reduces the fine assessment from Fifteen Thousand Dollars (\$15,000.00) to Nine Thousand Seven Hundred and Fifty dollars (\$9,750.00), taking into consideration the facts of this incident and the additional information presented by Respondent.
- 2.2 The Department hereby lifts the License Suspension and reinstates Respondent's unrestricted license nunc pro tunc.
- 2.3 The Department acknowledges the receipt of the following documentary evidence relating to the correction of the deficiencies discovered in the September 2011 Survey:

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- (a) Documentation regarding the employment and qualification of two (2) Registered Nurses (77 Ill. Admin. Code 205.530(e) and 205.330(a));
- (b) Written agreement with a laboratory to perform any required laboratory procedures not performed at the Respondents facility (77 Ill. Admin. Code 205.350);
- (c) Documentation regarding the employment and qualification of a physician with practice privileges at an Illinois Hospital (77 Ill. Admin. Code 205.230(a)(4)).

A copy of these documents is attached hereto as Group Exhibit C.

ARTICLE III General Provisions

- 3.1 This Consent Agreement shall become binding on, and shall inure to the benefit of, the parties hereto, their successors, or assignees immediately upon the execution of this Consent Agreement by the Director of Public Health, or his designee, dismissing the above-captioned matter with prejudice, except that this action may be reinstated should Respondent fail to comply with any provision of this Consent Agreement, as set forth, without limitation, in Paragraph 3.2 below, or any other action taken as provided in Paragraph 1.6 above.
- 3.2 The provisions of this Consent Agreement shall apply notwithstanding any transfer of Facility ownership or interest. Should Respondent fail to comply with any provisions of this Consent Agreement, the Department may reinstate this action against Respondent. The Department reserves its right to any remedy available under the law in the event that Respondent fails to pay the agreed fine amount as outlined in paragraph 1.4. In the event that the Facility chooses to remain closed and agrees to relinquish is license to the Department pursuant to Paragraph 3.3 below, the Department agrees to reduce the agreed fine amount from Nine Thousand Seven Hundred and Fifty dollars (\$9,750.00) to One Thousand dollars (\$1,000.00) ("reduced fine amount"), upon receipt of Respondent's license as outlined in paragraph 3.3 below. The reduced fine amount shall be paid and treated the same as the "agreed fine amount," as governed by paragraphs 1.4 and 1.5 above, except that payment will be due in one (1) installment, and shall be paid to the Department within fourteen (14) calendar days of the execution of the attached Final Order.
- 3.3 In the event that Respondent decides to remain closed once the license suspension has been lifted pursuant to this agreement, Respondent agrees to relinquish its license to the Department. Within fourteen (14) calendar days of the execution of the attached Final Order, Respondent must mail the original ASTC license, license number 7002967, to the Illinois Department of Public Health, Division of Health Facilities Standards, 525 West Jefferson Street, Fifth Floor, Springfield Blinois 62761.
- 3.4 In the event that any of the provisions of Article I are not complied with within the times specified therein, this Agreement will be held for naught, except for the provisions referred to in Paragraph 1.1 wherein Respondent has withdrawn its request for hearing to contest this matter.

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- 3.5 It is hereby agreed that this matter be dismissed with prejudice, all matters in controversy for which this matter was brought having been fully settled, compromised, and adjourned.
- 3.6 This Consent Agreement constitutes the entire agreement of the parties, and no other understandings, agreements, or representations, oral or otherwise, exist or have been made by or among the parties. The parties hereto acknowledge that they, and each of them, have read and understood this Consent Agreement in all respects.

DIS DEPARTMENT OF PUBLIC HEALTH By: Eva M. Byerley Assistant General Counsel Illinois Department of Public Health NORTHERN II INOIS WOMEN'S CENTER

By: Dr. Stewart Kernes Northern Illinois Women's Center

Jan. Date 4,2010

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Date

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THE DEPARTMENT OF PUBLIC HEALTH, STATE OF ILLINOIS,

Complainant,

v.

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Docket No. PTC 11-002

NORTHERN ILLINOIS WOMEN'S CENTER,

Respondent.

NOTICE OF EMERGENCY SUMMARY SUSPENSION, NOTICE OF FINE ASSESSMENT AND NOTICE OF OPPORTUNITY FOR HEARING

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

NOTICE OF EMERGENCY SUMMARY SUSPENSION

In accordance with Sections 5/10f and 5/10d of the Act, Section 205.840 of the Ambulatory Surgical Treatment Center Licensing Requirements Code (77 III. Admin. Code 205) (the "Code"), and Section 10-65(d) of the Illinois Administrative Procedure Act (5 ILCS 100/1-5 *et seq.*) (the "APA"), incorporated into the Act at 210 ILCS 5/10a, the Department issues this Notice of Summary Suspension and hereby orders the suspension of the license for the operation of the facility known as Northern Illinois Women's Center, Department license number 7002967, located at 1400 Broadway Street, Suite 201, Rockford, Illinois, 61104 (the "facility"). The license suspension shall commence immediately and shall continue indefinitely.

FINDINGS OF NONCOMPLIANCE

The Department has found conditions in the Respondent facility that are directly threatening to the public interest, health, safety and welfare requiring immediate, emergency action. (210 ILCS 10f). The conditions in the facility directly threatening to the public interest, health, safety and welfare include, but are not limited to, a substantial or continued failure to comply with the Act or any rule promulgated thereunder as referenced below and in the attached exhibits; violations of the provisions of the Act and the rules promulgated thereunder; and a failure to correct violations of the Act and the rules previously identified by the Department. These conditions and failure to comply with both the Act and the Code have resulted in the facility's inability to meet the public interest, health, safety and welfare needs of the community.

Department staff commenced a joint licensure and complaint investigation survey of the facility on June 6, 2011 through June 8, 2011. (the "June 2011 survey"). During the June 2011 survey, the Department observed conditions existing in the facility that threaten the public interest, health, safety and welfare. The findings from the June 2011 survey are hereby incorporated into this "Notice of Emergency License Suspension" and are more fully set forth in the Statement of Deficiencies. (A copy of the June 2011 Statement of Deficiencies is attached hereto as Exhibit "A").

On September 15, 2011, Department staff commenced a revisit survey of the facility in conjunction with three additional complaint surveys. (the "September 2011 survey"). During the September 2011 survey, the Department observed conditions existing in the facility that imminently threaten the public interest, health, safety and welfare. These conditions include, but are not limited to:

- The facility's failure to ensure the presence of a Registered Nurse in the operating room during all invasive or operative procedures (77 Ill. Admin. Code 205.530(e));
- The facility's failure to ensure the presence of a Registered Nurse to direct and supervise the nursing personnel and the nursing care of patients (77 Ill. Admin. Code 205.330(a));
- The facility's failure to ensure that either of the two physicians on staff have and maintain surgical practice privileges with an Illinois licensed hospital(s) (77 Ill. Admin. Code 205.230(a)(4)); and
- The facility's failure to have a written agreement with a laboratory which possesses a valid Clinical Laboratory Improvement Amendment certificate to perform any required laboratory procedures which are not performed in the center (77 Ill. Admin. Code 205.350(b)).

The findings from the September 2011 survey are hereby incorporated into this "Notice of Emergency License Suspension" and are more fully set forth in the Statement of Deficiencies. (A copy of the September 2011 Statement of Deficiencies is attached hereto as Exhibit "B").

These conditions constitute a substantial or continued failure on the part of the facility to comply with the Act and with the rules and regulations promulgated under the Act. The condition of the facility has deteriorated to a point where "the public interest, health, safety, or welfare imperatively requires" that the facility's license be suspended on an emergency basis. (210 ILCS 5/10f(c)).

NOTICE OF FINE ASSESSMENT

Pursuant to Section 5/10d of the Act and Section 205.850 of the Code, the Department hereby assesses a fine of \$500/day for the following violations (as set forth more fully above and in the attached exhibits):

Violation of 77 Ill. Admin. Code 205.530(e)): (9-15-11 to 9-29-11) 15 days x \$500/day = \$7,500.00

Violation of 77 Ill. Admin. Code 205.330(a)): (9-15-11 to 9-29-11) 15 days x \$500/day = <u>\$7,500.00</u>

TOTAL FINE:

<u>\$15,000.00</u>

NOTICE OF OPPORTUNITY FOR HEARING

The licensee has a right to a hearing to contest this action pursuant to, without limitation, Section(s) 5/10c, 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 (10) days of receipt of this Notice. Such request for a hearing must be sent to the Illinois Department of Public Health, Division of Health Facilities Standards, 525 West Jefferson Street, Fifth Floor, Springfield Illinois 62761.

FAILURE TO REQUEST THE 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 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** (20) days after receiving this Notice. Such answer must be sent to the Illinois Department of Public Health, Division of Health Facilities Standards, 525 West Jefferson Street, Fifth Floor, Springfield Illinois 62761.

FAILURE TO FILE AN ANSWER WITHIN TWENTY (20) DAYS OF THE RECEIPT OF THIS NOTICE SHALL CONSTITUTE RESPONDENT'S ADMISSION OF THE ALLEGATIONS OF NONCOMPLIANCE

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Damon T. Arnold, M.D., M.P.H. Director Illinois Department of Public Health

Dated this **2**? day of September, 2011.

THE DEPARTMENT OF PUBLIC HEALTH, STATE OF ILLINOIS,

Complainant,

Docket No. PTC 11-002

NORTHERN ILLINOIS WOMEN'S CENTER,

Respondent.

PROOF OF SERVICE

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

Dennis Christian (Registered Agent) Northern Illinois Womens Center Ltd. 1400 Broadway St. 201 Rockford, IL 61104

That said document was deposited in the United States Post Office at Springfield, Illinois, on the

William Bryant

Illinois Department of Public Health

v.

| HEALTH FANDARDS OF CORRECTION | D HOSPITAL | | PROVIDER'S PLAN OF CORRECTION AND COMPLETION DATE DATE TO BE COMPLETED | | 205.230 (2) Committee Meetings will go over each new or changed policy quarterly/as needed and | document in meeting notes. [Exhibit A.) (3 pgs) | Committee memoers responsible for setting up/reviewing Policy & Procedures. Medical and Clinical Director's responsible for monitoring. P&P Signature Sheet In front of P&P manual defines: date, p&p new/changed and Medical | Director's signature. (Exhibit B) | M Mortes 6.28.1 | |
|---|-------------------------------|--|---|--------------------------------|---|--|---|-----------------------------------|------------------------|--|
| ILLINOIS DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH FACILITIES STANDARDS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | DE ASTC D HHA D HMO D HOSPICE | acility Northern IllinoisWomen's Center 1400 Broadway Rockford, Illinois 61104 | ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY PROVID WHAT IS WRONG DATE TO | Standards of Professional Work | The consulting committee shall review development and content of written policies and procedures of the centerEvidence of such review shall be in the minutes. | This requirement is not met as evidenced by: (Eth | Based on review of Facility consulting committee (CC) minutes for 4 of 4 years (2008, Proc 2009, 2010 and 2011) and staff interview, it was determined that the Facility failed to ensure fron determined that and review of colicies and | | BY 07105 (Surveyor) | |
| | EE / | NAME AND ADDRESS of Facility North | LIST RULE VIOLATED | 205.230 (2) |), | | | Ĥ | DATE OF SURVEY6/8/11 | |

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| ILLINOIS DEPARTMENT OF PUBLIC HEALTH | DIVISION OF HEALTH FACILITIES STANDARDS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | |
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NAME AND ADDRESS OF FACILITY Northern Illinois Women's Center 1400 Broadway Rockford, Illinois 61104

| COMPLETION DATE | | | 11.11.9 | Ripresentative) 6.28.1 |
|--|--------------------------------|-------------------|---|--|
| PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED | | | 205.230 (2) Semi-Annual review of p&p is done by Medical Director and Clinic director, (see Exhibit A, pg 2) and documented on Exhibit B. Medical and Clinic Director's are responsible for implementing this correction. Clinic Director is responsible for monitoring this correction. | (Provider 5 Repres |
| ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG | Standards of Professional Work | Findings include: | On 6/7/11 at approximately 12:00PM, the CC minutes for 2008, 2009, 2010 and 2011, were reviewed. The CC minutes lacked documentation that the Facility's policy/procedure manual was reviewed. The above findings were confirmed by the Clinic Director during an interview on 6/7/11 at approximately 2:00PM. | 6/8/11 BY 0/105 DATE OF PRIOR SURVEY (Surveyor) |
| LIST RULE VIOLATED | 205.230 (2) | Cont. | | DATE OF SURVEY6/8/11 |

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| | a a B a | COMPLETION DATE | | | 11.21.9 | | | | Skepresentative) 6:28. | |
|------------|--|--|--------------------------------|---|--|---|---|--|------------------------|---|
| D HOSPITAL | | PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED | | 205.230 (5) (See Exhibit A, pg 1). Quarterly CC meetings also serve as Tissue Committee meeting. Each CC meeting pulis 15 to 20 charts from | that quarter and all members present review the tissue reports. The doctor's signature at the end of | CC meeting is evidence that the tissue reports were reviewed by all during the meeting. Weekly: Medical director reviews all pathology reports when received. His initial on the pathology report indicates the rissue report from each | patient was reviewed. Admin Assistant is responsible for giving all tissue reports to medical director. Clinic director monitors this is done by checking each tissue report for | are. | Provide 's Rep | |
| □ HOSPICE | 104 | PROVIDER'S PLAN OF CON DATE TO BE COMPLETED | | 205.230 (5) Quarterly C Tissue Com meeting pu | that quarte present rev The doctor | | patient wa patient wa Assistant i tissue repo Clinic direc by checkin | | | |
| | DRESS Northern Illinois Women's Center 1400 Broadway Rockford, Illinois 61104 | ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WIAT IS WRONG | nal Work | The consulting committee shall act as a tissue committee and shall review at least quarterly pathological reportsevidence of such review shall be recorded in the | t as evidenced by: | Based on review of Facility Consulting Committee (CC) minutes for 4 of 4 years (2008, 2009, 2010 and 2011) and staff interview, it was determined the Facility failed to ensure the minutes included review of surgical pathology reports. | 1.On 6/7/11 at approximately 11:30AM, "Consulting Committee Minutes" for 2008, 2009, 2010 and 2011 were reviewed. The minutes lacked documentation that the CC reviewed pathology reports. | The above findings were confirmed with the Clinic Director during an interview on 6/7/11 at approximately 11:50AM. | BY 07105 (Surveyor) | |
| IC D HHA | is Women's Center 1400 B | ITER SUMMARY OF REQUIR | Standards of professional Work | The consulting committee shall act as a tissue of and shall review at least quarterly pathological reportsevidence of such review shall be reco | minutes. This requirement was not met as evidenced by: | Based on review of Facility Consulting Committee (CC minutes for 4 of 4 years (2008, 2009, 2010 and 2011) a staff interview, it was determined the Facility failed to ensure the minutes included review of surgical patholo, reports. | 1.On 6/7/11 at approximately 11:30AM, "Consulting Committee Minutes" for 2008, 2009, 2010 and 2011 were reviewed. The minutes lacked documentation the CC reviewed pathology reports. | The above findings were confirmed with the Clinic Director during an interview on 6/7/11 at approximat 11:50AM. | E OF PRIOR SURVEY | NOTE: IF PLV, INDICATE DATE OF FRION SURVEY |
| ED ASTC | DRESS Northern Illino | 5 × | Ň | | <u> </u> | <u>н с ю е с</u> | | | VEY_6/8/11 | INDICATE DAT |
| | NAME AND ADDRESS OF FACILITY Northe | LIST RULE VIOLATED | | 205.230 (5) | | | - | | DATE OF SURVEY6/8/11 | NOTE: IF PLV, |

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

THE STREET 4 3 115

| COMPLETION DATE | | | | 6-17-11 | | | | When bi 22 |
|---|--|---|--|---|--|--|---|-----------------------------|
| MORPHENE | PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED TATE TO BE COMPLETED | cus.ezu(e) of the kept clean and organized at all times. Surgical supplies will be kept separate from office supplies by storing each in | different orawer of values of and worn for clinic will be cleaned and kept in the back closet by counseling rooms. 2. Surgical areas are checked for cleanliness. Anything stained, sonthed with dirt, etc., will be | appropriately cleaned or discarded Immediately. Clink director Initiated Weekly OR/Exam Room Cleaning Log. <u>Exhibit C</u> Each nurse | will examine her room weekly, sign Ex.C. Clinic director will ck & sign Ex C after staff & is responsible to maintain plan of correction. 3 Nuva Rings are now kept with | by the O R's. The fildge in the recovery room is used only for nourishment, food perishables. | Clinic director is responsible for implementing this correction. Admin Assist is responsible for monitoring this correction by checking both | (Provider's Representative) |
| nois 61104 | PROVIDE AND DATE TO | LUS: 4-10-24 Crgan Crgan Suppli | | | OR | - | | - |
| Center 1400 Broadway Rockford, Illinois 61104 | ARY OF REQUIREMENT AND Y WHAT IS WRONG | nt center shall insure Y | s evidenced by: and staff interview, it was ting rooms inspected (OR ure a sanitary environmen of clean equipment. | 15PM, OR#s 1, 2 and 3 w | e last used on 6/1/11. • contained shoes stored with an open box of •. Four (4) of 16 "gynecological cannulas"in (•. Hown substance. | opened surgical gloves; the wn substance. | Rings" (birh control) were ment refrigerator. Infirmed with the Clinic D 1 t approximately 1:00PM | BY 07105 (Surveyor) |
| Women's Center 1400 B | ENTER SUMMARY OF REQUIREM SPECIFICALLY WHAT IS WRONG | Sanitary Facility The ambulatory surgical treatment center shall insure maintenance of a sanitary facility | This requirement was not met as evidenced by: Based on an observational tour and staff interview, it was determined that for 3 of 3 operating rooms inspected (OR #s1, 2 and 3), the Facility failed to ensure a sanitary environment to and 3), the facility failed to ensure a sanitary environment to | Findings include: Con 6/7/11 at approximately 12:15PM, OR#s 1, 2 and 3 were | inspected. The rooms were last used on 6/1/11. 1.OR#2 and #3 contained shoes stored with an open box of surgical gloves. Four (4) of 16 "gynecological cannulas"in OR were stained with a brown substance. | OR #1 contained a box of opened surgical gloves; the gloves were stained with a dried brown substance. | Thirty nine (39) "Medical Rings" (birth control) were stored in the recovery room nourishment refrigerator. The above finding were confirmed with the Clinic Director The above finding were confirmed with the Clinic Director | uring an interview ou ou |
| RESS Northern Illinois Women's | ENTI | Sanit The a main | This Base deter | Prev Find | 1.C | - Ci M | <u></u> | (11/8/9 |
| NAME AND ADDRESS OF FACILITY North | | 205.420 (a) | | × | | | 1 | DATE OF SURVEY |

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ILLINOIS DEPARTMENT UP FUDLIC ANDARDS DIVISION OF HEALTH FACILITIES STANDARDS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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|---|-------------|---|--|--------------------------------------|
| BLIC HEALTH ES STANDARDS LAN OF CORRECTION | D HOSPICE | PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED | 205.420 (C) (2) (See Exhibit A pg 2) Weekly spore tests are done on both autoclaves. Autoclave tech documents test done in the dally autoclave log. The tests are monitored by MaxiTest Biological Monitoring System. Results are monitored by medical director, clinic director & autoclave technician & kept in autoclave technician & kept in autoclave log. (Exhibit E, 2 pgs) Clinic director will access spore reports by Internet as soon as available. In the event of a failed test, maintenance will be done and documented on maintenance log, (Exhibit F) a new spore test will be done on next clinic day. Clinic admin will sign off on cleaning and resending of spore test. | Provider's Representative) |
| ILLINOIS DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH FACILITIES STANDARDS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | OMH D VHH D | NAME AND ADDRESS Northern Illinois Women's Center. 1400 Broadway, Rockford, IL 61104 OF FACILITY LIST RULE VIOLATED WHAT IS WRONG | Sanitary Facility The Sterilization of materials shall be done by autoclaving the material in accordance with the recommendation of the manufacturer of the autoclave. The effectiveness of the autoclave shall be verified and documented at least weekly with a biological spore assay containing B. stearothermophilus. This requirement was not met as evidence by: This requirement was not met as evidence by: Based on review of the Autoclave Log, staff interview it was determined that the Facility failed to ensure weekly biological spore testing for 2 of 2 autoclave machines. | BY 19840 (Surveyor) (Surveyor) |
| | X ASTC | NAME AND ADDRESS Northern II OF FACILITY LIST RULE VIOLATED | 205.420 (C) (2) | DATE OF SURVEY6/8/11 |

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| | COMPLETION DATE | 6. [3,]] | sentative) |
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| D HOSPICE D HOSPITAL | FROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED | A daily autoclave log is kept for each autoclave and is stored in the autoclave book for inspection. (Exhibit E pg 1) Clinic administrator created a Maintenance Log for Autoclave to ensure passing spore tests on both autoclaves. Clinic director will monitor proper maint/cleaning done according to autoclave manual. In the event that a Service Call is required for maintenance, a copy of the service done and signature of serviceperson will be attached to maintenance log. Clinic Administrator will sign off on all cleaning/service done. (Exhibit F) CC committee initiated these policies and Clinic director will monitor them weekly to ensure poc remains in effect. | Povider's Representative) |
| E ASTC D HHA D HMO D | NAME AND ADDRESS Northern Illinois Women's Center. 1400 Broadway, Rockford, IL 61104 OF FACILITY LIST RULE WHAT IS WRONG | de: e log for July 2010 to June 6, ewed on 6/7/11 between11:30 . The log contained t of biological testing of the 2 hines for the following dates: hines for the following dates: (), 11/3/10 (failed), and 4/6/11 (passed). 6/11 (failed), and 4/6/11 (passed). w with the Administrator on oximately 2:00 PM The oximately 2:00 PM The arterly. | 11 BY 19840 (Surveyor) DATE OF PRIOR SURVEY |
| м Ш | NAME AND ADDRESS Northern I OF FACILITY | 205.420 (C) (2) Cont. | DATE OF SURVEY 6/8/11 B' |

