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.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH, STATE OF ILLINOIS, Complainant, v. NORTHERN ILLINOIS WOMEN'S CENTER, Respondent.	)	Docket No. PTC 11-002

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 January, 2012.

Eva M. Byerley
Assistant General Counsel
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

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH, STATE OF ILLINOIS, Complainant, v. NORTHERN ILLINOIS WOMEN'S CENTER, Respondent.	)	Docket No. PTC 11-002

FINAL ORDER

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

By: Dr. Kenneth Soyemi, M.D., Acting Director Date 1/15/12

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH, STATE OF ILLINOIS, Complainant,	)	Docket No. PTC 11-002
v.	)	
NORTHERN ILLINOIS WOMEN'S CENTER, Respondent.	)	

CONSENT AGREEMENT AND REQUEST FOR FINAL ORDER

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

RECITALS

1. The Illinois Department of Public Health (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.

3. 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

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

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 Respondent agrees that a repeat violation of Code Sections 205.530(e), 205.330a(a), 205.230(a)(4) and 205.350(b), as further described in the September 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:

(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 Illinois 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.

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.

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

Eva M. Byerley — Jan. 4, 2012

By: Eva M. Byerley
Assistant General Counsel
Illinois Department of Public Health

Date

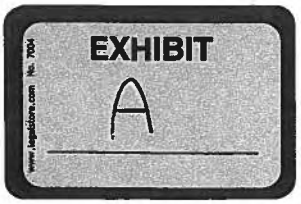
NORTHERN ILLINOIS WOMEN'S CENTER

2 Jan 12

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

Date

127646.1



DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH, STATE OF ILLINOIS, Complainant, v. NORTHERN ILLINOIS WOMEN'S CENTER, Respondent.	)	Docket No. PTC 11-002

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 Ill. 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 = $7,500.00

TOTAL FINE: **$15,000.00**

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

Damon T. Arnold MD MPH

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

Dated this 29 day of September, 2011.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH, STATE OF ILLINOIS, Complainant, v. NORTHERN ILLINOIS WOMEN'S CENTER, Respondent.	)	Docket No. PTC 11-002

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 29th day of September, 2011.

William Bryant
Illinois Department of Public Health

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

RECEIVED

☒ ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

NAME AND ADDRESS of Facility Northern IllinoisWomen's Center 1400 Broadway Rockford, Illinois 61104

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.230 (2)	**Standards of Professional Work** The consulting committee shall review development and content of written policies and procedures of the center…Evidence 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.	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 Signature Sheet in front of P&P manual defines: date, p&p new/changed and Medical Director's signature. **(Exhibit B)**	6.17.11

DATE OF SURVEY 6/8/11 BY 07105 (Surveyor)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

M Parton 6.28.11
(Provider's Representative) Clinic Administrator

7.5.11

EXHIBIT A

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

☒ ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

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

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.230 (2) Cont.	Standards of Professional Work Findings include: 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. 2. The above findings were confirmed by the Clinic Director during an interview on 6/7/11 at approximately 2:00PM.	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.	6.17.11

DATE OF SURVEY 6/8/11 BY 07105 (Surveyor)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

M Carter 6.28.1 (Provider's Representative)

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

☒ ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

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

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.230 (5)	**Standards of professional Work** The consulting committee shall act as a tissue committee and shall review at least quarterly pathological reports…evidence of such review shall be recorded in the 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) 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. 2. The above findings were confirmed with the Clinic Director during an interview on 6/7/11 at approximately 11:50AM.	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 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 tissue 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 MD signature.	6·17·11

DATE OF SURVEY 6/8/11 BY 07105 (Surveyor)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

M Sparks 6·28·
(Provider's Representative)

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

☒ ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

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

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.420 (a)	**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 prevent potential contamination of clean equipment. 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. 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. 2. OR #1 contained a box of opened surgical gloves; the gloves were stained with a dried brown substance. 3. Thirty nine (39) "Medical Rings" (birth 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.	205.420 (a) OR rooms, cabinets and 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 worn for clinic will be cleaned and 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 immediately. Clinic director initiated Weekly OR/Exam Room Cleaning Log. Exhibit C. 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 other refrigerated meds in the lab by the O R's. The fridge 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 fridges' at close of clinic. Exhibit D.	6.17.11

DATE OF SURVEY 6/8/11 BY 07105 (Surveyor)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

M Kartes 6.28
(Provider's Representative)

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

X ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

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

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.420 (C) (2)	**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.	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.	6-13-11

DATE OF SURVEY 6/8/11 BY 19840 (Surveyor)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

M Parker 6-28-11 (Provider's Representative)

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

Ξ ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

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

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.420 (C) (2) Cont.	Findings include: 1.The 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.	205.420 (C) (2) cont 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.	6·13·11

DATE OF SURVEY 6/8/11 BY 19840 (Surveyor)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

M Kanto 6·28·11
(Provider's Representative)

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

☒ ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

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

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.530 (e)	**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:** Based on review of Facility staff personnel files and staff interview, it was determined that for 2 of 2 Registered Nurses (E #3 & 4) previously 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. Findings include: 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.	205.530 (e) 1. On Wednesday June 22nd, 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 credentials (See Exhibit A, pg 3) and found her qualified for the Director of Nursing Position. 2. RN has Operating Room experience. (Exhibit G) She will be re-oriented by the doctor, clinic director (approx 2 to 3 wks.) Her performance will be re-evaluated by medical & clinical directors in 3 mos. & documented. Yearly evaluations thereafter. Exhibit Ga	6.22.11 Hired 6.22.11 6.25.11 Orientation 6.22 to 6.15.11 3 mth eval 9.21.11

DATE OF SURVEY 6/8/11 BY 19843 (Surveyor)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

M Martin 6.28.11 (Provider's Representative)

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

☐ ASTC HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

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

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Section 205.530 (e) Cont.	**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 did not include documentation of Pregnancy Termination