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

| ☐ HOSPITAL completion date | Hirel Granin Diantation 6:22-11 6:22-12 6-15-11 9.21-11 9.21-11 | rescritative) 6.28.1 |
|---|---|---|
| BLIC HEALTH ES STANDARDS LAN OF CORRECTION DI HOSPICE C 61104 C 61104 C 61104 | 205.530 (e) 1. On Wednesday June 22 ^{rd,} NIWC re-hired Licensed Registered Nurse (See: E #3 personnel file reviewed on 6/6/11@ 10:15 AM.) The Credentialing Committee reviewed E #3's Committee reviewed E #3's Committee reviewed E #3's and found her qualified for the Director found her qualified for the Director of Nursing Position. 2. RN has Operating Room acpertence. (Exhibit G) She will be experience. (Exhibit G) She will be experience (Exhibit G) She will be experience (Ishibit G) She will be thereafter. EX Nicht C M. | M M K Keresentative |
| ILLINOIS DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH FACILITTES STANDARDS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION HHA DHMO DEFICIENCIES AND PLAN OF CORRECTION Y Northern Illinois Women's Center, 1400 Broadway, Ste 201, Rockford, IL 61104 Y Northern Illinois Women's Center, 1400 Broadway, Ste 201, Rockford, IL 61104 | Operative Care Operative Care A registered nurse, qualified by training and experience in operating room nursing, shall be present error in the operating room and function as a circulating in the operating room and function as a circulating in the operating room and function as a circulating nurse during all invasive or operative procedures This requirement was not met as evidenced by: This requirement was not met as evidenced by: Nurses (E #3 & 4) previously employed by the Facility, Nurses (E #3 & 4) previously employed by the Facility, Nurses (E #3 & 4) previously employed by the Facility the Facility failed to ensure a Registered by training and experience in operating room nursing, was present in the operating room and functioned as a was present in the operating room and functioned as a presonnel files (E #3 & 4) were reviewed. There was no personnel files (E #3 & 4) were reviewed. There was no Registered Nurse currently employed. | 6/8/11 BY 19843 (Surveyor) |
| D STATEN STATEN HHA MAME AND ADDRESS OF FACILITY Northern Illinois | LIST RULE VIOLATED Section 205.530 (e) | DATE OF SURVEY6/8/11 NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY |

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| | D HOSPITAL | COMPLETION DATE | COMILIERING | | | | 0 | Un going | 0 | | | | 2 6 28 11 | rresentative) | |
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| AN OF CORRECTION | D HOSPICE | 61104 | PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED | | | 205.530 (e) cont. 2 Tha clinic continues to look for a | second RN, classified, word of mouth, etc.; so there is no gap should current RN leave | employment. RN will function as a | circulating nurse during an investor or operative procedures to comply with 205.530 (e). Clinic director is | vith proper qualifications. Medical director and Credentialing | determine any RN hired will fill requirements of 205.530 (e). | C | WI Have | Provider's Representative) | |
| DIVISION OF HEALTH FACILITIES STATEMENT OF CORRECTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | HHA DHMO | and the sector of the sector o | ENTER STIMMARY OF REQUIREMENT AND SPECIFICALLY | + | Operative Care (continued) | 2. E #3's personnel file included documentation that E #3 was hired on 1/7/11. E #3's employment application Aid not include documentation of Pregnancy Termination | or Operating Room experience or training. E#3 s use up of contain documentation of clinical orientation or was not contain documentation of severience as an OR circulating qualified by training or experience as an OR circulating | nurse. | 3. The Clinical Director stated during an interview on $6/6/11$ at 2:00 PM, that E #3 resigned on $4/8/11$. | 4. E #4's personnel file included the start date of 3/10/06. E #4's employment application did not include | documentation of rregulatory $E \# file did not containRoom experience or training. E \# file did not containdocumentation of clinical orientation or was qualified bytraining or experience as an OR circulating nurse. E \# 4^{\circ}straining or experience as an OR circulating nurse. E \# 6^{\circ}sfile included a letter of resignation dated 10/10/07.$ | 5. These findings were confirmed by the Clinical | Director/ Administrator during an unclaved of 2:15 PM. | 11BY[9843 | ATE OF PRIOR SURVEY |
| | D ASTC | | NAME AND ADDRESS OF FACILIA | LIST RULE VIOLATED | Contion 205.530 (e) | cont. | | | | | | | | DATE OF SURVEY6/8/11 | NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY |

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ILLINOIS DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH FACILITIES STANDARDS EMENT OF DEFICIENCIES AND PLAN OF CORRECT

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| | L | COMPLETION DATE | | S Representative) |
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| BLIC HEALTH SS STANDARDS AN OF CORRECTION | D HOSPICE D HOSPITAL | PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED | 205.540 (f) New form created by medical and clinic directors' and approved by CC meeting. (See Exhibit A, pg 2) At discharge the patient indicates with whom she will be leaving the clinic. This new form was put in place on 6.10.11. All old forms have been destroyed. Assist Admin will monitor these forms before every clinic day to be sure correct form is being used. (See Exhibit 1) | (Provide S Rep |
| ILLINOIS DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH FACILITTIES STANDARDS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | O HHO D HHO | NAME AND ADDRESS Northern Illinois Women's Center. 1400 Broadway, Rockford, 1L 61104 OF FACILITY LIST RULE VIOLATED WHAT IS WRONG | Postoperative Care The name or relationship to the patient, of the person accompanying the patient upon discharge from the facility shall be noted in the patient's medical record. This requirement is not met as evidenced by: This requirement is not met as evidenced by: ased on review of clinical records and staff interview, it was determined that for 5 of 5 (#1, interview, it was determined that for 5 of 5 (#1, 2, 3, 4, & 5) clinical records reviewed, the 2, 3, 4, & 5) clinical records reviewed, the surgical procedure. | BY 19840 (Surveyor) |
| | EASTC | NAME AND ADDRESS Northern Illi OF FACILITY LIST RULE VIOLATED | 205.540 (f) | DATE OF SURVEY6/8/11 |

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COMPLETION DATE wider's Representative) 0 **HOSPITAL** PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION DIVISION OF HEALTH FACILITIES STANDARDS ILLINOIS DEPARTMENT OF PUBLIC HEALTH **HOSPICE** relationship of the person accompanying the Pt. ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG lacked the name, or relationship of the person reviewed on 6/6/11 between 1:00 PM and 3:00 procedure performed on 4/13/11. The record 2. Pt. #1, a 23 year old female, had a surgical PM. The clinical records lacked the name, or accompanying the Pt. upon discharge after BY 19840 (Surveyor) NAME AND ADDRESS Northern Illinois Women's Center. 1400 Broadway, Rockford, IL 61104 1. The clinical record of Pt.s' #1-5 were D HIMO discharge after surgical procedure. NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY surgical procedure. O HHA Findings include: **E ASTC** DATE OF SURVEY ____6/8/11. 205.540 (f) OF FACILITY LIST RULE VIOLATED Cont.

| C HEALTH TANDARDS OF CORRECTION | SPICE DHOSPITAL | PROVIDER'S PLAN OF CORRECTION AND COMPLETION DATE DATE TO BE COMPLETED | | | M Marcie 6.28 | (Provider's Representative) |
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| ILLINOIS DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH FACILITIES STANDARDS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | E ASTC D HHA D HMO DHOSPICE | NAME AND ADDRESS Northern Illinois Women's Center. 1400 Broadway, Rockford, 1L 61104 OF FACILITY CF FACILITY LIST RULE VIOLATED VIOLATED | 205.540 (f)3. Pt. #2, a 22 year old female, had a surgical procedure performed on 3/4/11. The record lacked the name, or relationship of the person accompanying the Pt. upon discharge after surgical procedure. | 4. Pt. #3, a 21 year old female, had a surgical procedure performed on 5/6/11. The record lacked the name, or relationship of the person accompanying the Pt. upon discharge after surgical procedure. | 5. Pt. #4, a 27 year old female, had a surgical procedure performed on 3/2/11. The record lacked the name, or relationship of the person accompanying the Pt. upon discharge after survical procedure. | DATE OF SURVEY _6/8/11 |

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1.82.9 COMPLETION DATE vider's Representative) **D HOSPITAL** PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED **HOSPICE** Administrator during an interview on 6/7/11, at ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG lacked the name, or relationship of the person procedure performed on 3/16/11. The record 7. The above findings were confirmed with accompanying the Pt. upon discharge after 6. Pt. #5, a 2 year old female, had surgical NAME AND ADDRESS Northern Illinois Women's Center. 1400 Broadway, Rockford, IL 61104 OMH D (Surveyor) BY_19840_ approximately 10:00 AM O HHA NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY surgical procedure. **E ASTC** DATE OF SURVEY ____6/8/11. 205.540 (f) OF FACILITY LIST RULE VIOLATED Cont.

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

| | | COMPLETION DATE | 9.10.1 | sentative) |
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| BLIC HEALTH ES STANDARDS LAN OF CORRECTION | D HOSPICE D HOSPITAL | PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED | 205.610 (b) Updated "surgical form" has section for Physical Exam and docurnentation of exam clearly stated. Medical and clinic directors' revamped form. CC meeting approved the form. (See Exhlibit A, pg 2) Signature on form of the doctor verifies physical exam findings. This form is part of patient records. Form has been in place since 6.10.11. All old versions have been destroyed. Admin Assist monitors these forms before every clinic day to be sure correct form is being used. (See Exhlibit 2.) | Provder's Representative) |
| ILLINOIS DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH FACILITIES STANDARDS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | O HHO D HHO | NAME AND ADDRESS Northern Illinois Women's Center. 1400 Broadway, Rockford, 1L 61 104 OF FACILITY LIST RULE VIOLATED WHAT IS WRONG | Clinical Records Accurate and complete clinical records shall be maintained for each patient the record shall include but not limited to the following: admitting information includingphysical examination findings, diagnosis or need for medical services. This requirement was not met as evidenced by: Based on review of clinical records and staff interview, it was determined that for 5 of 5 (#1, 2, 3, 4, & 5) clinical records reviewed, the Z, 3, the medical records reviewed, the facility failed to ensure physical exams were documented in the medical records. | 11BY19840 |
| | X ASTC | NAME AND ADDRESS Northern II OF FACILITY LIST RULE VIOLATED | 205.610 (b) | DATE OF SURVEY 6/8/11 |

| | L COMPLETION DATE | -0 -0 | der's Representative) |
|---|---|---|---|
| ILLINOIS DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH FACILITIES STANDARDS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X ASTC HHA HMO HOSPICE HOSPICE NAME AND ADDRESS Northern Illinois Women's Center. 1400 Broadway, Rockford, IL 61104 EROVIDER'S PLAN OF CORRECTION AND OF FACILITY ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY PROVIDER'S PLAN OF CORRECTION AND LIST RULE WHAT IS WRONG | Findings include: 1. The clinical record of Pt.s' #1-5 were 1. The clinical record of Pt.s' #1-5 were PM. The clinical records lacked documentation PM. The clinical records lacked documentation of a physical examination. of a physical examination. 2. Pt. #1, a 23 year old female, had surgical 2. Pt. #1, a 23 year old female, had surgical procedure performed on 4/13/11. The clinical procedure performed on 4/13/11. The clinical examination. | 3. Pt. #2, a 22 year old female, had surgical procedure performed on 3/4/11. The clinical procedure performed on 3/4/11. The clinical record lacked documentation of a physical record lacked documentation of a physical examination. BY 19840 [Surveyor] DATE OF PRIOR SURVEY [Curveyor] |
| | X A NAME AND ADDRESS Northern OF FACILITY | 205.610 (b) Cont. | 3. Pt. #2, a procedure F record lack examinatio bATE OF SURVEY_6/8/11 DATE OF SURVEY_6/8/11 NOTE: IF PLV, INDICATE DATE OF PRIOR |

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| ADDRESS Northern II | llinois Women's | NAME AND ADDRESS Northern Illinois Women's Center. 1400 Broadway, Rockford, IL 61104 | ockford, IL 61104 | | | |
| OF FACILITY LIST RULE VIOLATED | ENTER SUM WHAT IS W | ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG | NT AND SPECIFICALLY | PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED | ORRECTION AND ED | COMPLETION DATE |
| 205.610 (b) Cont. | 4. Pt. #3, a 2. procedure pe record lacked examination. | 4. Pt. #3, a 21 year old female, had surgical procedure performed on 5/6/11. The clinical record lacked documentation of a physical examination. | e, had surgical 11. The clinical 1 of a physical | | | |
| | 5. Pt. #4, a 2' procedure pe record lacked examination. | 5. Pt. #4, a 27 year old female, had surgical procedure performed on 3/2/11. The clinical record lacked documentation of a physical examination. | le, had surgical /11. The clinical n of a physical | | | 1.0.1 |
| | 6. Pt. #5, a 23 procedure per record lacked examination. | 6. Pt. #5, a 23 year old female, had surgical procedure performed on 3/16/11. The clinical record lacked documentation of a physical examination. | ile, had surgical 6/11. The clinical n of a physical | | | - - - |
| | 7. The a Adminis approxii | 7. The above findings were confirmed with Administrator during an interview on 6/7/11, at approximately 10:00 AM. | confirmed with erview on 6/7/11, at | | 01.0 | |
| DATE OF SURVEY6/8/11B | | 7 | 19840 (Surveyor) | | (Provider's Representative) | 10.28.11 sentative) |

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| COMPLETION DATE | | 11.21.9 | | | | nor ho 28: | epresentative) |
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| PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED | | 205.610 (o) A revised form of recovery notes was created by medical and clinical director and renamed "post counseling notes" & approved in CC | meeting (See Exhlbit A, pg 2). This form reflects all the post counseling with patient. Once counseling is complete pt initials she has had all questions answered. (Exhlbit 1) This form is now in use. All old versions | have been destroyed. Admin assist is responsible for seeing that only this version of form is used. Forms will be checked before each clinic day. | | AMA | (Provider's R |
| Illinois Center 1400 Broadway Rockford, Illinois 61104 ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG | Clinical Records Accurate and complete records shall be maintainedthe record shall includepost counseling notes. This requirement was not met as evidenced by: | Based on clinical record review and staff interview, it was determined that in 1 of 10 records reviewed (Pt. #6), the Facility failed to ensure a patient received post operative counseling. | Findings include: 1.On 5/6/11 at approximately 10:30AM, clinical records 1-10 were reviewed. The record for Pt. #6 lacked a post operative counseling note. | Pt. #6, a 24 year old female, had a surgical procedure on 3/2/11. The clinical record lacked a post operative counseling note. | 2. The above finding was confirmed with the Clinic Director during an interview on 6/7/11 at approximately 9:30AM. | | 6/8/11 BY 07105 (Surveyor) |
| NAME AND ADDRESS OF FACILITY Northern LIST RULE VIOLATED | 205.610 (o) | | | | | | DATE OF SURVEY6/8/11 NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY |

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| SLIC HEALTH ES STANDARDS AN OF CORRECTION | L HOSPICE | DO BE COMPLETED O BE COMPLETED COMPLETED COMPLETED COMPLETED Cred orientation on Wed 6/22/11. Le response to 205.530 (e) le response to |
| ILLINOIS DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH FACILITTES STANDARDS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | OMH | NAME AND ADDRESS OF FACILITY Northern Illinois Women's Canter, 1400 Broadway, Sta 201, Roadford, IL 61104 LIST RULE ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY PROVID VIOLATED WHAT IS WRONG CARE OUTERMENT AND SPECIFICALLY PROVID Section 205.330 (a) Mursing Personnel Section 205.330 (a) Mursing Personnel This requirement was not mer sevidence in surgical postgraduate education or experience in surgical postgraduate education or experience in surgical postgraduate education or experience in surgical Regulate education or experience in surgical postgraduate education or experience in surgical postgraduate Findings include: PU 108-30 AM, 2 of 2 RN personnel files (E 1. On 6/6/11 at 10:15 AM, 2 of 2 RN personnel files (E 1. On 6/6/11 at 10:15 AM, 2 of 2 RN personnel files (E 1. On 6/6/11 at 10:15 AM, 2 of 2 RN personnel files (E 1. MATE OF SURVEY 6/8/11 ANDTE: IF PLV, INDICATE DATE OF PRIOR SURVEY (SurveYOF) NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY (SurveYOF) |
| | ASTC | NAME AND ADDRESS OF FACILI LIST RULE VIOLATED Section 205.330 (a) |

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

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| COMPLETION DATE | | | | | | | | NES 6.28 11 | s Representative) |
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| | PROVIDER'S FLAN OF CORRECTION AND DATE TO BE COMPLETED | | | | | | | MADA | (Provided 5 Rep |
| | A THE STIMMARY OF REQUIREMENT AND SPECIFICALLY | | Nursing personnel (continued) | 2. E #3's personnel file included documentation that E #3 was hired on 1/7/11. The Clinical Director stated that E | R. The supervise nursing staff and on the premises for the mast 2 months. | E #4's personnel file included a hire date of 3/10/06 E #4's personnel file included a hire date of 3/10/06 and a resignation date of 10/10/07. Therefore, the Facility had no RN to supervise patient care for over 4 vears (10/07 to 1/11). | 4. The Clinical Director/Administrator stated on $6/6/11$ at 9:15 AM, that the local Hospitals and Nursing Homes employ all the RNs in the area and the Facility has not employ all the RNs in the area and the Facility been able to hire and keep an RN on staff. The Facility has 3 Licensed Practical Nurses (E #4 – 6) to provide | | 6/8/11 BY 19843 (Surveyor) |
| | NAME AND ADDRESS OF FACILIT | LIST RULE VIOLATED | Continu 205.330 (a) | | | | | | DATE OF SURVEY |

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY .

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

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NAME AND ADDRESS OF FACILITY Northern Illinois Women's Center, 1400 Broadway, Sto 201, Rockford, IL 61104

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| LIST RULE VIOLATED | ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG | PROVIDER'S FLAN OF COMPLETED | | |
| Section 205.330 (a) | Nursing personnel (continued) patient care. On 6/6/11 at 2:15 PM, the Clinical Director stated that 1 of the 3 LPNs (E #4) provided staff supervision. 5. These findings were confirmed by the Clinical Director during the interview on 6/6/11 at 2:15 PM. | | | |
| DATE OF SURVEY 6/8/11. | 111BY19843(Surveyor) | (Jeovider's Representative) | | |
| NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY | TE OF PRIOR SURVEY | | | |

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NAME AND ADDRES PREGNANCY TERMINATION CENTER

| lative) | (Provider's Representative) | 9/15/11 BY 19840 (Surveyor) | DATE OF SURVEY9/15/11 |
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| | | Clinical recordspost counseling notes | 205.610 (o) Corrected |
| | | Clinical Recordsphysical examination | 205.610 (b) Corrected |
| 2 | | Postoperative Care | 205.540 (f) Corrected |
| | | Sanitary Facility | 205,420 (C)(2) Corrected |
| | | Sanitary Facility | 205.420 (a) Corrected |
| | | Standard of Professional Work | 205.230 (5) Corrected |
| | | Standards of Professional Work | 205.230 (2) Corrected |
| COMPLETION DATE | PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED | ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG | LIST RULE VIOLATED |
| | | OF FACILITY | OF FACILITY |

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

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

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 NAME AND ADDRESS
 Northern Illinois Women's Center 1400 Broadway, Rockford, IL 61104

 OF FACILITY
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 IS WRONG
 Section 205.530 (e) **Repeat deficiencies: Operative Care** ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT | PROVIDER'S PLAN OF CORRECTION AND IS WRONG | DATE TO BE COMPLETED as a circulating nurse during all operative procedures. nursing, was present in the operating room and functioned qualified by training and experience in operating room Facility, The Facility failed to ensure a Registered Nurse, Registered Nurses (E #1) currently employed by the Nurse during all invasive or operative procedure..." A registered nurse, qualified by training and approximately 9:30 AM. The Director stated that a new Findings include: files and OR Log review, it was determined that for 1 of 1 Based on staff interview and review of Facility personnel This requirement was not met as evidenced by: in the operating room and function as a circulating experience in operating room Nursing shall be present 1. The Clinic Director was interviewed on 9/13/11 at **COMPLETION DATE**

(Provider's Re

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

DATE OF SURVEY

9/15/11

BY

19840

(Surveyor)

(Provider's Representative)

PREGNANCY TERMINATION CENTER **HOSPICE**

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NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

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

ASTC PREGNANCY TERMINATION CENTER **HIHA HMO**

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NAME AND ADDRESS Northern Illinois Worr n's Center 1400 Broadway. Rockford. IL 61104

| ative) | (Provider's Representative) | 9/15/11BY19840 (Surveyor) | DATE OF SURVEY |
|-----------------|---|--|-----------------------------|
| | | 4. The Clinic Director was interviewed on 9/14/11 at approximately 10:00 AM and 11:15 AM. The Director stated that E #1 was still on orientation and on 9/14/11 was just observing procedures day to day operations. The finding was confirmed with the Director during the interview. | Section 205.530 (e) Cont |
| COMPLETION DATE | PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED | ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG | LIST RULE VIOLATED |

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

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

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 PREGNANCY TERMINATION CENTER

NAME AND ADDRESS OF FACILITY Northern Illinois Women's Center, 1400 Broadway, Ste 201, Rockford, IL 61104

| | DATE OF SURVEY 9/1 | | VIOLATED Section 205.530 (e) | LIST RULE |
|-----------------------------|--------------------|--|---------------------------------|---|
| (Surveyor) | 9/15/11 BY 19843 | Operative Care A registered nurse, qualified by training and experience in operating room nursing, shall be present in the operating room and function as a circulating nurse during all invasive or operative procedures" This requirement was not met as evidenced by: B. Based on review of clinical records and staff interview, it was determined, that for 2 of 10 (Pts. #6 & 9) clinical records reviewed, the Facility failed to ensure a Registered Nurse, qualified by training and experience in operating room nursing, was present in the operating room and functioned as a circulating nurse during all operative procedures. Findings include: | WHAT IS WRONG | ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY |
| (Provider's Representative) | 8 | | DATE TO BE COMPLETED | PROVIDER'S PLAN OF CORRECTION AND |
| ntative) | | | | COMPLETION DATE |

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

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

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NAME AND ADDRESS OF FACILITY Northern Illinois Women's Center, 1400 Broadway, Ste 201, Rockford, IL 61104

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

(Surveyor)

(Provider's Representative)

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| OF FACILITY LIST RULE VIOLATED | ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG | PROVIDER'S PLAN OF CORRECTION AND COMPLETION DATE DATE TO BE COMPLETED |
| Section 205.330 (a) | Nursing Personnel | |
| | At least one registered professional nurse with postgraduate education or experience in surgical nursing shall direct and supervise the nursing personnel and the nursing care of patients and shall be on duty at all times, on the premises, when patients are present. | |
| | This requirement was not met as evidenced by: | |
| | Based on review of Facility personnel file, review of the Operating Room Day Sheets (OR log) and staff interview, it was determined that for 5 of 5 surgical procedure days the Facility failed to ensure that a Registered Nurse with postgraduate education or experience in surgical nursing was present on the premises to supervise nursing personnel and nursing care when patients are present. | |
| | Findings include: | |
| | 1. The Clinic Director was interviewed on 9/13/11 at approximately 9:30 AM. The Director stated that the RN hired on 6/22/11 left the position on 8/29/11, and a new RN was hired and began training on 9/7/11. | |
| ATE OF SURVEY | _9/15/11BY19840 | (Provider's Representative) |

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

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(FIDVIDEL & Representative)

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

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NAME AND ADDRESS Northern Illinois Women's Center 1400 Broadway, Rockford, IL 61104

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| Section 205.330 (a) | Nursing Personnel (continued) | | |
| Cont | 2. The personnel file of E #1 was reviewed on 9/13/11 at approximately 10:00 AM. E #1 with a hire date of 9/7/11 began orientation on 9/7/11. E #1's employment application did not include documentation of post education or experience in surgical nursing. | | |
| | 3. The OR Log was reviewed on 9/14/11 at approximately 10:00 AM. The log included documentation that surgical procedures were performed on 9/14/11, 9/9/11, 9/7/11, 9/2/11, and 8/31/11. There was no experienced surgical nurse present to supervise nursing care on the above dates. | | |
| | 4. The Clinic Director was interviewed on 9/14/11 at approximately 10:00 AM and 11:15 AM. The Director stated that the new RN is in the Facility however is still training and is only observing procedures and day today operation of the Facility. The finding was confirmed with the Director during the interview. | | |
| DATE OF SURVEY | BY19840 | | |

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

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NAME AND ADDRESS OF FACILITY Northern Illinois Women's Center, 1400 Broadway, Ste 201, Rockford, IL 61104

| ntative) | (Provider's Representative) | DATE OF SURVEY9/15/11 BYBY19843 NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY(Surveyor) | NOTE |
|-----------------|---|---|-----------------------|
| | | A. Based on review of physician personnel files and staff interview, it was determined that, for 2 of 2 (E #2 & 3), physicians working in the Facility, the Facility failed to ensure physicians working in the Facility had clinical privileges and appointments in an Illinois licensed Hospital. | |
| | | This requirement was not met as evidenced by: | |
| | | or documents shall be available for inspection by the Department. A list of privileges granted each medical staff member of the ambulatory surgical treatment center shall be available at all times for use by the staff of the center and for inspection by Department staff. As used in this subsection, "skilled-equivalent" means the ability to perform similar procedures requiring the same level of training and expertise. | |
| | | | |
| 6 | | (New Deficiencies) Standards of Professional Work Section 205.230 (a)(4) | (Ne) |
| COMPLETION DATE | PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED | ULE ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY TED WHAT IS WRONG | LIST RULE VIOLATED |

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NAME AND ADDRESS OF FACILITY Northern Illinois Women's Center, 1400 Broadway, Ste 201, Rockford, IL 61104

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| Section 205.230 (a)(4) | Standards of Professional Work (continued) | | |
| | Findings include: | | |
| | On 9/15/11 at 3:15 PM, the personnel files for the physicians (E #2 & 3) working in the Facility were reviewed. E #2 was the Medical Director and had performed all the surgical procedures during the past 4 months (June 2011 – September 2011). E #3 was the former Medical Director. Neither personnel file (E #2 & 3) included documentation of privileges or appointment in an Illinois licensed hospital. | | |
| | 2. On 9/15/11 at 3:10 PM, an interview was conducted with the Facility's Clinical Manager. The Manager stated that E #2 did not have clinical privileges or appointment in any Hospital and E #3 did have privileges and appointment in a Wisconsin Hospital, but not in Illinois. E #3's Wisconsin Hospital appointment documentation was not included in the personnel file. The Manager confirmed the findings during the interview. | | |
| DATE OF SURVEY9 | 9/15/11BY19843 | | |
| NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY | TE OF PRIOR SURVEY (Surveyor) | (Provider's Representative) | tative) |

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

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NAME AND ADDRESS OF FACILITY Northern Illinois Women's Center, 1400 Broadway, Ste 201, Rockford, IL 61104

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| Section 205.330 (a) | Nursing Personnel | | |
| | At least one registered professional nurse with postgraduate education or experience in surgical nursing shall direct and supervised the nursing personnel and the nursing care of patients and shall be on duty at all time, on the premises, when patients are present | | |
| | This requirement was not met as evidenced by: | | |
| | A. Based on review of the Illinois Nursing Practice Act, Certified Nurses Aid (CNA) job description, staff personnel files, clinical records, and staff interview, it was determined that for 4 of 10 (Pts. #1, 7, 8, & 9), clinical records reviewed, the Facility failed to ensure medications were administered by a licensed professional qualified to administer medication. | | |
| | Findings include: | | |
| DATE OF SURVEY9/ | 9/15/11BY19843 | | 42 |
| NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY | ATE OF PRIOR SURVEY (Surveyor) | (Provider's Representative) | ntative) |

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

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NAME AND ADDRESS OF FACILITY Northern Illinois Women's Center, 1400 Broadway, Ste 201, Rockford, IL 61104

| The Illinois Nurse Practice Act 225 ILCS 65 sec. 50- 75 c) was reviewed on 9/14/11 at 2:00 PM and included, "A registered professional nurse shall not delegate any nursing activity requiring the specialized knowledge, judgment, and skill of a licensed nurse to an unlicensed person, including medication administration. A registered nurse may delegate tasks to other licensed and unlicensed persons. The intent of the Nurse Practice Act to allow the delegation of tasks to other unlicensed persons is not to be interpreted as to allow all types of procedures or practices" On 9/15/11 at 10:30 AM, the combined Licensed Practical Nurse and Certified Nurses Aid job description was reviewed. The job description included, "Administers meds as directed by the doctor" The job description does not conform to the Illinois Nurse Practice Act. | occupit teoror (a) I manification for the former (continued) |
|--|--|
| persons is not to be interpreted as to allow all types of procedures or practices" 2. On 9/15/11 at 10:30 AM, the combined Licensed Practical Nurse and Certified Nurses Aid job description was reviewed. The job description included, "Administers meds as directed by the doctor" The job description does not conform to the Illinois Nurse Practice Act. | |
| | 2. On 9/15/11 at 10:30 AM, the combined Licensed Practical Nurse and Certified Nurses Aid job description was reviewed. The job description included, "Administers meds as directed by the doctor" The job description does not conform to the Illinois Nurse Practice Act. |

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

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NAME AND ADDRESS OF FACILITY Northern Illinois Women's Center, 1400 Broadway, Ste 201, Rockford, IL 61104

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| Section 205.330 (a) | Nursing personnel (continued) | | |
| | 3. Staff personnel files were reviewed on 9/14/11 at 11:00 AM. Clinical staff files included RNs, LPNs, Counselors (E #4 & 5) and 1 CNA (E #6). | | |
| | 4. The clinical record of Pt. #1 was reviewed on 9/13/11 at 10:30 AM. Pt. #1 was a 21 year old female, who underwent a Termination of Pregnancy (TOP) at 18 weeks procedure on 3/11/11. Naproxen, 220 mg, was administered by a CNA (E #6) on 3/11/11 at 8:00 AM and Misoprostol (Cytotec), 200 mcg, was also administered by E #6 on 3/11/11 at 8:10 AM. | | |
| | 5. The clinical record of Pt. #7 was reviewed on 9/14/11 at 1:30 PM. Pt. #7 was a 19 year old female, who underwent a TOP at 14 weeks on 8/3/11. Naproxen, 220 mg, was administered by a Counselor (E #4) on 8/3/11 at 9:16 AM and Misoprostol 200 mcg, was also administered by E #4 on 8/3/11 at 9:18 AM. | | |
| DATE OF SURVEY9 | 9/15/11 BY 19843 | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | DIVISION OF HEALTH FACILITIES STANDARDS | ILLINOIS DEPARTMENT OF PUBLIC HEALTH |
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NAME AND ADDRESS OF FACILITY Northern Illinois Women's Center, 1400 Broadway, Ste 201, Rockford, IL 61104

| Nursing personnel (continued) 6. The clinical record of Pt. #8 was reviewed on 9/14/11 at 1:45 PM. Pt. #8 was a 28 year old female, who underwent a TOP at 16 weeks on 8/5/11. Naproxen, 220 mg, was administered by a Counselor (E #4) on 8/5/11 at 8:08 AM and Misoprostol 200 mcg, was also administered by E #4 on 8/5/11 at 8:10 AM. 7. The clinical record of Pt. #9 was reviewed on 9/14/11 at 1:50 PM. Pt. #9 was a 27 year old female, who underwent a TOP at 14 weeks on 8/10/11. Naproxen, 220 mg, was administered by a CNA (E #6) on 8/10/11 at 8:55 AM and Misoprostol 200 mcg, was also administered by E #6 on 8/10/11 at 9:00 AM. 8. These findings were confirmed by the Clinical Director during an interview on 9/15/11 at 10:00 AM. | brive) | (Provider's Representative) | 9/15/11BY19843(Surveyor) | DATE OF SURVEY |
|---|-----------------|---|--|-----------------------|
| Nursing personnel (continued) | | | 6. The clinical record of Pt. #8 was reviewed on 9/14/11 at 1:45 PM. Pt. #8 was a 28 year old female, who underwent a TOP at 16 weeks on 8/5/11. Naproxen, 220 mg, was administered by a Counselor (E #4) on 8/5/11 at 8:08 AM and Misoprostol 200 mcg, was also administered by E #4 on 8/5/11 at 8:10 AM. 7. The clinical record of Pt. #9 was reviewed on 9/14/11 at 1:50 PM. Pt. #9 was a 27 year old female, who underwent a TOP at 14 weeks on 8/10/11. Naproxen, 220 mg, was administered by a CNA (E #6) on 8/10/11 at 8:55 AM and Misoprostol 200 mcg, was also administered by E #6 on 8/10/11 at 9:00 AM. 8. These findings were confirmed by the Clinical Director during an interview on 9/15/11 at 10:00 AM. | |
| | | | Nursing personnel (continued) | Section 205.330 (a) |
| ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY PROVIDER'S PLAN OF CORRECTION AND COMPLETION DATE WHAT IS WRONG DATE TO BE COMPLETED DATE | COMPLETION DATE | PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED | ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG | LIST RULE VIOLATED |

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| Section 205.350 | Laboratory Services | | |
| <u>, , , , , , , , , , , , , , , , , , , </u> | (b) Have a written agreement with a laboratory which possesses a valid CLIA certificate to perform any required laboratory procedures which are not performed in the center. | | |
| | Based on review of CLIA (Clinical Laboratory Improvement Amendment) certificates and staff interview, it was determined that the Facility Failed to ensure the Facility had a written agreement with a CLIA certified laboratory to perform lab procedures not | | |
| | Findings include: | | |
| | 1. On 9/13/11 at approximately 10:00AM two (2) CLIA (Clinical Laboratory Improvement Amendment) certificate of compliance were reviewed. The first certificate was for the Facility's external pathology lab services, with a lab certification for Histopathology and a certificate expiration date of 5/16/2013. | | - |
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DIVISION OF HEALTH FACILITIES STANDARDS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION **HOSPICE HOSPITAL**

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 NAME AND ADDRESS Northern Illinois Women's Center 1400 Broadway, Rockford, IL 61104
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LIST RULE Section 205.350 Cont... approximately 2:00 PM. 3. The above findings were confirmed with the Clinic Director during an interview on 9/15/11 at lab have no written laboratory agreement with any outside agreement with a lab for procedures not performed in approximately 9:30 AM. A request for a written 2. The Clinic Director was interviewed on 9/15/11 at the Facility was made. The Director stated that they date of 1/10/2013. certification for ABO & RH Group, with an expiration Laboratory Services (continued) ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG The second certificate was the Facility's internal lab **COMPLETION DATE**

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BY

(Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

DATE OF SURVEY

Northern Illinois Women's Center Ltd. 1400 Broadway, Suite 201 Rockford, Illinois 61104 Phone: (815) 963-4101

Fax: (815) 963-6122

Illinois Department of Public Health Division of Health Facilities Standards 525 West Jefferson Street, Fifth Floor Springfield, IL 62761

RE: The Department of Public Health v. Northern Illinois Women's Center Docket No. PTC 11-002

Dear Mr Arnold:

Enclosed you will find the completed Plan of Corrections.

Respectfully,

NIWC Administrator





Pat Quinn, Governor Damon T. Arnold, M.D., M.P.H., Director

122 8. Michigan Ave., Suite 2009 - Chicago, Illinois 60603-6152 - www.idph.state.il.us

Via Faculmile

Dr. Dennis Christensen Medical Director Northern Illinois Women's Center Ltd. 1400 Brosdway St. 201 Rockford, IL 61104 Fax Number: 815-963-6122

Meg Larkin Administrator Northern Illinois Women's Center Ltd. 1400 Broadway St. 201 Rockford, IL 61104

Re: <u>NOTICE OF EMERGENCY SUSPENSION</u> Northern filtnois Women's Center, IDPH License No. 7002967

Dear Dr. Christensen and Ms. Larkin:

Please be advised of the attached Notice of Emergency Summary Suspension, which was executed by the Director of the Illinois Department of Public Health yesterday and sent out to your facility via certified mail, in accordance with applicable law. <u>Effective upon</u> the close of business today, Friday, September 30, 2011, the Northern Illinois <u>Women's Center must cease all operations pursuant to the attached Notice</u>. Upon receipt of this Notice, Northern Illinois Women's Center's current license with the Department is hereby suspended and invalid pending further action.

Until further notice, any patient admission, care or procedure is **STRICTLY PROHIBITED**. The only exception to this prohibition is any action that needs to be immediately taken and/or continued in order to protect the direct health of a patient. Any such further activitics conducted in contravention of the attached Notice will be deemed as unlicensed and unauthorized and will be prosecuted to the fullest extent of the law.

If you have any questions regarding this letter or the attached Notice, please contact the Illinois Department of Public Health attorney handling this matter, Eva Byerley, at (312) 814-3577.

Sin NICOIS eputy General Counsel

cc: Toinette Colon, Deputy Director, IDPH Jason R. Boltz, General Counsel, IDPH

printed on recycled paper

| DATE OF SURVEY | 205.230 (2) | VIOLATED | NAME AND ADDRESS | |
|-----------------------|---|----------------------|--|--|
| DATE OF SURVEY | Standards of Professional Work The consulting committee shall review development and content of written policies and procedures of the centerEvidence of such review shall be in the minutes. This requirement is not met as evidenced by: Based on review of Facility consulting committee (CC) minutes for 4 of 4 years (2008, 2009, 2010 and 2011) and staff interview, it was determined that the Facility failed to ensure development and review of policies and procedures. | WHAT IS WRONG | | ILLINOIS DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH FACILITIES STANDARDS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECT |
| (Providents Represent | 205.230 (2) Committee Meetings will go over each new or changed policy quarterly/as needed and document in meeting notes. (Exhibit A.) (3 pgs) Committee Members responsible for setting up/reviewing Policy & Procedures. Medical and Clinical Director's responsible for monitoring, P&P Manual defines: date, p&p new/changed and Medical Director's signature. (Exhibit B) | DATE TO BE COMPLETED | □ HOSPICE □ HOSPITAL Rockford, Illinois 61104 | PUBLIC HEALTH TIES STANDARDS PLAN OF CORRECTION |
| 2 6.28.1 | 6.17.1 | COMPLETION DATE | | |

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| DATE OF SURVEY | | | 205.230 (2) Cont. | VIOLATED | LIST RULE | NAME AND ADDRESS OF FACILITY North | [1] | |
|--|--|--|---|----------|---|---|------------------------|---|
| DATE OF SURVEY 6/8/11 BY 07105 (Surveyor) (Surveyor) | 2. The above findings were confirmed by the Clinic Director during an interview on 6/7/11 at approximately 2:00PM. | 1.On 6/7/11 at approximately 12:00PM, the CC minutes for 2008, 2009, 2010 and 2011, were reviewed. The CC minutes lacked documentation that the Facility's policy/procedure manual was reviewed. | Standards of Professional Work Findings include: | | ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY | RESS Northern Illinois Women's Center 1400 Broadway Rockford, Illinois 61104 | ED ASTC D HHA D HMO DI | ILLINOIS DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH FACILITIES STANDARDS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTI |
| (Provider's Ripresentative) | 5 | 205.230 (2) Semi-Annual review of p&p is done by Medical Director and Clinic director, (see Exhibit A, pg 2) and documented on Exhibit B. Medical and Clinic Director's are responsible for implementing this | | | PROVIDER'S PLAN OF CORRECTION AND COMPLETION DATE | | D HOSPICE D HOSPITAL | BLIC HEALTH ES STANDARDS LAN OF CORRECTION |

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| DIVISION OF HEALTH FACILITIES STANDARDS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | ILLINOIS DEPARTMENT OF PUBLIC HEALIN |
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| VIOLATED | | DATE TO BE COMPLETED | |
| | Standards of professional Work | | |
| 205.230 (5) | The consulting committee shall act as a tissue committee and shall review at least quarterly pathological reportsevidence of such review shall be recorded in the minutes. | 205.230 (5) (See Exhibit A, pg 1). Quarterly CC meetings also serve as Tissue Committee meeting. Each CC meeting pulls 15 to 20 charts from that quarter and all members | |
| | This requirement was not met as evidenced by: | The doctor's signature at the end of | 6.17.11 |
| | Based on review of Facility Consulting Committee (CC) minutes for 4 of 4 years (2008, 2009, 2010 and 2011) and staff interview, it was determined the Facility failed to ensure the minutes included review of surgical pathology | tissue reports were reviewed by all during the meeting. Weekly: Medical director reviews all pathology reports when received. | |
| | reports. | His initial on the pathology report indicates the tissue report from each | |
| - | 1.On 6/7/11 at approximately 11:30AM, "Consulting Committee Minutes" for 2008, 2009, 2010 and 2011 were reviewed. The minutes tacked documentation that the CC reviewed pathology reports. | patient was reviewed. Admin Assistant is responsible for giving all tissue reports to medical director. Clinic director monitors this is done by checking each tissue report for | |
| | 2. The above findings were confirmed with the Clinic Director during an interview on 6/7/11 at approximately 11:50AM. | MD signature. | |
| DATE OF SURVEY 6/8/11 | 1 BY 07105 | The Darks | nta 6.28. |
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| 1.OR#2 and #3 contained shoes stored with surgical gloves. Four (4) of 16 "gynecolog 2 were stained with a brown substance. 2 OR #1 contained a box of opened surgic | | 9. 8 ¢ œ | 205.420 (a) Saa Th ma | | NAME AND ADDRESS | ED ASTC | |
|---|--|---|--|--|--|-----------------|---|
| 1.OR#2 and #3 contained shoes stored with an open box of surgical gloves. Four (4) of 16 "gynecological cannulas" in OR 2 were stained with a brown substance. | Findings include: On 6/7/11 at approximately 12:15PM, OR#s 1, 2 and 3 were inspected. The rooms were last used on 6/1/11. | Based on an observational tour and staff interview, it was determined that for 3 of 3 operating rooms inspected (OR #s1, 2 and 3), the Facility failed to ensure a sanitary environment to prevent potential contamination of clean equipment. | Sanitary Facility The ambulatory surgical treatment center shall insure maintenance of a sanitary facility This requirement was not met as evidenced by: | ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG | RESS Northern Illinois Women's Center 1400 Broadway Rockford, Illinois 61 104 | C D HHA | ILLINOIS DEPARTMENT OF FUELC MEANING DIVISION OF HEALTH FACILITIES STANDARDS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |
| ad with an open box or coological cannulas"in OR ice. | , OR#s 1, 2 and 3 were | ff interview, it was oms inspected (OR #s1, 2 anitary environment to an equipment. | er shall insure need by: | G PROV | vay Rockford, Illinois 61 104 | анмо анс | ILLINOIS DEPARTMENT OF FUELO MEANDARDS DIVISION OF HEALTH FACILITIES STANDARDS MENT OF DEFICIENCIES AND PLAN OF CORRE |
| Catter start at is responsion to maintain plan of correction. 3 Nuva Rings are now kept with other refrigerated meds in the la by the O R's. The fridge in the | immediately. Clinic director initiated Weekly OR/Exam Room Cleaning Log. <u>Exhibit C</u> . Each nurse will examine her room weekly, sign Ex C. Clinic director will ck & sign Ex Ex C. Clinic director will ck & sign Ex | kept in the back closet by counseling rooms. 2. Surgical areas are checked for cleanliness. Anything stained, spotted with dirt, etc., will be appropriately cleaned or discarded | tables will be kept clean and organized at all times. Surgical supplies will be kept separate from office supplies by storing each in different drawer or cabinet. 1. Shoes different drawer or cabinet. and worn for clinic will be cleaned and | PROVIDER'S PLAN OF CORRECTION AND NATE TO BE COMPLETED 205.420 (a) OR rooms, cabinets and | | D HOSPICE D HOS | N OF CORRECTION |
| with with the lab | 0°~ ×4 | sed | noes | nd COMPLETION DATE | | D HOSPITAL | |

DATE OF SURVEY NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY 6/8/11 3. Thirty nine (39) "Medical Rings" (birh control) were stored in the recovery room nourishment refrigerator. 4. The above finding were confirmed with the Clinic Director during an interview on 6/7/11 t approximately 1:00PM. BY. Y 07105 (Surveyor) nourishment, tood perisnaures. Clink director is responsible for implementing this correction. Admin Assist is responsible for monitoring this correction by checking both fridges' at close of clinic. Exhibit D. (Provid presentative) 5 Ĉ 6.25

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| DATE OF SURVEY6\8/11 P NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY | 205.420 (C) (2) Sanitai The Sta autocla recomma autocla shall b Weekly B. stea Based intervi failed for 2 c | UST RULE ENTER S | X ASTC | ST |
|---|---|----------------------|--------|--|
| BY19840 (Surveyor) RJOR SURVEY(Surveyor) | Sanitary Facility The Sterilization of materials shall be done by autoclaving the material in accordance with the recommendation of the manufacturer of the autoclave. The effectiveness of the autoclave shall be verified and documented at least weekly with a biological spore assay containing B. stearothermophilus. This requirement was not met as evidence by: Based on review of the Autoclave Log, staff interview it was determined that the Facility failed to ensure weekly biological spore testing for 2 of 2 autoclave machines. | TCALLY | | ILLINOIS DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH FACILITIES STANDARDS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECT |
| Provider's Representative) | 205.420 (C) (2) (See Exhibit A pg 2) Weekly spore tests are done on both autoclaves. Autoclave tech documents test done in the daily autoclave log. The tests are monitored by MaxITest Biological Monitoring System. Results are monitored by medical director, clinic director & autoclave technician & kept in autoclave log. (Exhibit E, 2 pgs) Clinic director will access spore reports by internet as soon as available. In the event of a failed test, maintenance will be done and documented on maintenance log. (Exhibit F) a new spore test will be done on next clinic day. Clinic admin will sign off on cleaning and resending of spore test. | DATE TO BE COMPLETED | | UBLIC HEALTH TES STANDARDS PLAN OF CORRECTION |

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| DATE OF SURVEY 6 | 205.420 (C) (2) Cont. | NAME AND ADDRESS Norther OF FACILITY LIST RULE VIOLATED |
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| DATE OF SURVEY 68/11 BY 19840 (Surveyor) (Provider's Representative) | Findings include: Findings include: A carry autoclave rugs is very to carry autoclave log for July 2010 to June 6, 2011, was reviewed on 6/7/11 between11:30 and 12:30 PM. The log contained documentation of biological testing of the 2 autoclave machines for the following dates: 7/7/10 (passed), 11/3/10 (failed), 11/17/11 (negative), 3/16/11 (failed), and 4/6/11 (passed). 2. An interview with the Administrator on 6/6/11 at approximately 2:00 PM The Administrator stated that biological testing is performed quarterly. (1) (1) (1) (1) (1) (1) (1) (1) (1) (1) | DN HOSI |

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| | DATE OF SURVEY | | | | | | | Section 205.530 (e) | UIST RULE VIOLATED | NAME AND ADDRESS OF FACILI | MASTC | | - |
|-----------------------------------|-----------------------------|----------|--|--|---|---|--|---------------------|---------------------------------|-----------------------------------|-----------------|---|---|
| TT AMPLICATE DATE OF PRIOR SURVEY | 6/8/11BY19843(Surveyor) | | 1. On $6/6/11$ at 10:15 AM, the 2 of 2 terminated RN's personnel files (E #3 & 4) were reviewed. There was no Registered Nurse currently employed. | Findings include: | Based on review of according that for 2 of 2 Registered interview, it was determined that for 2 of 2 Registered the Facility, Nurses (E #3 & 4) previously employed by the Facility failed to ensure a Registered Nurse, qualified by training and experience in operating room nursing, by training and experience in operating room nursing, was present in the operating room and functioned as a was present in the operating norm and functioned as a circulating nurse during all operative procedures. | This requirement was not met as evidenced by: | A registered nurse, qualified by training and experience in operating room nursing, shall be present in the operating room and function as a circulating nurse during all invasive or operadive procedures" | Operative Care | ENTER SUMMARY OF REQUIREMENT OF | - " | HHA D HMO | ILLINOIS DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH FACILITIES STANDARDS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | |
| | (Provider's Representative) | JUN UNA | thereafter. Exhibit Ga | medical & clinical directors in 3 mos. | | | | | DATE TO BE COMPLETED | PROVIDER'S PLAN OF CORRECTION AND | DHOSPICE | BLIC HEALTH ES STANDARDS LAN OF CORRECTION | |
| ļ | • | · 28. 11 | | | 3 mill eval 9.31-11 | 6.22 to 6. 15-11 | Afired biss " | | 1-12-11 | COMPLETION DATE | HOSPITAL | | |

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NOTE IF PLV, INDICATE D t

NAME AND ADDRESS OF FACILITY Northern Illinois Women's Center, 1400 Broadway, Ste 201, Rockford, IL 61104 VIOLATED GY. Section 205.530 (e) DATE OF SURVEY DASTC 6/8/11 ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG **Operative Care (continued)** #3 was hired on 1/7/11. E #3's employment application or Operating Room experience or training. E #3's file did did not include documentation of Pregnancy Termination qualified by training or experience as an OR circulating not contain documentation of clinical orientation or was 6/6/11 at 2:00 PM, that E #3 resigned on 4/8/11. 3. The Clinical Director stated during an interview on nurse. E #4's employment application did not include 4. E #4's personnel file included the start date of 3/10/06. Room experience or training. E #4 file did not contain documentation of Pregnancy Termination or Operating 5. These findings were confirmed by the Clinical Director/ Administrator during an interview on 6/6/11 at file included a letter of resignation dated 10/10/07. training or experience as an OR circulating nurse. E #4's documentation of clinical orientation or was qualified by 2:15 PM. E #3's personnel file included documentation that E HIHA BΥ 19843 (Surveyor) DHMO PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED 3. The clinic continues to look for a second RN, classified, word of circulating nurse during all invasive employment. RN will function as a should current RN leave mouth, etc.; so there is no gap 205.530 (e) cont responsible to hire additional RN with 205.530 (e). Clinic director is or operative procedures to comply with proper qualifications. Medical determine any RN hired will fill **Committee responsible to** director and Credentialing requirements of 205.530 (e). **HOSPICE** Provider's Representative) 2 Un going COMPLETION DATE **D HOSPITAL** 6.28.11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

DIVISION OF HEALTH FACILITIES STANDARDS ILLINOIS DEPARTMENT OF PUBLIC HEALTH

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

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| DATE OF SURVEY | 205.540 (f) | NAME AND ADDRESS Non OF FACILITY LIST RULE VIOLATED | |
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| 6/8/11 | | | A A S |
| DATE OF SURVEY 6/8/11 BY 19840 (Surveyor) (Surveyor) | Postoperative Care The name or relationship to the patient, of the person accompanying the patient upon discharge from the facility shall be noted in the patient's medical record. This requirement is not met as evidenced by: This requirement is not met as evidenced by: Interview, it was determined that for 5 of 5 (#1, interview, it was determined that for 5 of 5 (#1, 2, 3, 4, & 5) clinical records reviewed, the Facility failed to document the person accompanying the patient from the Facility post surgical procedure. | NAME AND ADDRESS Northern Illinois Women's Center. 1400 Broadway, Rockford, IL 61104 OF FACILITY LIST RULE ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY VIOLATED WHAT IS WRONG | ASTC D HHA D HMO C |
| (Provide S Representative) | 205.540 (f) New form created by medical and clinic directors' and approved by CC meeting. (See Exhibit A, pg 2) At discharge the patient indicates with whom she will be leaving the clinic. This new form was put in place on 6.10.11. All old forms have been destroyed. Assist Admin will monitor these forms before every clinic day to be sure correct form is being used. (See Exhibit 1) | PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED | D HOSPICE D HOSPITAL |
| | 6.17.11 | COMPLETION DATE | |

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| DATE OF SURVEY6/8/11 NOTE: IF PLV, INDICATE D | | 205.540 (f) Cont. | OF FACILITY LIST RULE VIOLATED | NAME AND ADDRESS N | |
|--|---|--|--------------------------------------|---|-------------------|
| DATE OF SURVEY | relationship of the person accordance. discharge after surgical procedure. 2. Pt. #1, a 23 year old female, had a surgical procedure performed on 4/13/11. The record lacked the name, or relationship of the person lacked the name, or relationship of the person surgical procedure. | Findings include: 1. The clinical record of Pt.s' #1-5 were reviewed on 6/6/11 between 1:00 PM and 3:00 reviewed on 6/6/11 between 1:00 PM and 3:00 PM. The clinical records lacked the name, or PM. The clinical records lacked the name, or | ENTER SUMMARY | Women's Center. 1400 Broadway, Rockford, IL 61104 | EASTC DHHA DHMO D |
| Mark Lo | | | | PROVIDER'S PLAN OF CORRECTION AND CON | DHOSPICE |
| 5 (6·28.) | | | | COMPLETION DATE | |

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| NOTE: IF PLV, INDICAT | DATE OF SURVEY6/8/11. | | | 205.540 (f) Cont. | NAME AND ADDRESS Northern OF FACILITY LIST RULE VIOLATED | | |
|---|--|--|--|--|---|------------------------------------|---|
| NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY | (Surveyor) (Provider's Representative) | 5. Pt. #4, a 27 year old female, had a surgical procedure performed on 3/2/11. The record lacked the name, or relationship of the person accompanying the Pt. upon discharge after surgical procedure. | 4. Pt. #3, a 21 year old female, had a surgical procedure performed on 5/6/11. The record lacked the name, or relationship of the person accompanying the Pt. upon discharge after surgical procedure. | 3. Pt. #2, a 22 year old female, had a surgical procedure performed on 3/4/11. The record lacked the name, or relationship of the person accompanying the Pt. upon discharge after surgical procedure. | NAME AND ADDRESS Northern Illinois Women's Center. 1400 Broadway, Rockford, 1L 61104 OF FACILITY OF FACILITY LIST RULE VIOLATED VIOLATED COMPLETED COMPLETED COMPLETED COMPLETED COMPLETED COMPLETED | EASTC DHHA DHMO DHOSPICE DHOSPITAL | ILLINOIS DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH FACILITIES STANDARDS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |

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| NOTE: IF PLV, INDICAT | DATE OF SURVEY _6/8/11 | | | 205.540 (f) Cont. | NAME AND ADDRESS Norther OF FACILITY LIST RULE VIOLATED | [1] | | |
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| NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY | BY_19840 (Surveyor) (Surveyor) | 6.28 | 7. The above findings were confirmed with Administrator during an interview on 6/7/11, at approximately 10:00 AM | 6. Pt. #5, a 2 year old female, had surgical procedure performed on 3/16/11. The record lacked the name, or relationship of the person accompanying the Pt. upon discharge after surgical procedure. | Northern Illinois Women's Center. 1400 BIDBUWES, NUMBER, TELEVISION AND COMPLETION DATE ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY DATE TO BE COMPLETED WHAT IS WRONG | D HOSPICE D HOSPITAL | ILLINOIS DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH FACILITIES STANDARDS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | |

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| DATE OF SURVEY | 205.610 (b) | NAME AND ADDRESS NOR OF FACILITY LIST RULE VIOLATED |
|-----------------------------|---|--|
| DATE OF SURVEY6/8/11BY19840 | Clinical Records Accurate and complete clinical records shall be maintained for each patient the record shall include but not limited to the following: admitting information includingphysical examination findings, diagnosis or need for medical services. This requirement was not met as evidenced by: Based on review of clinical records and staff interview, it was determined that for 5 of 5 (#1, 2, 3, 4, & 5) clinical records reviewed, the Facility failed to ensure physical exams were documented in the medical records. | ILLINOIS DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH FACILITIES STANDARDS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTI STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTI OF FACILITY OF FACILITY LIST RULE NAME AND ADDRESS Northern Illinois Women's Center. 1400 Broadway, Rockford, IL 61104 NAME AND ADDRESS Northern Illinois Women's Center. 1400 Broadway, Rockford, IL 61104 VIOLATED ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG PROVIDER'S PLAN OF CORR |
| Provider's Representative) | 6 | UBLIC HEALTH TIES STANDARDS PLAN OF CORRECTION HOSPICE DHOSPITAL DATE TO BE COMPLETED CONFLETION DATE |

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| ILLINOIS DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH FACILITIES STANDARDS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |
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NAME AND ADDRESS Northern Itinois Women's Center. 1400 Broadway, Rockford, IL 61104 Of FACILITY LIST RULE VIOLATED ENTER SUMMARY OF REQUIREMENT AND SPECIFI Cont. 205.610 (b) DATE OF SURVEY _6/8/1 X A\$TC ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG Findings include: 1. The clinical record of Pt.s' #1-5 were of a physical examination. PM. The clinical records lacked documentation reviewed on 6/6/11 between 1:00 PM and 3:00 2. Pt. #1, a 23 year old female, had surgical procedure performed on 4/13/11. The clinical record lacked documentation of a physical 3. Pt. #2, a 22 year old female, had surgical examination. procedure performed on 3/4/11. The clinical record lacked documentation of a physical examination. .BY 19840 (Surveyor) PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED fov der's Representative) ô 11.01.9 COMPLETION DATE 6.28.1

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | STANDARDS | LIC HEALTH |

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AND ADDRESS Northern Illinois Women's Center. 1400 Broadway, Rockford, IL 61104

| DATE OF SURVEY B | | | | 205.610 (b) Cont. | LIST RULE VIOLATED | NAME AND ADDRESS NOTITED |
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| BY 19840 (Surveyor) | 7. The above findings were confirmed with Administrator during an interview on 6/7/11, at approximately 10:00 AM. | 6. Pt. #5, a 23 year old female, had surgical procedure performed on 3/16/11. The clinical record lacked documentation of a physical examination. | 5. Pt. #4, a 27 year old female, had surgical procedure performed on 3/2/11. The clinical record lacked documentation of a physical examination. | 4. Pt. #3, a 21 year old female, had surgical procedure performed on 5/6/11. The clinical record lacked documentation of a physical examination. | ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG | 4 |
| (Provider's Representative) | | | | | DATE TO BE COMPLETED | AND AND PARTY AND CODDECTION AND |
| entative) | | | 6.10.11 | | | COMPLETION DATE |

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| DATE OF SURVEY | 205.610 (0) | NAME AND ADDRESS OF FACILITY Nor LIST RULE VIOLATED | DE ASTC | |
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| DATE OF SURVEY6/8/11BY07105 NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY* | Clinical Records Accurate and complete records shall be maintainedthe Accurate and complete records shall be maintainedthe Accurate and complete records counseling notes. This requirement was not met as evidenced by: Based on clinical record review and staff interview, it was determined that in 1 of 10 records reviewed (Pt. #6), the determined that in 1 of 10 records reviewed (Pt. #6), the determined that in 1 of 10 records reviewed (Pt. #6), the determined that in 1 of 10 records reviewed (Pt. #6), the determined that in 1 of 10 records reviewed post operative counseling. Findings include: I.On 5/6/11 at approximately 10:30AM, clinical records 1-10 were reviewed. The record for Pt. #6 lacked a post operative counseling note. Pt. #6, a 24 year old female, had a surgical procedure on 3/2/11. The clinical record lacked a post operative counseling note. 2. The above finding was confirmed with the Clinic Director during an interview on 6/7/11 at approximately 9:30AM. | Northern Illinois Center 1400 Broadway Rockford, Illinois 61104 ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG | SUB ACUTE D HHA D HMO | ILLINOIS DEPARTMENT OF FUBLIC HEALTH DIVISION OF HEALTH FACILITIES STANDARDS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |
| (Provider's Repre | 205.610 (o) A revised form of recovery notes was created by medical and clinical director and renamed "post counseling notes" & approved in CC meeting (See Exhibit A, pg 2). This form reflects all the post counseling with patient. Once counseling is complete pt initials she has had all questions answered. (Exhibit 1) This form is now in use. All old versions have been destroyed. Admin assist is responsible for seeing that only this version of form is used. Forms will be checked before each clinic day. | PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED | D HOSPICE D HOSPITAL | PLAN OF CORRECTION |
| presentative) | 6. 17. 11 | COMPLETION DATE | ι. | |

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| DATE OF SURVEY | | Section 205.330 (a) | NAME AND ADDRESS OF FACIL LIST RULE | D ASTC | |
|--|--|---|--|-------------|---|
| DATE OF SURVEY6/8/1 BY19843 DATE OF SURVEY6/8/1 BY (Surveyor) | are present This requirement was not met as evidenced by: This requirement was not met as evidenced by: Based on review of Facility staff personnel files and staff Based on review of Facility staff personnel files and staff Based on review of Facility staff personnel at the Facility, Nurses (E #3 & 4) who previously worked at the Facility, Nurses (E #3 & 4) who previously worked at the Facility, nurses (E #3 & 4) who previously worked at the Facility, nurses (E #3 & 4) who previously worked at the Facility, nurses (E #3 & 4) who previously worked at the Facility, nurses (E #3 & 4) who previously worked at the Facility, Findings include: 1. On 6/6/11 at 10:15 AM, 2 of 2 RN personnel files (E #3 & 4) were reviewed. | Nursing Personnel At least one registered professional nurse with postgraduate education or experience in surgical nursing shall direct and supervised the nursing personnel and the nursing care of patients and shall be on duty at all time, on the premises, when patients | NAME AND ADDRESS OF FACILITY Northern Illinois Women's Center, 1400 Broadway, Site 201, ROOMIN, 12 CONTRACT PROVID LIST RULE ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY DATE 1 VIOLATED WHAT IS WRONG | HHA DI HMO | ILLINOIS DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH FACILITIES STANDARDS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |
| (Provide's Lope | care of patients and times when patients are present. Medical director, clinical director, will be responsible to oversee RN's patient care and her presence when patients are in the clinic. Clinic director is responsible to see to it that an RN is always employed by the clinic. Clinic Director will continues to look for a second RN, classified, word of mouth, etc.; so there is no gap should current RN leave employment. | 205.330 (a) See 205.530 (a) A Registered Nurse is hired and started orientation on Wed 6/22/11. (See response to 205.530 (e)) RN will direct and supervise all nursing personnel and the nursing | PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED | HOSPICE | BLIC HEALTH ES STANDARDS LAN OF CORRECTION |
| Representative) | Saurch Sm Zul RN- Zul RN- Ongoing. | thired 6.22.11 | COMPLETION DATE | [] HOSPITAL | |

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| DATE OF SURVEY6/8/11 | | | Section 205.330 (a) | VIOLATED . | ME AND ADDRESS OF FACILI | I ASTC | | |
|---|---|---|-------------------------------|---|---|-----------------|---|--|
| 6/8/11BY19843 6/8/11BY(Surveyor) DATE OF PRIOR SURVEY(Surveyor) | Facility had no RN to supervise paucific car or stated on 6/6/11 years (10/07 to 1/11). 4. The Clinical Director/Administrator stated on 6/6/11 at 9:15 AM, that the local Hospitals and Nursing Homes at 9:15 AM, that the local Hospitals and the Facility has not employ all the RNs in the area and the Facility has not been able to hire and keep an RN on staff. The Facility has 3 Licensed Practical Nurses (E #4 – 6) to provide has 3 Licensed Practical Nurses (E #4 – 6) to provide | E #3's personnel file included documentation users of was hired on 1/7/11. The Clinical Director stated that E was hired on 4/8/11 and there was no Registered Nurse #3 resigned on 4/8/11 and there was no Registered Nurse currently employed at the Facility. The Facility had no currently employed at the Facility. The Facility had no RN to supervise nursing staff and on the premises for the past 2 months. E #4's personnel file included a hire date of 3/10/06 E #4's personnel file included a hire date of 3/10/06 | Nursing personnel (continued) | ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG | MAME AND ADDRESS OF FACILITY Northern Illinois Women's Center, 1400 Broadway, Ste 201, Rockford, IL 61104 | HHA D HMO | ILLINOIS DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH FACILITIES STANDARDS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | |
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| S Representative) | | | | | COMPLETION DATE | HOSPITAL | | |

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| DATE OF SURVEY | | Section 205.330 (a) | LISTRULE | ASTC | | |
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| ATE OF PRIOR SURVEY (Surveyor) | 5. These findings were confirmed by the Clinical Director during the interview on 6/6/11 at 2:15 PM. | Nursing personnel (continued) patient care. On 6/6/11 at 2:15 PM, the Clinical Director stated that 1 of the 3 LPNs (E #4) provided staff supervision. | ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY PROVIDER'S FLAN OF CORRECTION AND DATE TO BE COMPLETED | ASTC HHA. Directory Northern Illinois Women's Center, 1400 Broadway, Sto 201, Rockford, IL 61104 | | ILLINOIS DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH FACILITIES STANDARDS |
| ntative) 6.28.11 | 5 | | COMPLETION DATE | | DHOSPITAL | |

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(Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

OF FACILITY OF FACILITY Standards of Professional Work ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG PREGNANCY TERMINATION CENTER E ASTO **D HIHA DHMO HOSPICE**

DATE OF SURVEY LIST RULE 205.610 (o) Corrected 205.610 (b) Corrected 205.540 (f) Corrected 205.420 (a) Corrected 205.230 (2) Corrected Corrected 205,420 (C)(2) 205.230 (5) Corrected 9/15/11 Clinical records...post counseling notes Postoperative Care Standard of Professional Work Clinical Records...physical examination Sanitary Facility Sanitary Facility AG Y 19840 (Surveyor) PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED COMPLETION DATE

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

| DATE OF SURVEY | | | | Section 205.530 (e) | Repeat deficiencies: | LIST WULK | NAME AND ADDRESS | |
|----------------|--|------------------|--|---|----------------------|---|--|--|
| 0/11/11 | 1. The Clinic I approximately | Findings include | Based on staff i files and OR Lo Registered Nun Pacility, The Fa qualified by trai nursing, was po as a circulating | | s: Operative Care | BY WRONG | E ASTO PRECN Northern Illinois Women's Co | STAT |
| 10010 | 1. The Clinic Director was interviewed on 9/13/11 at approximately 9:30 AM. The Director stated that a new | R | Based on staff interview and review of Facility personnel files and OR Log review, it was determined that for 1 of 1 Registered Nurses (E #1) currently employed by the Facility, The Facility failed to ensure a Registered Nurse, qualified by training and experience in operating room nursing, was present in the operating room and functioned as a circulating nurse during all operative procedures. | A registered nerse, qualified by training and experience in operating room Nursing shall be present in the operating room and function as a circulating Nurse during all invasive or operative procedure" This requirement was not met as evidenced by: | a | ENTER SUMMAARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG | E ASTC D HHA DHMO PREGNANCY TERMINATION CENTER MARE AND ADDRESS Northern Illinois Women's Optor 1400 Broadway, Roddowd, IL 61104 | ILLINOIS DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH FACILITIES STANDARDS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIO |
|) MAC | | | has as many as 30 yrs of OR experience and as circulating nurse. <u>Exhibit B</u> Resume of RN BB. Documentation of other training RN's for your review is in RN DN employee file. | Section 205.530(e) RN, DN (E#1) Is now trained in operating room. See <u>Exhibit A.</u> This exhibit documents training in OR and as circulating RN at NHC in Peorla. The RN that trained DN RN | | PROVIDER'S FLAN OF COMBLECTION AND DATE TO BE COMPLETED | [] HOSPICE | BLAC HEALTH ES STANDARDS LAN OF CORRECTION |
| Pril C | | | | 10.6.201 | | COMPLETION BATE | | |

| DATE OF SURVEY | | | | Section 205.530 (c) Cont | VIOLATED | NAME AND ADDRESS N | | |
|----------------|---|--|--|--|--|--|----------------------|---|
| 9/15/11 | 4. The Facility d training and exp present during a a circulating Nu | 3. The OR Log v approximately 1 documentation (on 9/9/11, 9/7/1 | 2. The personnel approximately 10 9/7/11 began ori application did n Operating Room documentation o circulating surse | | WHAT IS WINONG Operative Care (continued) | erhen Illinds Womer's Ge I ENTER SChrowy | DASTC | I |
| BY 19840 | 4. The Facility did not have an RN who was qualified by training and experience in operating room nursing present during all invasive procedure, and functioning as a circulating Nurse on 9/9, 9/7, 9/2, and 8/31/11. | 3. The OR Log was reviewed on 9/14/11 at approximately 10:00 AM. The log included documentation that surgical procedures were performed on 9/9/11, 9/7/11, 9/2/11, and 8/31/11. | 2. The personnel file of E #1 was reviewed on 9/13/11 at approximately 10:00 AM. E #1 with a hire date of 9/7/11 began orientation on 9/7/11. E #1's employment application did not include experience or training in Operating Room mursing. E #1's file lacked documentation of training or experience as an OR circulating nurse. | RN (E #1) was hired and began orientation on 9/7/11. The Director stated that an RN hired on 6/22/11 gave notice on 8/29/11. | (continued) | I AND ADDRESS. Northern Illinois Women's Center 1400 Broadway, Rockbed, IL 61104 | ASTC I HHA I HMO | ILLINOIS DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH FACILITIES STANDARDS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |
| m ta | | | | BB, RN <u>(Exhibit B)</u> was hired at NIWC on Sept 28, 2011. RN BB is (2 nd) RN on staff @ NIWC. Resume included, | BATE TO BE COMPLETED | PROVIDER'S FLAN OF COURSECTION AND | D HOSPICE D HOSPITAL | PUBLIC HEALTH THES STANDARDS > PLAN OF CORRECTION |
| bio | | | 10.28.11 | | | COMPLETION BATE | | |

| DATE OF SURVEY | Section 205.530 (e) Cont | NAME AND ADDRESS North LIST MULT VIOLATED | | |
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| DATE OF SURVEY | | | | STATE |
| BY_19840 (Surveyor) | Operative Care (conditional) 4. The Clinic Director was interviewed on 9/14/11 at approximately 10:00 AM and 11:15 AM. The Director stated that E #1 was still on orientation and on 9/14/11 was just observing procedures day to day operations. The finding was confirmed with the Director during the interview. | n Binds Weinn's Carls 1400 Housing, Boctind, IL 61104 ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WEAT IS WRONG | ASTC D HHA D HMO PREGNANCY TERMINATION CENTER | LLINOIS DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH FACILITIES STANDARDS STATEMENT OF DEFICIENCIES AND FLAN OF CORRECTION |
| My Janker | RN DN (E#1) completed all orientation and signed off. Medical Director and Clinic Director signed off as well. All orientation was completed satisfactorily and in a timely fashion. Exhibit <u>C.</u> | FROVIDER'S FLAN OF COODECTION AND DATE TO BE COMPLETED | D HOSPICE D HOSPITAL | VBLIC HEALTH TTHES STANDARDS) PLAN OF CORRECTION |
| | 9.14.11 | COMPLETION DATE | ſ | |

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| DATE OF SURVEY | | | | · · · · · · · · · · · · · · · · · · · | Section 205.530 (e) | LIST RULE VIOLATED |
|--------------------------|-------------------|---|---|--|---------------------|--|
| 9/15/11BY | Findings include: | B. Based on review of clinical records and staff interview, it was determined, that for 2 of 10 (Pts. #6 & 9) clinical records reviewed, the Faoility failed to ensure a Registered Nurse, qualified by training and experience in operating room sursiag, was present in the operating room and functioned as a direulating nurse during all operative procedures. | This requirement was not met as evidenced by: | A registered surse, qualified by training and experience in operating room nursing, shall be present in the operating room and function as a circulating nurse during all invasive or operative procedures ³⁰ | Operative Care | ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG |
| 19843 (Surveyor) | | d records and staff that for 2 of 10 (Pta, wed, the Faoility failed qualified by training born nursiag, was and functioned as a serative procedures. | et as evidenced by: | by training and a norsing, shall be rs and function as a invasive or operative | | 1 |
| Provide a Representative | | | procedures. This will be assured by keeping 2 RN's on staff at all times. | Section 205.530(e) Operative Care See Exhibit A, B, C. Medical and Clinic Director will assure qualified RN, with operating | | PROVIDERS FLAX OF CONSECTION AND DATE TO BE COMPLETED |
| ashin | | | | ٩.28.11 | | COMPLETION DATE |

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

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NAME AND ADDRESS OF FACILITY Northern Rithorts Women's Center, 1400 Broadway, Ste 201, Rockford, IL 61164

| NOTE: IF PLV. INDIC | DATE OF SURVEY 9/15/11 | | | | Section 205.530(a) | UST RULE VIOLATED |
|---|------------------------|---|--|--|----------------------------|--|
| NOTE: IF PLV. INDICATE DATE OF PRIOR SURVEY | 11/21/0 | 3. These findings Director during an AM. | 2. The olimical rec 9/14/11 at 1:50 PN female, who under 8/10/11. The nurs dated 8/10/11, waa (E #6), not a RN. | 1. The clinical record of Pt. #6 was n 9/14/11 at 1:20 PM. Pt. #6 was a 20 female, who underwent a Terminatio (TOP) procedure at 17 weeks on 7/22 nursing section of the operative repor 7/29/11, was written by a Licensed P (E #7), not a Registered Nurse (RN). | Operative Care (continued) | ENTER SUMMARY OF |
| | (M661 A.G | 3. These findings were confirmed by the Clinical Director during an interview on 9/15/11 at 10:00 AM. | 2. The clinical record of Pt. #9 was reviewed on 9/14/11 at 1:50 PM. Pt. #9 was a 27 year old female, who underweat a TOP at 14 weeks on 8/10/11. The nursing section of the operative report dated 8/10/11, was written by a Certified Nurse Aid (E #6), not a RN. | The clinical record of Pt. #6 was reviewed on 9/14/11 at 1:20 PM. PL #6 was a 20 year old female, who underwent a Termination Of Pregnancy (TOP) procedure at 17 weeks on 7/29/11. The nursing section of the operative report dated 7/29/11, was written by a Licensed Practical Nurse (E #7), not a Registered Nurse (RN). | athurd) | ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY |
| (Provider's Repre | m Man | 2 | | | | PROVEDERS PLAN OF CORRECTION AND DATE TO BE COMPLETED |
| 's Representative) | her | | , | | 81 | COMPLETION BATE |

FEB-23-1997 22:13

| DATE OF SURVEY | | | | Section 205.330 (a) | VIOLATED | NAME AND ADDRESS NO | |
|------------------------|--|---|---|---|---|--|--|
| DATE OF SURVEY | 1. The Clinic Disc approximately 9:30 hired on 6/22/11 k RN was hired and | Based on review of Operating Room D it was determined t the Facility failed t postgraduate educe was present on the personnel and nurs Findings include: | This requirement | Nursing Personnel At least one registe postgraduate educ aversing shell three personnel and the on duty at all these present. | ENTER SUMMARY OF | arthern Blineis Women's Cen | I STATE |
| BY 19840 (Surveyor) | 1. The Clinic Diacctor was interviewed on 9/13/11 at approximately 9:39 AM. The Director stated that the RN hired on 6/22/11 left the position on 8/29/11, and a new RN was hired and began training on 9/7/11. | Based on review of Facility personnel file, review of the Operating Room Day Sheets (OR log) and staff interview, it was determined that for 5 of 5 surgical procedure days the Facility failed to ensure that a Registered Nanse with postgraduate education or experience in surgical nursing was present on the premises to supervise nursing personnel and nursing care when patients are present. Findings include: | This requirement was not met as evidenced by: | Nursting Personnel At least one registered professional nurse with postgraduate education or experience in surgical nursing shall direct and supervise the nursing personnel and the nursing care of patients and shall be on duty at all threes, on the premises, when patients are present. | ENTISK SUMALARY OF DEQUERCOMENT AND SPECIFICALLY WEAT IS WEONG | NAME AND ADDRESS Northern Elinets Women's Center 1400 Broadway, Rockford, IL 61 104 OF FACILITY | ILLINOIS DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH FACILITIES STANDARDS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECT DI HHA DI HMO DI HOSPICE |
| Provider' Reproden | | See Section 205.530 (e) and supporting Exhibits A, B, C | Section205.330 (a) | | PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED | | IBLIC HEALTH THES STANDARDS PLAN OF CORRECTION II HOSPICE II HOSPITAL |
| ative) | | | 9.28.11 | | COMPLETION DATE | | |

| DATE OF SURVEY | | | Section 205.330 (a) Cont | VIOLATED | NAME AND ADDRESS OF FACILITY | | |
|------------------------|---|--|--|---|---|------------------|---|
| DATE OF SURVEY | 4. The Clinic Director was intervi approximately 10:90 AM and 11: stated that the new RN is in the Fi training and is only observing pro operation of the Facility. The find the Director during the interview. | 3. The OR Log was reviewed on 9/14/11 at approxin 10:00 AM. The log included documentation that sur- procedures were performed on 9/14/11, 9/9/11, 9/7/1 9/2/11, and 8/31/11. There was no experienced surgi- nurse present to supervise nursing care on the above dates. | | IS WRONG | NAME AND ADDRESS Northern Ethnals Wemen's Cent OF FACILITY | DASTC | STATE |
| | ctor was intervie 90 Abf and 11:1 vRN is in the Fa v observing proc acility. The finds acility. The finds | g included doeu g included doeu gformed on 9/1 1.There was no pervise nursing | the of B #1 was n 00 AM. B #1 wi 00 9/7/11. B #1 wi 1 include documu 1 include documu | | nier 1400 Broudwey, Rocidard, IL 61194 | O HIHA | MENT OF DE |
| BY 19840 (Surveyør) | 4. The Clinic Director was interviewed on 9/14/11 at approximately 10:90 Ab4 and 11:15 Ab4. The Director stated that the new RN is in the Facility however is still training and is only observing procedures and day today operation of the Facility. The finding was confirmed with the Director during the interview. | 3. The OR Log was reviewed on 9/14/11 st approximately 10:00 A.M. The log included documentation that surgical procedures were performed on 9/14/11, 9/9/11, 9/7/11, 9/2/11, and 8/31/11. There was no experienced surgical nwrse present to supervise nursing care on the above dates. | 2. The personnel file of E #1 was reviewed on 9/13/11 at approximately 10:00 AM. E #1 with a hire date of 9/7/11 began orientation on 9/7/11. E #1's employment application did not include documentation of post education or experience in surgical nursing. | ENTER SUBJEART OF BEQUIRGERENT AND SPELENCALLT WHAT IS WRONG | tocidard, IL 6) 194 | CI HIMO | PARTMENT OF PHEALTH FACI EPICIENCIES A |
| | | | | BATE TO BE COMPLETED | 4 | DHOSPICE | ILLINOIS DEPARTMENT OF FUBLIC HEALTH DIVISION OF HEALTH FACILITIES STANDARDS STATEMENT OF DEFICIENCIES AND FLAN OF CORRECTION |
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| DATE OF SURVEY | (New Deficiencies) Section 205.230 (a)(4) | NAME AND ADDRESS OF FACT LIST RULE VIOLATED | D ASTC PREGNANCY | |
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| 9/15/11 BY384338433984338843_388433884338843_38843_38843_38843_388436363636666666666 | Standards of Professional Work Each member of the modical stall granted upcills surgical practice privilages shall provide a notarized statement or documentation indicating the name of the Illinois' lucement branches provide privilages. Such entorements or documentation indicating the name of the Illinois' lucements indicating practice privilages. Such entorements of the ambulatory surgical each under a documents shall be available for lapped treatment of the center shall be available for lapped treatment raft. As used in this subsection, "skilled-equivalent practice and for happediate procedure requirating the same level of training and expertises requirate the same level of training and expertise. This requirement was not met as evidenced by: A. Based on review of physician personnel files and staff interview, it was determined that, for 2 of 2 (B file 4.3), physicians working in the Facility had clinical privilages and appointments in an Illinois licensed | NAME AND ADDRUSS OF FACILITY Northern Illinois Wennen's Center, 1400 Breadway, Sie 201, Bookford, IL 61104 LIST RULE ENTER SUMMAARY OF REQUIREMENT AND SPECIFICALLY PROVU VIOLATED WRAT IS WRONG | DASTC HHA DHMO | STATEMENT OF DEFICIENCIES AND PLAN OF CORREC |
| (Provider's Represe | Section 205.230 (a)(4) Plans to privilege physicians providing services are in progress. It is unclear the length of time this will require, but attempts to accomplish this are proceeding as expediently as possible. Privileges will be in a Hospital in the State of IL. Once this has been accomplished, the Medical Director will be responsible to assure contract is current at all times. Clinic Director will keep records to assure privileges are current and renewed in a timely fashion. | IL 61104 FROVIDER'S FLAN OF CONSUCTION AND BATE TO BE COMPLETED | I HOSPICE | PLAN OF CORRECTION |
| cutative) | ongoing 11.30-11 Mid-Dec 2011 | COMPLETION DATE | I HOSPITAL | |

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| NOTE: IF PLV, INDICATE DATE OF PRIOR SLEWEY | | 1. 3) or base | Soction 205.230 (a)(4) Star | VIOLATES EN | NAMB AND ADDRESS OF FACILITY A | D ASTC PREGNANCY TERMINATION CENTER | |
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| PRIOR SURVE | On 9/15/11 at h the Facility's t E #2 did not 1 any Hospital any Hospital pointment in a 1 pointment in a 1 pointment in a 1 pointment in a 1 pointment in a 1 | 1. On 9/15/11 at 3:15 PM, physicians (B #2 & 3) wou reviewed. E #2 was the 1 performed all the surgical pr months (June 2011 - Septem former Medical Director, Net 3) included documentations of is an Illinois Densed hospital. | Standards of Prof Findings include: | AT IS WRONG | Vorthern Minois Wo | HHA | DIN |
| BY 19843 (Surveyor) | 2. On 9/15/11 at 3:10 PM, an interview was conducted with the Feedhty's Clinical Manager. The Manager stated that E #2 did not have efficial privileges or appointment in any Hospital and E #3 did have privileges and appointment in a Wisconsin Hospital, but not in Elitasis. B #3's Wisconsin Hospital appointment documentation was not included in the personnel file. The Managar confirmed the findings during the interview. | 1. On 9/15/11 at 3:15 PM, the personnel files for the physicians (E #2 & 3) working in the Facility were reviewed. E #2 was the Medical Director and had performed all the surgical procedures during the past 4 months (June 2011 - September 2011). E #3 was the former Medical Director. Neither personnel file (E #2 & 3) included documentation of privileges or appointment is an Illinois Broused hospital. | Standards of Professional Work (continued) Findings include: | ENTER SUBMIALY OF REQUIREMENT AND SPECIFICALLY WHAT IS WINOWD | NAMB AND ADDRESS OF FACILITY Northern Illinoid Women's Center, 1400 Broadway, Str 201, Rockbed, IL 61104 | CENTER D HMO | ILLINOIS DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH FACILITIES STANDARDS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |
| Manuer's Representative | S . | Section 205.230 (a)(4) cont. Dr E #3 Documentation of privileges in Wisconsin Hospital, is personnel file for your review. | | PROVIDER'S FLAN OF CORRECTION AND DATE TO BE COMPLETED | R. 61104 | D HOSPICE | UBLIC HEALTH TES STANDARDS PLAN OF CORRECTION |
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Section 205.330 (a)

Nursing Person

At least one registered professional surse with

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Section 205.330(a) Nursing

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Findings include:

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medications were admin

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administered. Medical and Clinical

insure med was properly designated areas in pt records to

Personnel ONLY.Exhibit E, (2pgs) ensure meds given were by Licensed directors monitor charts daily to chinical neords reviewed, the Facility failed to ensure

was determined that for 4 of 10 (Pts. #1, 7, 8, & 9), personnel filles, clinical records, and staff interview, it

Certified Numes Aid (CNA) job description, shift A. Bused on review of the Illinois Nursing Practice Act,

personnel initials med given on

RN on duty will monitor medication

distribution each clinic day. Licensec

Change was made and approved by

9.14.11

was educated on change. This

Medical Director, RN and Clinic Dir.

& Procedure book. Exhibit D. Staff

description is in place in NIWC Policy Nurse Practice Act. New Job been corrected to conform to the IL Job description of LPN / CNA. has

be on duty at all time, on the preatises, when patients

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NAME AND ADDRESS OF FACILITY Northern Illindia Women's Center, 1400 Broadway, Ste 201, Rockford, EL 61104

| NOTE- IF BI V INTO TA | DATE OF SURVEY | Section 205.330 (a) | VIOLATED |
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| | 9/13/11 BY | Nursing personnel (continued) 1. The Illinois Nurse Practice Act 225 ILCS (5 sec. 50- 75 c) was serieved on 9/14/11 et 2:00 PM and included, "A registered professional muse shell not delegate any nursing activity requiring the specialized knowledge, judgment, and skill of a licensed surse to an unlicensed person, including molication administration. A registered series may delegate tails to other licensed unlicensed periods. The intent of the Nurse Practice Act to allow the delegation of fasts to other unlicensed persons is not to be interpreted as to allow all types of procedures or practices" 2. On 9/15/11 at 10:30 AM, the combined Licensed Practical Nurse and Certified Nurses Aid job description was reviewed. The job description included, "Administers meds as directed by the doctor" The job description does not conform to the Illinois Nurse Practice Act. | ENTER BUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG |
| (Surveyar) | 19843 | continued) e Practice Act 225 ILCS 65 sec. 56- on 9/14/11 at 2:00 FM and included, alonal nume shall not delegate any align the specialized knowledge, of a licensed numer to an unlicensed adication administration. A y delegate tasks to other lucensed adication administration. A y delegate tasks to other lucensed interpreted as to allow all types of interpreted as to allow all types of interpreted as to allow all types of ices* 10:30 AM, the combined Licensed I Certified Numes Aid job description The job description included, ds as directed by the doctor" The s not conform to the Illinois Nume | NT AND SPECIFICALLY |
| (Providuc's Representative) | MOla | Medication Administration Prototol Is in Policy and Procedure book in Main Office for your review. Staff has been educated by physician and RN on this protocol. <u>Exhibit F.</u> RN will monitor the giving of all medications and Initial of licensed professional will ensure protocol is followed. Clinical Director will monitor all pt files as well. | PROVIDER'S FLAN OF CORRECTION AND BATE TO BE COMPLETED |
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DATE OF SURVEY AIDY BOI'S NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY Section 205.330 (a) 31175116 3. Staff personnel files were reviewed on 9/14/11 at 11:00 AM, Clinical staff files included RNs, LPNs, Counselors (E #4 & 5) and 1 CNA (B #6). Nursing personnel (continued) ENTER BUNDARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WINONG 4. The clinical second of Pt. #1 was reviewed on 9/13/11 mg, was administered by a Counselor (B #4) on 8/3/11 at 9:16 AM and Minoprostol 200 meg, was also administered by B #4 on 8/3/11 at 9:18 AM. underwent a TOP at 14 works on 8/3/11. Naproxen, 220 at 1:30 PM. Pt #7 was a 19 year old female, who 5. The clinical accord of Pt. #7 was reviewed on 9/14/11 and Misoprostol (Cytotec), 200 mcg, was also administered by E #6 on 3/11/11 at 8:10 AM. weeks procedure on 3/11/11. Naprosen, 229 mg, was administered by a CNA (B #6) on 3/11/11 at 8:00 AM underwent a Termination of Programcy (TOP) at 18 at 10:30 AM. Pt. #1 was a 21 year old female, who 8 (Surveyor) 19843 FROVINGRYS FLAN OF CORRECTION AND DATE TO BE COMPLETED Providence Net COMPLETION DATE

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PROVIDER'S FLAN OF CORRECTION AND DATE TO BE COMPLETED

COMPLETION DATE

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Section 205.339 (a)

Nursing personnel (continued)

mg, was administered by a Counselor (E #4) on 8/5/11 at 8:08 AM and Miscarcortal 200 mcg, was also administered by E #4 on 8/5/11 at 8:10 AM.

at 1:50 PM. Pt. #9 was a 27 year old female, who

anderwout a TUP at 14 weeks on 8/10/11. Naprosen, 220

mg, was administered by a CNA (B #6) on &/10/11 at 8:55 AM and Misoprostal 200 mcg, was also administered by B #6 on 8/10/11 at 9:00 AM.

7. The chinical record of Pt, #9 was reviewed on 9/14/11

8. These findings were confirmed by the Clinical

Director during an interview on 9/15/11 at 10:00 AM.

6. The clinical second of PL #8 was reviewed on 9/14/11 at 1:45 PM. PL #8 was a 28 year old female, who

underwent a TOP at 16 weeks on 8/5/11. Naproxen, 229

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| | Section 205.350 Cent | NAME AND ADDRESS NO OF FACILITY LIST ROLLTY VENULATED |
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| | Laboratory Services (continued) The second certificate was the Faccertification for ABO & RH Group date of 1/10/2013. The Clinic Diroctor was interviapproximately 9:30 AM. A request superconnent with a lab for procedure the Facility was made. The Diroctor tave so written lab for procedure have so written laboratory agreement with a boratory agreement of the Bart and the facility was made. The Diroctor fare so written lab for procedure function approximately 2:40 PM. | STATE D ASTC PREGNANCY PREGNANCY PREGNANCY |
| BY (Surveyor) | Laboratory Services (constituted) The second certificate was the Facility's internal lab certification for ABO & RH Group, with an expiration date of 1/10/2013. The Clinic Director was interviewed on 9/15/11 at approximately 9:30 AM. A request for a written agreement with a lab for procedures not performed in the Facility was made. The Director stated that they have no written laboratory agreement with any outside lab. The above findings were confirmed with the Clinic Director during an interview on 9/15/11 at spproximately 2:40 PM. | LLINOIS DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH FACILITIES STANDARDS STATE MENT OF DEFICIENCIES AND FLAN OF CORRECTION OF PRECNANCY FERMINATION CENTER NAME AND ADDRESS Northern Blant Women's Coder 1408 Breadwry, Nectional, E. 61104 OF PRECNANCY FERMINATION CENTER NAME AND ADDRESS Northern Blant Women's Coder 1408 Breadwry, Nectional, E. 61104 YOULATED TAXABLE STANDARD FERMINATION CENTER NAME AND ADDRESS Northern Blant Women's Coder 1408 Breadwry, Nectional, E. 61104 |
| (Previdents Representative) | 2 | PUBLIC HEALTH THES STANDARDS PLAN OF CORRECTION HOSPICE DHOSPITAL |

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'ional Care, Inc.

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10/06/2011 12:12

7405 N. University Street, Suite I Pcoria, Illinois 6161 309-691-907 (Illinois) 800-322-162 (Iowa) 800-322-544 www.aborrionaccessnhc.cor

October 6, 2011

Meg Larkin, Administrator Northern Illinois Women's Center 1400 Broadway #201 Rockford, IL 61104

Dear Ms. Larkin:

You asked us to provide operating room instruction and training for the second second

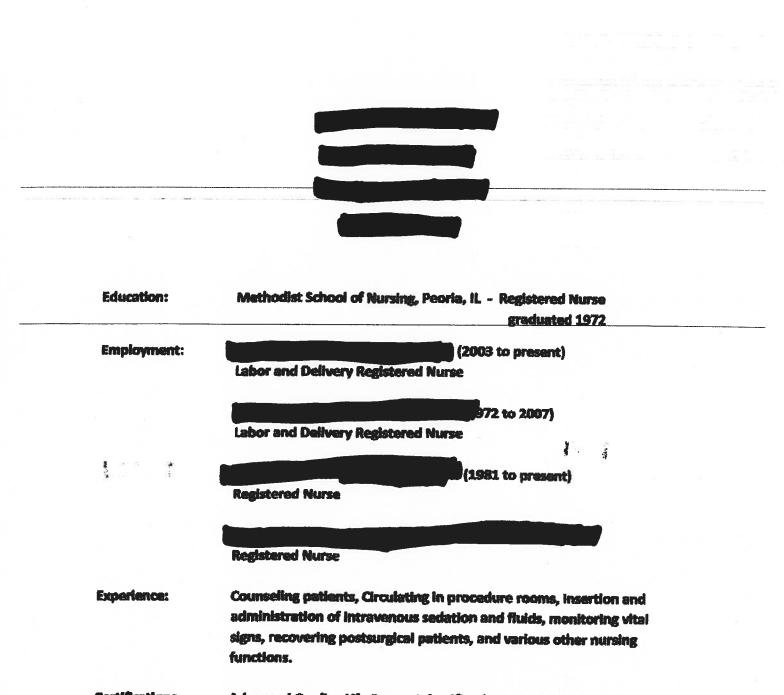
My staff nurses have 30 and 26 years experience respectively in the operating room and my newest nurse works in the operating room at a local hospital. All of my staff nurses are ACLS and CPR certified.

If I can be of further assistance please let me know.

Respectfully,

Exhibit A

Margaret Van Duyn Administrator



Certifications: Advanced Cardiac Life Support Certification Cardio Pulmonary Resuscitation Certification Neonatal Resuscitation Provider Certification

References: Available upon request

Exhibit B

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Exhibit B.

| | Pt # Age Date / _ / |
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| | 1. Preg test (NS) Height Weight BP/ Pulse Hgb |
| | Rh Rho-gam Leuk Nitr Prot Glu Initials |
| | 2. LNMP /// Calc EGA Gravida Para Prior Cesarean? (yes / no) |
| 2 | Sac CRL BPD Gest. Age (U/S) Cardiac Activity. (yes / no) |
| 200 | Long Transverse Placenta: Anterior Posterior yolk sac identified? |
| | ectopic precautions given Sens preg test: fetal number sonographer initials |
| E | EGA: Uterine position: Antcm Midcm Postcm Adnexa: nl abnl |
| exam | Abnormalities noted: Heart Lungs AbdPelvis |
| | Start Finish Block |
| | Paracervical Block: 1. 1% Lidocaine w/ atropine, buffered + 1 u vasopressin (up to 12 + 6 weeks) |
| 5 | 2. 1% Lidocaine w/ atropine, buffered + 2 u vasopressin (13 weeks and up) |
| | Cervix dilated to (Fr) Uterine depth cm Cannula mm |
| | suction D&E MVA laminariainserted removed Rhogam lot # (exp. date:/ |
| | Rhogam, micro Rhogam, full Atropine 0.4 mg Pitocin 10 u (I.C.) |
| | Location: by: int. |
| | Total Volume |
| | Tissue |
| | Fluid Est D Villi Equivocal |
| | Measured Sac Histologic |
| Ð | EBL D micro |
| | Impression: 🗆 Complete 🗔 Scant tissue 🗇 scant protocol initiated |
| 3 | Patient tolerance: Good Easy Satisfactory Difficult Poor Complication |
| 2 | |
| - | Comments: |
| | |
| | (Signature here indicates entire form has been reviewed and approved)M.D./ D.O. |
| | |
| 2 | L.O.C Alert and responsive |
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| | Nursing Comments: |
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ExhibitC

Director of Nursing/RN

1. Establishes policies and procedures for nursing care.

2. Assumes management and education responsibilities for all nursing personnel.

3. Oversees clinic functioning as related to all nursing services.

4. Collaborates with Medical Director and Clinic Director in interpretation of medical policies and procedures.

5. Supervises maintenance/ordering of supplies and equipment.

6. Is "circulating nurse" in OR during all invasive or operative procedure.

7. Procedure room-sets up sterile field, assists doctor during procedure, documents pt vitals, and tolerance levels, during procedure.

8. Documents surgical charts in OR.

9. Is on the premises anytime there are patients present.

10. Administers medication per physician orders.

11. On-call for post clinic-hour calls.

Licensed Practical Nurse

1. Works in various areas: lab, procedure rooms, and recovery.

2. Assists patient in OR, monitors vitals.

3. Administers meds as directed by the doctor. Escorts patient to recovery.

4. Assists doctor with post-abortion follow ups.

5. Works to help maintain equipment and supplies through regular testing and inventory checks.

6. Maintains emergency equipment through regular testing.

7. On-call for post clinic-hour calls.

8. Maintains pt information on charts.

9. Assesses patient flow.

10. Works under direct supervision of RN and physician.

CNA

Same as non-licensed personnel.

May work in any area of clinic where a license is not required.

Exhibit D

COUNSELING INFORMATION

| Patient no.: | Patient Name: | ···· | |
|---|--|---|--------------------------|
| Date: IS IT TH | HE PATIENT'S CHOICE TO BE HER | RE TODAY? YES NO | Staff Intl |
| | List: None | | |
| | □Yes □No If NO document | | |
| # Children: Vaginal_ | C-SectionCo | mplications? | |
| Any Previous Abortions? # | Date of Last One: | Any Complications | > |
| | | | |
| | | | |
| Who accompanied you today? |) | Do they support you? | |
| Birth Control: What birth co | ntrol were you using? | | |
| Choice for birth control today? |) — — — — — — — — — — — — — — — — — — — | · · · · · · · · · · · · · · · · · · · | |
| On the signed order of the phy | rsicians, please give the following for | r surgical abortions only (circle order | ing physician): |
| Dennis Christensen, MD | Stewart Kernes, DO | | |
| Misoprostol 200 mcg #2 | Misoprostol 200 mcg #2 | 🗆 Laminaria consent | Time Given: |
| 12.0 weeks or greater Route: Vaginally | 12.0 weeks or greater Route: Vaginally | Misoprostol consent | Given by: |
| Naproxen Sodium 220 mg | #2 □ ibuprofen suspension (| 100mg/5cc) 40 cc | Time Given: Given by: |
| 🗆 Dr 🛛 Preg 🖾 Surg/M | edical consent 🛛 Alternative 🛛 | Procedure 🗆 Rh 🗆 After ca | re +meds |

My counselor and I discussed my decision to have an elective abortion today. We discussed alternatives and my reasons for being here today. The abortion procedure was fully explained in terms that I understand and all of my questions have been answered to my satisfaction. I have received the name of the physician who will be caring for me.

SURGICAL ABORTION

I have received both oral and written instructions concerning my care and how to contact the clinic should an emergency arise. Birth control was explained to me. I understand the importance of a check-up. If at the time of my check-up, my doctor feels I need additional treatment, I WILL CALL THE CLINIC IMMEDIATELY. If I choose not to return for additional care, any expense I incur will be my responsibility.

MEDICAL ABORTION

Cul: L+ [

I have received both oral and written instructions concerning my care, and how to contact the clinic should an emergency arise. Birth control was explained to me, and I understand that I must return here in 2 weeks to have a check-up.

Checking this box indicates that I have signed, read, and understood all consent forms

Patient's signature

Counselor's signature

Date

| 1 | | | 1001 | COUNSELING N | | Date: | |
|---|----------------------------|--------------------------|-------------------|-------------------------------------|------|------------------------------|--------|
| 1 | Patient # | | _ | Patient Name: | | | |
| t | Time | BP | Pulse | Pain | Flow | Comments | |
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| 2 | Direction | Lot # | | Exp Date | INIT | 'IALS: | TIALS: |
| | | es patient want to | | | | | |
| | Nuva Rin Samples Comments: | ng # given with 6 mor | nths written refi | | | e questions answered | |

MEDICATION ADMINISTERED/PROTOCOL

Any medication ordered by the physician, that is given to a patient regardless of whether it is over the counter or prescription:

MUST BE ADMINISTERED BY A LICENSED PERSON (Physician, RN, LPN). (This included pain meds given in counseling **AND** recovery/post counseling.) Once a medication is dispensed, the licensed personnel will document:

Time medication is given Kind and dose of medication given initial of licensed personnel.

Counseling

Any non-licensed personnel in counseling/recovery will:

- 1. Have an RN/LPN come into counseling, go over any medication consent forms, gather necessary signatures, then give medication to patient as ordered by physician, documenting time given. <u>Initial</u>
- 2. or counselor can walk patient to OR, licensed staff will go over medication consent forms and acquire signatures needed, then administer meds ordered by the physician. RN/LPN documents time given. <u>Initial</u>

Recovery/Post Counseling

 RN/LPN will dispense the antibiotic and/or any medication ordered by the physician, to the patient before she takes patient to the recovery room. RN/LPN will document lot # and expiration date. <u>Initial</u>

This is to conform to the Illinois Nurse Practice Act (225 ILCS 65 sec 50-75c) includes: A registered professional nurse shall not delegate any nursing activity requiring the specialized knowledge, judgment, and skill of a licensed nurse to an unlicensed person...

9.14.11

Exhibit F

LABORATORY SERVICE AGREEMENT

AGREEMENT MADE THIS ______ day of ______, 20 ____ by and between SwedishAmerican Reference Laboratory ("LABORATORY") AND_______ ("NORTHERN ILLINOIS WOMEN'S CENTER").

WHEREAS, LABORATORY is engaged in the business of providing clinical laboratory services; and

WHEREAS, NORTHERN ILLINOIS WOMEN'S CENTER desires to arrange with LABORATORY to provide clinical laboratory services ordered by NORTHERN ILLINOIS WOMEN'S CENTER for NORTHERN ILLINOIS WOMEN'S CENTER'S patients, and LABORATORY desires to provide such services;

IT IS THEREFORE AGREED AS FOLLOWS:

TESTING SERVICES

LABORATORY agrees to perform or otherwise provide clinical laboratory testing services for NORTHERN ILLINOIS WOMEN'S CENTER, as shall be ordered by NORTHERN ILLINOIS WOMEN'S CENTER in accordance with requirements of Federal, State, local laws, and regulations. NORTHERN ILLINOIS WOMEN'S CENTER'S shall provide LABORATORY with accurate lab test order codes and ICD-9 diagnosis codes for all tests ordered.

LABORATORY SERVICES

Specimen Pickup and Test Reporting. LABORATORY will provide a courier service to transport specimens for testing from NORTHERN ILLINOIS WOMEN'S CENTER'S office to the laboratory NORTHERN ILLINOIS WOMEN'S CENTER at which testing will be performed.

LABORATORY will deliver to NORTHERN ILLINOIS WOMEN'S CENTER test results as reasonably required by NORTHERN ILLINOIS WOMEN'S CENTER and agreed to by LABORATORY.

Supplies. LABORATORY will provide, as part of its services, certain necessary items, devices, or supplies used solely to collect, transport, process, or store specimens to be submitted to LABORATORY for testing.

Facsimile Machine, Computer Hardware/Software, Printer. LABORATORY may furnish NORTHERN ILLINOIS WOMEN'S CENTER with a communications device which will be used in connection with services by LABORATORY hereunder.

Exhibit G

NORTHERN ILLINOIS WOMEN'S CENTER acknowledges that the device placed in NORTHERN ILLINOIS WOMEN'S CENTER's office is property of LABORATORY, is integral to laboratory services being provided by LABORATORY, and shall not be used except to order tests or receive test results from LABORATORY.

Consultation. LABORATORY customer service staff will be available to consult with NORTHERN ILLINOIS WOMEN'S CENTER by telephone during normal business hours to discuss Laboratory's procedures, to provide status of tests ordered by NORTHERN ILLINOIS WOMEN'S CENTER, and to discuss appropriate testing and ordering of tests from LABORATORY.

FEES AND BILLING

For any clinical laboratory services for which NORTHERN ILLINOIS WOMEN'S CENTER requests LABORATORY to bill NORTHERN ILLINOIS WOMEN'S CENTER, and as legally permitted, LABORATORY will submit to NORTHERN ILLINOIS WOMEN'S CENTER a monthly statement reflecting such laboratory services furnished to NORTHERN ILLINOIS WOMEN'S CENTER by LABORATORY. Such statement shall reflect charges included on the attached Fee Schedule (if applicable). NORTHERN ILLINOIS WOMEN'S CENTER shall pay LABORATORY information within thirty (30) days. Overdue accounts are subject to a service charge of 1.5% per month on the unpaid balance. Or the maximum charge permitted by law, if less.

LABORATORY agrees to bill directly the patient or other responsible party (including, but not limited to, Medicare, Medicaid and private third-party insurers) for tests performed under this agreement where NORTHERN ILLINOIS WOMEN'S CENTER requests such direct billing, or direct billing is required by law or contract. LABORATORY'S fees shall be based on its usual charge for the test. NORTHERN ILLINOIS WOMEN'S CENTER shall provide LABORATORY information to bill the patient or third party payer, including, but not limited to, patient demographic information, patient diagnosis (ICD-9 codes), responsible third party payer information (if any), and in the case of a test ordered for a Medicare beneficiary, information regarding any third party payer that is primary to Medicare under the Medicare Secondary Payer provisions.

MEDICARE TESTING

NORTHERN ILLINOIS WOMEN'S CENTER acknowledges that Medicare will pay only for tests that meet the Medicare definition of "medical necessity" and that Medicare may deny payment for a test that NORTHERN ILLINOIS WOMEN'S CENTER believes is appropriate, such as a screening, but which does not meet the Medicare definition of "Medical Necessity". NORTHERN ILLINOIS WOMEN'S CENTER, not LABORATORY, shall be responsible for determining the "medical

Exhibit 6 2 or d

necessity" of tests ordered by NORTHERN ILLINOIS WOMEN'S CENTER. NORTHERN ILLINOIS WOMEN'S CENTER agrees that if the tests ordered do not meet the Medicare Medical Necessity requirement, it is the NORTHERN ILLINOIS WOMEN'S CENTER's responsibility to have the Medicare patient sign an Advance Beneficiary Notice (ABN) and submit that signed ABN to the LABORATORY so that if the claim is denied or reimbursement is subsequently recouped based on the determination that the test was not medically necessary, the LABORATORY can bill the Medicare patient for the services provided. The failure of the NORTHERN ILLINOIS WOMEN'S CENTER to furnish appropriate diagnosis codes or to obtain an ABN, can result in the LABORATORY not receiving payment for services provided.

INDEPENDENT CONTRACTOR RELATIONHIP

This Agreement is not intended to create, nor shall be deemed or construed to create, any relationship between NORTHERN ILLINOIS WOMEN'S CENTER and LABORTORY other than that of

Independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement.

Neither of the parties hereto, nor any of their respective employees, shall be construed to be agent, employer, or representative of the other.

INDEMNIFICATION

NORTHERN ILLINOIS WOMEN'S CENTER shall hold harmless and indemnify LABORATORY from any

claims, losses, damages, judgments, liabilities and costs, expenses or obligations, including but not limited to attorney's fees and expenses, arising out of or resulting from NORTHERN ILLINOIS WOMEN'S CENTER'S from NORTHERN ILLINOIS WOMEN'S

CENTER'S errors, omissions, negligence or misconduct in the provision of services under this agreement.

NORTHERN ILLINOIS WOMEN'S CENTER agrees to adhere to all applicable federal and state laws with regard

to the confidentiality of patient medical record information. NORTHERN ILLINOIS WOMEN'S CENTER will assume the

responsibility for the education and training of NORTHERN ILLINOIS WOMEN'S CENTER staff with regard to these

regulations and laws. Upon request, NORTHERN ILLINOIS WOMEN'S CENTER agrees to provide LABORATORY with

documented evidence of staff confidentiality education and training.

Exhibit G 3 of 4

TERM

This Agreement shall become effective on ______ and shall continue in effect until terminated by either party by giving the other no less than 30 days advance written notice.

ENTIRE AGREEMENT

This Agreement, together with attachments contains the complete agreement concerning LABORATORY'S provision of clinical laboratory services ordered by NORTHERN ILLINOIS WOMEN'S CENTER, and supersedes all previous agreements between the parties, oral or written.

CHOICE OF LAW

This Agreement, its interpretation and performance, is to be construed in accordance with and pursuant to the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this agreement to be executed on the day and year above written by their respective representatives, each of whom is duly authorized to do the same.

LABORATORY CENTER

By: _____ Signature

Print Name

Date

NORTHERN ILLINOIS WOMEN'S

By

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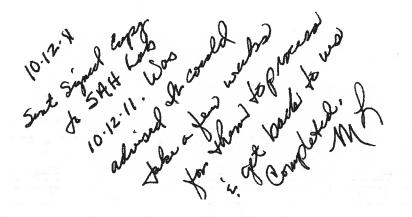


Exhibit O

APPLICATION FOR EMPLOYMENT nicleage to Peoria 133 Equal Opportunity Employer Important Legal Notice: An employer may not use any information provided by a job applicant in a way which results in illegal discrimination against the job applicant under applicable federal, state, or local law. For example, an employer may be subject to legal liability for denying a job opportunity to an applicant on the basis of information provided by the applicant regarding his or her educational background unless the information is reasonably related to the applicant's ability to perform the job or there is an otherwise legitimate business reason. PERSONAL INFORMATION NAME (Last) (first) (Middle) ADDRESS CITY Rockford ZIP STATE $-L \sim$ TELEPHON (Area Code/Number) Are you legally authorized to work in the US: Yes _____No _____ POSITION DESIRED POSITION <u>R.N.</u> SALARY/WAGES EXPECTED <u>Alegotatel</u> DATE YOU CAN START Now " ARE YOU EMPLOYED NOW? _____CAN WE QUESTION YOUR PRESENT EMPLOYER? ____ HAVE YOU EVER APPLIED TO THIS COMPANY BEFORE? IF SO, WHERE?

EXHIBIT

(Cont.)

IMPORTANT NOTICE TO APPLICANTS

Under Illinois law, job applicants are not obligated to disclose sealed or expunged records of conviction or arrest or expunged juvenile records of conviction or arrest.

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All Information provided on this form by the job applicant or employer is provided voluntarily. The Illinois Department of Employment Security ("IDES") does not investigate or validate this information, nor does IDES assume any legal liability or responsibility as to the accuracy, currency, quality or validity of this information, nor does IDES make any warranties or guarantees, express or implied, with respect to this information, nor does IDES assume any legal liability or responsibility as to the accuracy, currency, quality as to the accuracy, currency, quality or validity of this information, nor does IDES assume any legal liability or responsibility as to the accuracy, currency, quality, or validity of this information. By using this form, job applicants and employers agree to hold IDES and its officers, employees and agents hamless from any cause of action which might arise as a result of the job applicant's or employer's use of this form. Job applicants and employers assume the risk of use of, and reliance on information provided through, this form. Neither IDES nor its officers, employees or agents shall be liable under any theory, legal or equitable, for any claims or damages related to a job applicant's or employer's use of this form.

Form W-4 (2007)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2007 expires February 16, 2008. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds \$850 and includes more than \$300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

Basic instructions. If you are not exempt, complete the Personal Allowances Worksheet below. The worksheets on page 2 adjust your withholding allowances based on

itemized deductions, certain credits, adjustments to income, or two-earner/multiple job situations. Complete all worksheets that apply. However, you may claim fewer (or zero) allowances.

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the Personal Allowances Worksheet below, See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances. Nonwage income. If you have a large amount of nonwage income, such as Interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax

for individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P. Two earners/Multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others

Nonresident alien. If you are a nonresident atien, see the Instructions for Form 8233 before completing this Form W-4,

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2007. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

| | | Persona | Allowances Works | heet (Keep for yo | ur records.) | |
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| A Enter "1" | " for yourself | f if no one else can | claim you as a depend | ent | | A |
| | • Yo | u are single and ha | ive only one job; or | | | |
| B Enter "1" | " if: { • Yo | u are married, have | only one job, and your | spouse does not wor | tk; or | В |
| | [● Υοι | ur wages from a seco | ond job or your spouse's | wages (or the total of | both) are \$1,000 or less. | |
| C Enter "1' | " for your spo | ouse. But, you may | choose to enter "-0-" i | f you are married and | have either a westing a | Douse or |
| | ai one job. (C | menny -o-mayn | ieip you avoid having to | 0 little tax withheld) | | C |
| E Enter "1" | if you will fit | indents (other than | your spouse or yoursel | f) you will claim on yo | our tax return | , , , D |
| F Enter "1" | if you have | e as nead or nouse | enoid on your tax return | (see conditions unde | Head of household ab | ove) E |
| (Note, D | n you nave a | child support on the | mid or dependent care | expenses for which | you plan to claim a credi | it , F |
| G Child Ta | x Credit (incl | uding additional chi | ild tax credit). See Pub | and Dependent C | are Expenses, for details. |) |
| | lotal income | will be less than \$5 | 57.000 (\$85.000 if marri | of) enter "?" for onch | allathia shital | AVER By: |
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| For accur | | enter total here. Note | e. Inis may be different from | the number of exemptio | ns you claim on your tax retu | im.) 🕨 H |
| complete | all and A | djustments Work | or claim adjustments to sheet on name 2 | income and want to | reduce your withholding, | see the Deductions |
| workshee | sts { ● lf vo | u have more than on | has been are married and | vou and your shouse h | oth work and the combined | l annines from the s |
| that apply | | | | | | |
| | C • IT NO | enner of the above | situations applies, stop | here and enter the nu | mber from line H on line 5 | of Form W-4 below. |
| Department of the | Treasury | Whether you are ent | titled to claim a certain our | nber of allowances or ex | | OMB No. 1545-0074 |
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| Department of Homeland Security U.S. Citizenship and Immigration Services | | | OMB No. 1615-0047; Expires 06/30 Form I-9, Employme Eligibility Verification |
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| Please read instructions carefully before c | ompleting this form. The in | structions must be available (| furing completion of this form. |
| ANTI-DISCRIMINATION NOTICE: specify which document(a) they will as future expiration date may also consti | ccept from an employee. | The refusal to hire an indi | dividuals. Employers CANNOT vidual because the documents have |
| Section 1. Employee Information and | Verification. To be comp | leted and signed by employe | e at the time employment begins. |
| Print Name: Last | First | Middle Initial | Maiden Name |
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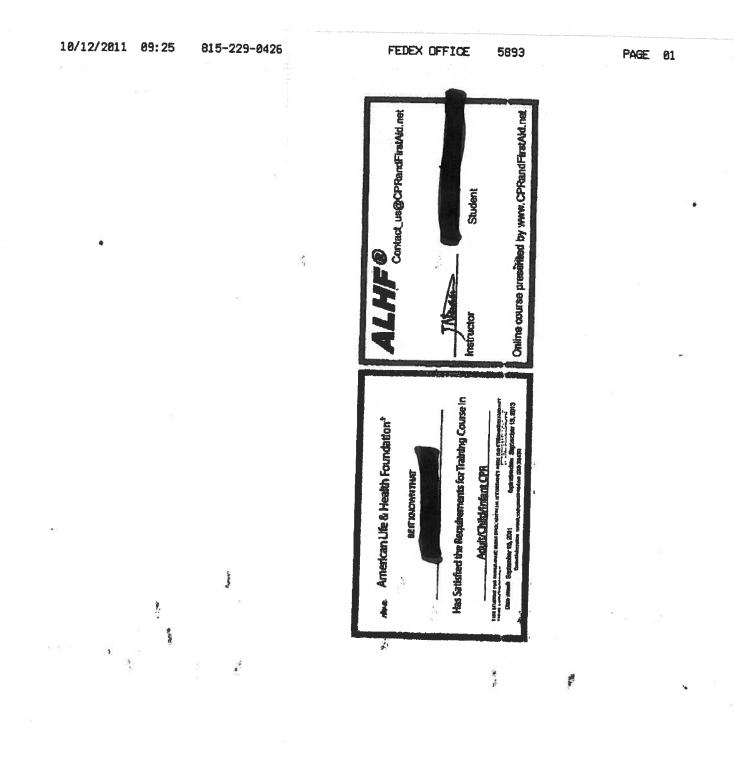
State of Illinois Department of Employment Security

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New Hire Reporting Form

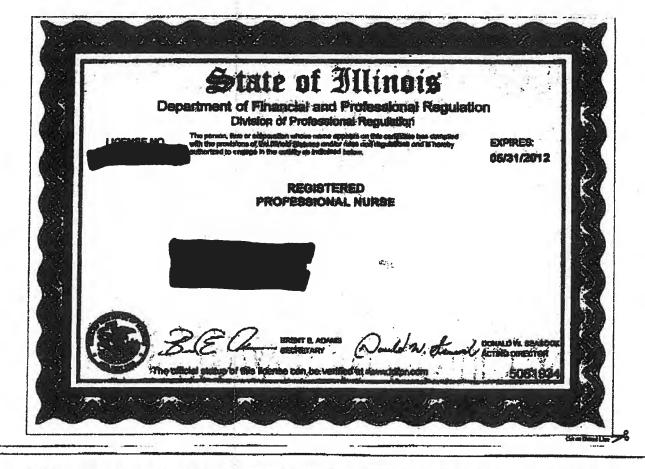


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| Programs, services and employment are Department if you require reasonable ac | equally available to everyone. Please inform the Human Resources commodation for the application or interview. | Date of Interview (Month/Day/Year): 09128 2011 |
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| | itemized deductions, certain credits, adjustments to income, or iwo-earner/multiple job situations. Complete all worksheets that | for Individuals. Otherwise, you may owe additional tax. If you have pension or annuli prome see Buth 919 to find out if you also |
|--|--|---|
| Purpose. Complete Form W-4 so that your employer can withhold the correct federal income | apply, However, you may claim fewer (or zero) allowances. | income, see Pub. 919 to find out if you sho adjust your withholding on Form W-4 or W- |
| tax from your pay. Because your tax situation | Head of household. Generally, you may claim | Two earners/Multiple jobs. If you have a working spouse or more than one job, figure |
| may change, you may want to refigure your withholding each year. | head of household filing status on your tax return only if you are unmarried and pay more | the total number of allowances you are entit |
| Exemption from withholding. If you are | than 50% of the costs of keeping up a home | to claim on all jobs using worksheets from c one Form W-4. Your withholding usually will |
| exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your | for, yourself and your dependent(s) or other qualifying individuals. | be most accurate when all allowances are claimed on the Form W-4 for the highest |
| exemption for 2007 expires February 16, 2008. See Pub. 505, Tax Withholding and Estimated | Tax credits. You can take projected tax | paying job and zero allowances are claimed |
| Tax. | credits into account in figuring your allowable number of withholding allowances. Credits for | the others. Nonresident alien. If you are a nonresident |
| Note. You cannot claim exemption from withholding if (a) your income exceeds \$850 | child or dependent care expenses and the child tax credit may be claimed using the | alien, see the instructions for Form 8233 |
| and includes more than \$300 of unearned | Personal Allowances Worksheet below. See | before completing this Form W-4. Check your withholding. After your Form V |
| income (for example, interest and dividends) and (b) another person can claim you as a | Pub. 919, How Do I Adjust My Tax Withholding, for information on converting | takes effect, use Pub. 919 to see how the |
| dependent on their tax return. | your other credits into withholding allowances. | dollar amount you are having withheld compares to your projected total tax for 200 |
| Basic Instructions. If you are not exempt, complete the Personal Allowances | Nonwage income. If you have a large amount of nonwage income, such as interest or | See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 |
| Worksheet below. The worksheets on page 2 | dividends, consider making estimated tax | (Married). |
| adjust your withholding allowances based on Personal | Allowances Worksheet (Keep for your | |
| A Enter 1" for yourself if no one else can | | records.) |
| You are single and have | | ······································ |
| | only one job, and your spouse does not work; | or BØ |
| Your wages from a seco | and job or your spouse's wages (or the total of bo | oth) are \$1.000 or less. |
| C Enter "1" for your spouse. But. you may | choose to enter "-0-" if you are married and h | ave either a working spouse or |
| more than one job. (Entering "-0-" may he | alp you avoid having too little tax withheld.) | сØ |
| D Enter number of dependents (other than y E Enter "1" if you will file as head of house | your spouse or yourself) you will claim on your | tax return |
| Enter "1" if you win me as nead of house | hold on your tax return (see conditions under l hild or dependent care expenses for which yo | Head of household above) E |
| (Note. Do not include child support paym | ents. See Pub. 503, Child and Dependent Care | Pupian to claim a credit |
| G Child Tax Credit (including additional chill | d tax credit). See Pub 972, Child Tax Credit, fo | or more information |
| If your total income will be less than \$5 | 7,000 (\$85.000 if married), enter "2" for each e | sigible child. |
| If your total income will be between \$57, shild plus "1" additional if you have 4 or | 000 and \$84,000 (\$85,000 and \$119,000 if mar | ried) ontor "1" for each allrible |
| | more eligible ehildren | neul, enter i loi each eilgible |
| child plus "1" additional if you have 4 or i Add lines A through G and enter total here. Note | more eligible children. | GØ |
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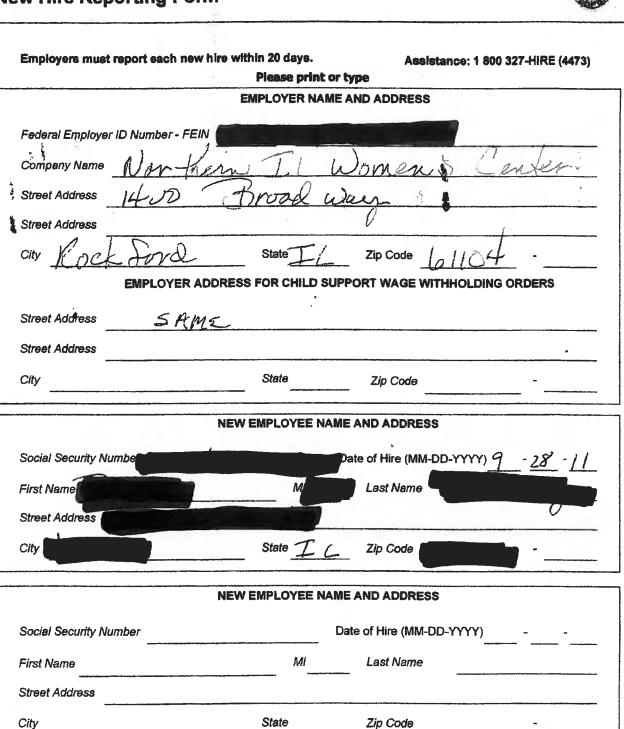
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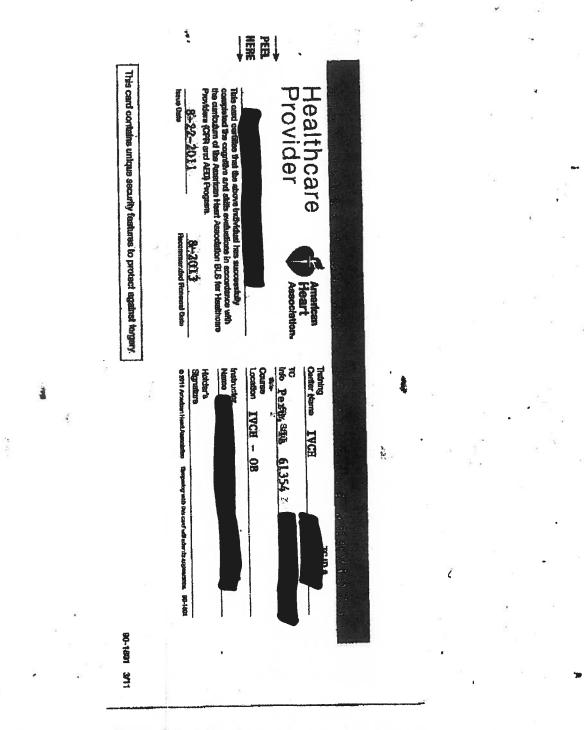
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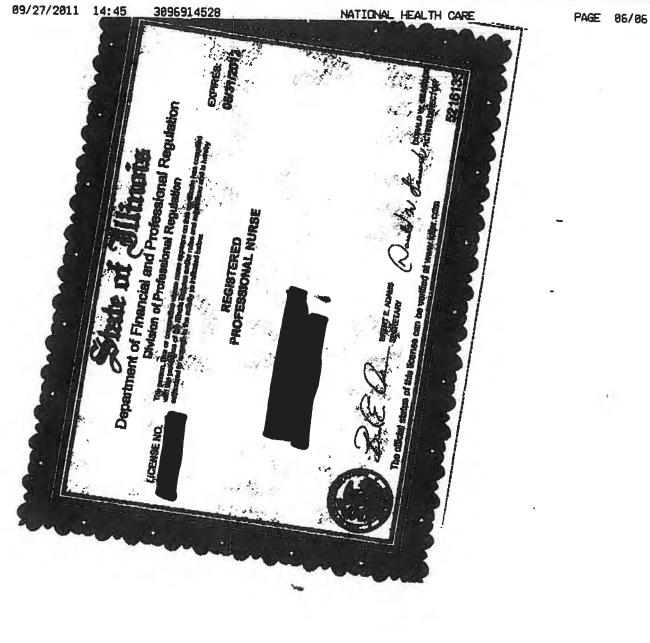


| Return your completed form either by FAX 1-217-557-1947 or by mail to IDES, P.O. Box 19473, Springfield, IL 62794-9473 | - M- |
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| or report new hires online at http://www.ides.state.il.us/employer/newhire/general.asp | By: Date: 10-3-11 |



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Contracts Department 6370 Wilcox Road Dublin, Ohio 43016

Telephone: 614-889-1061

December 16, 2011

Northern Illinois Women's Center, LTD. 1400 Broadway, #201 Rockford, Illinois 61104 Attention: Meg Larkin

Dear Ms. Larkin:

Enclosed please find the following fully executed document for your file:

Laboratory Services Agreement

We look forward to continuing service of your reference clinical laboratory needs. If you have any questions or require additional information, please do not hesitate to contact your LabCorp Representative, Dodie Beaudette at (630) 297-2899.

Sincerely,

Laboratory Corporation of America Holdings Contracts Department, Central Division

Enclosures

LABORATORY SERVICES AGREEMENT

THIS AGREEMENT made this <u>1st</u> day of <u>Necamber</u>, 2011, by and between Northern Illinois Women's Center, LTD., ("CLIENT") and Laboratory Corporation of America Holdings ("LABORATORY").

WHEREAS, LABORATORY is engaged in the business of providing reference clinical laboratory services (the "Services"); and

WHEREAS, CLIENT desires to contract with LABORATORY to provide reference clinical laboratory services for CLIENT, and LABORATORY desires to provide the Services described herein.

IT IS THEREFORE AGREED AS FOLLOWS:

1. TERM AND TERMINATION

This Agreement shall become effective on the date set forth above and shall continue in effect until terminated by either party. This Agreement shall have an initial term of one (1) year ("Initial Term") and shall be automatically renewed for additional periods of one (1) year ("Renewal Term") at the end of the Initial Term or any Renewal Term, unless previously terminated by either party.

This Agreement may be terminated by either party, with or without cause, at any time, by giving the other party thirty (30) days prior written notice to the address set forth in Section 9.

2. TESTING SERVICES

LABORATORY agrees to perform such Services for CLIENT as may be requested by CLIENT, if available, during the term of this Agreement. The Services shall include those tests listed in LABORATORY's current Directory of Services, as the same may be modified from time to time by LABORATORY and such additional services as the parties may agree to in writing.

The service area under this Agreement shall be the state of Illinois ("Service Area").

3. ADDITIONAL SERVICES

A. SPECIMEN PICK UP AND REPORT DELIVERY

LABORATORY will provide a reference specimen pick up and report delivery service to CLIENT on a daily basis Monday through Friday of each week, except on holidays. For the purposes of this Agreement, holidays shall include New Year's Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day and Christmas Day. LABORATORY shall make reasonable efforts to deliver or transmit results of a routine nature (general routine chemistries) to CLIENT within 24 hours of the time the specimen is received by LABORATORY's testing facility. LABORATORY shall make reasonable efforts to deliver or transmit results of tests performed on specimens of a special nature (special chemistries, tissues, etc.) to CLIENT within the times set forth in LABORATORY's then current turn-around-time schedule. LABORATORY shall report panic or critical values performed at LABORATORY facilities in a manner consistent with LABORATORY's standard policies and procedures. CLIENT hereby represents and warrants that it has reviewed such policies and procedures and further acknowledges that it understands and agrees with LABORATORY policies and procedures.

B. SUPPLIES

*

LABORATORY will provide, as part of its charges for the Services, such items, devices or supplies that are used solely to collect, transport, process or store specimens to be submitted to LABORATORY for testing.

C. CONSULTATION

LABORATORY staff shall be available to consult with CLIENT by telephone during normal LABORATORY working hours to discuss LABORATORY's procedures and to provide the status of test results.

Northern Illinois Women's Center, LTD. # 12452205

4. FEES

CLIENT agrees to pay, to the extent responsible for payment, for the Services provided under this Agreement the fees set forth in Exhibit A. CLIENT shall pay the greater of the fees listed in Exhibit A or the charges to LABORATORY for reference testing performed by a laboratory not owned by or affiliated with LABORATORY. After the Initial Term of this Agreement, CLIENT and LABORATORY agree that fees shall either increase on the renewal date hereof or with LABORATORY's general annual fee increase of which CLIENT shall receive thirty (30) days written notice. CLIENT and LABORATORY acknowledge and agree that fees shall not be adjusted more frequently than once a year.

Notwithstanding the foregoing, CLIENT acknowledges that LABORATORY may develop and/or provide new technologies and/or new methodologies during the term of this Agreement. LABORATORY shall notify CLIENT when such technologies and/or methodologies are available and the fee associated with such technologies and/or methodologies. If, during the term of this Agreement, any nationally recognized professional medical association makes recommendations that establish or change a standard of care for testing, the parties will work in good faith to agree on an appropriate rate of payment for testing affected by the new or modified standard of care on a fee for service basis. If the parties cannot reach agreement, LABORATORY shall have the right to terminate this Agreement by giving thirty (30) days written notice to CLIENT.

5. BILLING

CLIENT shall indicate the entity responsible for payment of Services rendered on the requisition submitted to LABORATORY.

If CLIENT indicates that CLIENT is responsible for payment, LABORATORY will submit to CLIENT a monthly itemized statement of Services rendered to CLIENT by LABORATORY for the prior month. Payment for Services is due thirty (30) days after the date of invoice. Failure to remit payment within said time may result, among other remedies available to LABORATORY, in the loss or reduction of CLIENT's discount and/or special prices on future Services or discontinuation of Service. If, as a result of such non-payment, LABORATORY reduces or removes any discount and/or special prices, the terms and prices contained in LABORATORY's current Fee Schedule shall become the Fees payable by CLIENT. LABORATORY may, at its option, reinstate any discount and/or special prices after CLIENT brings its balance current. Nothing in the foregoing shall waive any rights or remedies available to LABORATORY with respect to late payment by CLIENT. If LABORATORY is compelled to bring suit to collect amounts due hereunder, it shall be entitled to recover interest on amounts due, reasonable attorneys' fees and costs incurred in connection with the action.

If CLIENT indicates that a third party is responsible for payment, LABORATORY, in accordance with legal and regulatory requirements, agrees to bill the patient or other responsible party, including Medicare, Medicaid and insurance companies, for Services performed under this Agreement. CLIENT agrees to promptly provide LABORATORY with all necessary information to accomplish the billing and collection of amounts due, including required diagnosis information. If LABORATORY is unable to obtain payment from any third party due to CLIENT's failure to provide the information required by this Agreement, or as a result of CLIENT's failure to follow applicable rules or regulations, CLIENT agrees to pay LABORATORY for all such Services.

6. ACCREDITATION OF TESTING SITES

The Services performed hereunder shall be performed at testing facilities to be selected by LABORATORY. LABORATORY's facilities are and shall remain duly licensed clinical laboratories under applicable federal, state and local law. Reasonable documentation of such credentials shall be provided upon written request.

7. CHANGE IN LAW OR REGULATION

The terms of this Agreement are intended to be in compliance with all federal, state and local statutes, regulations and ordinances applicable on the date the Agreement takes effect including but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Deficit Reduction Act of 2005 ("DRA"), and applicable State False Claims Acts ("SFCA"). The parties agree to execute amendments as may be necessary for the continuing compliance with the aforementioned Acts, as additional regulations are promulgated or become final and effective. Should either party reasonably conclude that any portion of this Agreement is or may be in violation of such requirements or subsequent enactments by federal, state or local

Northern Illinois Women's Center, LTD. # 12452205 authorities, or if any such change or proposed change would materially alter the amount or method of compensating LABORATORY for Services performed for CLIENT or for any other party under this Agreement, or would materially increase the cost of LABORATORY's performance hereunder, the parties agree to negotiate written modifications to this Agreement as may be necessary to establish compliance with such authorities or to reflect applicable changes.

8. NON-ASSIGNABILITY

This Agreement may not be assigned by either party without the written consent of the other party which consent shall not be unreasonably withheld or delayed.

9. NOTICES

Any notice required to be given pursuant to the terms and provisions hereof shall be in writing and shall be sent by certified or registered mail to LABORATORY at:

Laboratory Corporation of America Holdings 6370 Wilcox Road Dublin, Ohio 43016 Attention: Contracts Administrator

with a copy to:

Laboratory Corporation of America Holdings 531 South Spring Street Burlington, North Carolina 27215 Attention: Law Department

and to CLIENT at:

Northern Illinois Women's Center, LTD. 1400 Broadway, #201 Rockford, Illinois 61104 Attention: Mag Larkin

10. INDEPENDENT RELATIONSHIP

None of the provisions of this Agreement are intended to create, nor shall be deemed or construed to create, any relationship between CLIENT and LABORATORY other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Neither of the parties hereto, nor any of their respective employees shall be construed to be the agent, employer or representative of the other.

11. FORCE MAJEURE

LABORATORY shall not be liable for any claims or damages and shall be excused for such claims, damages, failures and delays in the performance of it obligations under this Agreement due to any act or cause beyond the reasonable control and without the fault of LABORATORY including, without limitation, acts of God such as fire, flood, tornado, earthquake; acts of government (i.e., civil injunctions or enacted statutes and regulations); or acts or events caused by third parties such as riot, strike, power outage or explosion; or the inability due to any of the aforementioned causes to obtain necessary labor or materials.

12. WARRANTY

- A. CLIENT WARRANTS TO LABORATORY THAT NEITHER CLIENT NOR ANY OF ITS EMPLOYEES OR OWNERS HAVE BEEN DEBARRED, SUSPENDED, DECLARED INELIGIBLE OR EXCLUDED FROM MEDICARE, MEDICAID OR ANY OTHER FEDERAL OR STATE GOVERNMENT HEALTHCARE PROGRAM.
- B. LABORATORY WARRANTS TO CLIENT THAT NEITHER LABORATORY NOR ANY OF ITS EMPLOYEES OR OWNERS HAVE BEEN DEBARRED, SUSPENDED, DECLARED INELIGIBLE OR EXCLUDED FROM MEDICARE, MEDICAID OR ANY OTHER FEDERAL OR STATE

Northern Illinois Women's Center, LTD. # 12452205

GOVERNMENT HEALTHCARE PROGRAM.

- C. LABORATORY WARRANTS TO CLIENT THAT ALL SERVICES PROVIDED HEREUNDER SHALL BE IN ACCORDANCE WITH ESTABLISHED AND RECOGNIZED CLINICAL LABORATORY TESTING PROCEDURES AND WITH REASONABLE CARE IN ACCORDANCE WITH APPLICABLE FEDERAL, STATE AND LOCAL LAWS.
- D. NO OTHER WARRANTIES ARE MADE BY LABORATORY.
- E. IN NO EVENT SHALL LABORATORY BE RESPONSIBLE FOR ANY PUNITIVE DAMAGES OR ANY CONSEQUENTIAL, INCIDENTAL, INDIRECT, OR SPECIAL DAMAGES OF CLIENT OR OF ANY THIRD PARTY.

13. BENEFIT

This Agreement is intended to inure only to the benefit of LABORATORY and CLIENT. This Agreement is not intended to create, nor shall be deemed or construed to create, any rights in any third parties.

14. NONDISCRIMINATION

All Services provided by LABORATORY hereunder shall be in compliance with all applicable Federal and State laws, regulations and ordinances prohibiting discrimination on the basis of race, color, religion, sex, national origin, handicap, veteran status or any other protected class.

15. HEADINGS

The headings in this Agreement are for convenience and reference only and are not intended to, and shall not, define or limit the scope of the provisions to which they relate.

16. ENFORCEABILITY/SEVERANCE CLAUSE

The invalidity or unenforceability of any term or provisions of this Agreement in any jurisdiction shall not affect the validity or enforceability of any of the other terms or provisions in that jurisdiction or of the entire Agreement in any other jurisdiction. If any provision is held invalid by a court of competent jurisdiction, such shall be severed and the Agreement shall be interpreted as though the severed provision had not existed.

17. WAIVER

No course of dealing between the parties or any delay on the part of either party in exercising any rights they may have under this Agreement shall operate as a waiver of any of the rights of the other party. No express waiver shall affect any condition, covenant, rule, regulation, right or remedy other than the one specified in such waiver and only for the time and in the manner specifically stated.

18. ACCESS TO BOOKS AND RECORDS

If the Services to be provided by LABORATORY hereunder are subject to the disclosure requirements of 42 U.S.C. 1395x (v) (1) (I), LABORATORY shall until expiration of ten (10) years make available, upon written request of the Secretary of Health and Human Services, or upon request to the Comptroller General, or any of their duly authorized representatives, a copy of this Agreement and the books, documents and records of LABORATORY that are necessary to certify the nature and extent of the costs incurred under this Agreement through a subcontractor with a value or cost of \$10,000.00 or more over a twelve (12) month period. In addition, with respect to any applicable subcontract, such subcontract shall contain a clause to the effect that, should the subcontractor be deemed a related organization, until the expiration of six (6) years after the furnishing of services pursuant to such subcontract, the subcontractor shall make available upon written request of the Secretary of Health and Human Services, or upon request to the Comptroller General, or any of their duly authorized representatives, a copy of the subcontract, and the books, documents and records of such third party that are necessary to verify the nature and extent of the costs incurred under this Agreement.

During the term of this Agreement, upon reasonable prior written request and during normal business hours, LABORATORY shall allow CLIENT reasonable access to LABORATORY records concerning the Services provided hereunder. CLIENT warrants and represents that it has obtained any necessary written consent from CLIENT patients for the release of such records. Such consent shall satisfy all applicable laws and regulations including but not limited to the privacy regulations of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Northern Illinois Women's Center, LTD. # 12452205

19. MODIFICATION

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This Agreement may only be modified in a writing signed by authorized representatives of each party.

20. ENTIRE AGREEMENT

This Agreement constitutes the entire understanding between the parties hereto concerning the subject matter herein and is a complete statement of the terms thereof and shall supersede all previous understandings between the parties, whether oral or written with respect to the subject matter herein. The parties shall not be bound by any representation made by either party or agent of either party that is not set forth in this Agreement. Any applicable provisions required by federal, state, or local law are hereby incorporated by reference.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed in their names as their official acts by their respective representatives, each of whom is duly authorized to execute the same.

| LABORATORY: |
|--|
| Laboratory Corporation of America Holdings |
| By: |
| Print Name |
| Date: 12/6/11 |
| CLIENT: |
| Northern Illinois Women's Center, LTD. |
| By: M Karkin |
| Print Name: Meg Larkin |
| Date: 12 · 1 · 1 |

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LAP #: 1635001 AU ID: 1182090 September 16, 2011

Laboratory Corporation of America 6370 Wilcox Rd Dublin, OH 43016-1269

Dear

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Sincerely,

Laboratory Corporation of America, in Dublin, Ohio under the direction of the second s

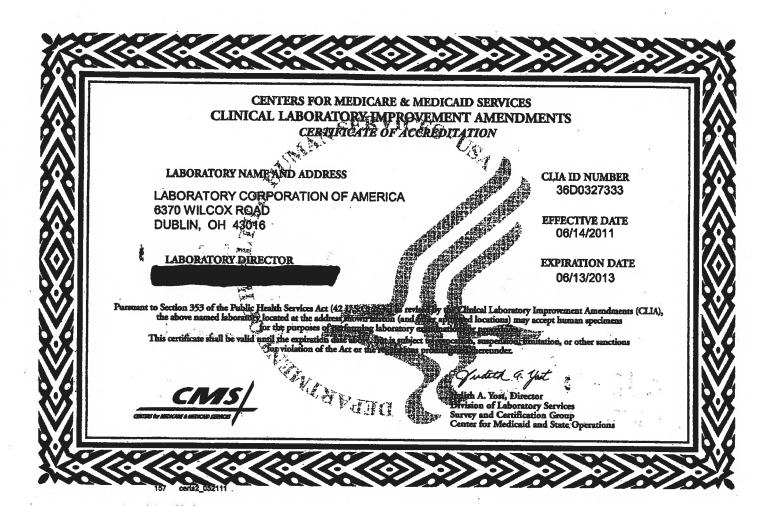
Accreditation is a continual process. A laboratory remains accredited until otherwise notified. Accreditation does not necessarily terminate on the expiration date of the Accreditation certificate.

If you have any questions regarding this matter, please call 800-323-4040.

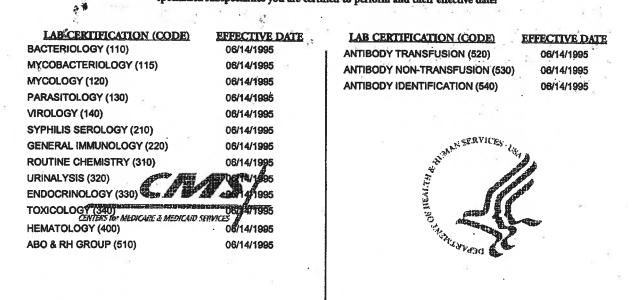
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Laboratory Accreditation Programs College of American Pathologists

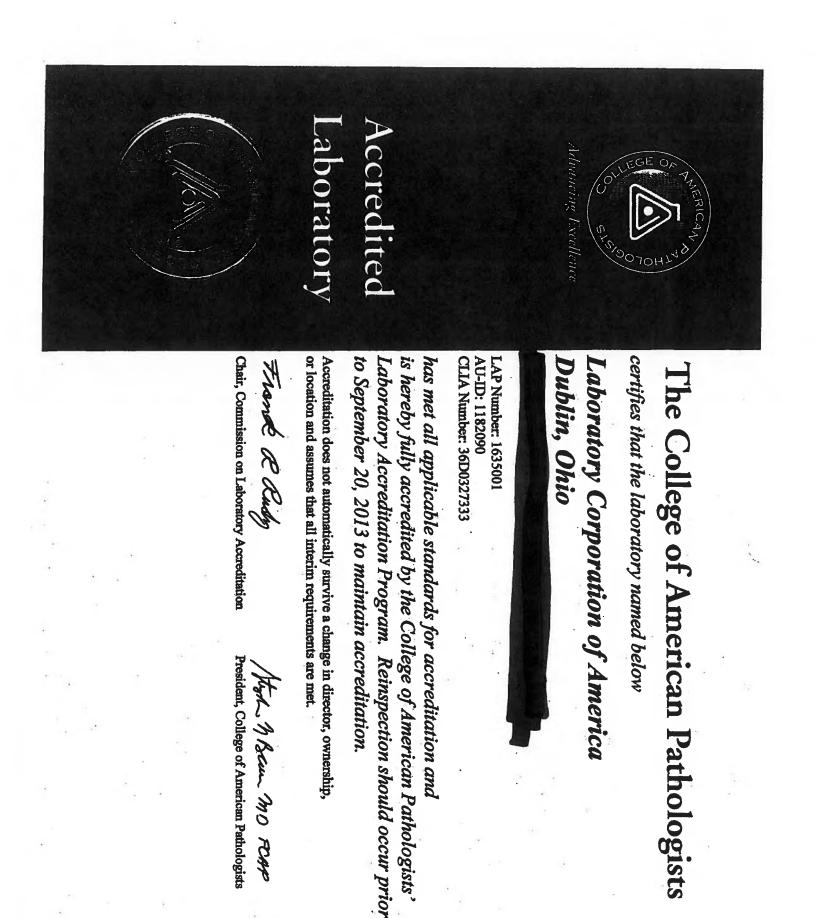
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If you currently hold a Certificate of Compliance or Certificate of Accreditation, below is a list of the laboratory specialties/subspecialties you are certified to perform and their effective date:



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



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Methodist Hospital of Chicago

5025 North Paulina Street Chicago, Illinois 60640 (773) 271-9040 Fax: (773) 271-2010

November 1, 2011

Sent via fax to (815)963-6122

Northern Illinois Women's Center Attn: Meg Largen 1400 Broadway Rockford, Illinois 61104

RE:

To Whom It May Concern:

Due to high volume of request for information and the multiplicity of forms, we are responding to your request for the following information on the above-referenced practitioner:

DEPARTMENT:

SURGERY

ACTIVE

SPECIALTY:

GYNECOLOGY

APRIL 1994 - PRESENT

APPOINTMENT DATE:

STAFF CATEGORY:

M.D. is a Medical Staff member in good standing at Methodist Hospital of Chicago. There are no quality of care issues identified through the hospital's quality assessment and improvement activities. His/her ability to practice his/her specialty is not impeded by any identified health issues.

Should you have any further questions, please feel free to contact me at (773)989-1382.

Sincerely,

Medical Staff Coordinator

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| Specialty: | Obstetrics and Gynecology |
|-----------------------------|---|
| Education and Training: | University of Illinois, B.S. 1954 Chicago Medical School, M.D. 1958 Michael Reese Hospital, Rotating Internship, 1958-59 Mt.Sinal Hospital Ob-Gyne Residency, 1961-64 |
| Experience: | U.S. Airforce, 1959-61 Private Practice of Ob-Gyne, 1964 - present |
| Professional Organizations: | Chicago Medical Society Illinois State Medical Society AMA American College of Ob-Gyne American Fertility Society |
| Certification: | American Board of Ob- Gyne (1967) |
| Personal Information: | and the second second second second second |
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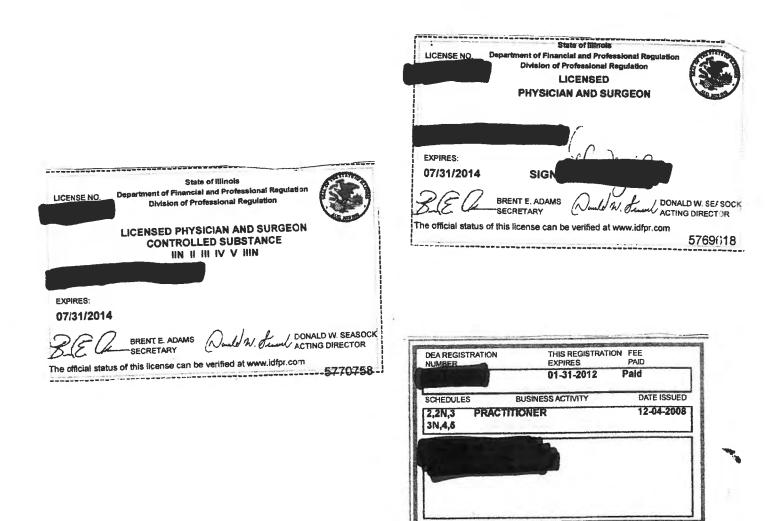
| liculties <u>Xismie.com</u> | oly log an lo encounter difficu underwrtlingsfatar | ISMLE Did you know that online premium payments are now available? To pay your premiums online simply log onto Tip: www.ismle.com - go to your MySMLE screen and select the "Pay My Pramium" option. Should you encounter difficulties during the process or have questions, please contact our Underwriting Division at 800-782-4787 or underwriting@ismle.com | n 18 |
|--------------------------------|---|---|--|
| | \$8,028.50 \$8,028.50 | Current Quarterly Installment:(2 of 4) | Current Quai Total Due: |
| | | Total Annual Premium \$32,114.00 Total billed to date for this policy period \$8,028.50 Bafance to be billed \$24,085.50 | Total Annua Total billed t Bafance to b |
| | -\$7,779.00 \$32,114.00 | Loss Free Discount | Loss Free Di Total Annval |
| | \$66,488.00 \$26,595.00 \$39,893.00 | Your premium for the period 07/01/2011 thru 07/01/2012 is based upon: Specialty: Gynecological Surgery County: Cook, Illinois Limits: \$1,000,000 /Each Person \$3,000,000 Aggregate/Year Base Premium | Your premiu Specialty: Gy County: Cool Limits: \$1,00 Base Premiu Part Time Ar Adjusted Bas |
| | | ISMIE Policyfielder: Matual Insurance Policy Number: Transport Policy Number: Transport Billing Period: Staturo Chaponilism Avenue Involce: Type: Involce: Type: Staturo Chaponilism Avenue Due Date: Staturo Chaponilism Avenue Date prepared: Staturo Chaponilism Avenue Staturo Chaponilism Avenue | Jaking In Jaking In Received Working Suite 700 Chi-spo Bin Deletions 312-782-780 Deletions 312-780 Deletions 3 |

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Northern Illinois Women's Center 1400 Broadway, Ste 201 November 1, 2011 Credentialing Committee Meeting

Attended: Stewart Kernes, DO Dennis Christensen, MD Meg Larkin, Administrator

Meeting started @ 1:00 pm

This meeting was held to Credentian and the MD and the second are to our facility on October 29th. He brought with him the following documentation.

Current Illinois License DEA Number

12

He toured the clinic and offered to work with NIWC as an Independent Contractor.

On October 31, 2011 Control of the second state of the second stat

We found his current credentials to be satisfactory and in accord with our physician requirements. We will work for NIWC one day a week.

Credentialing Meeting Adjourned @ 2:30 pm.

0 1, 2011

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Dennis Christensen, MD

Stewa Kerne

Meg Lakkin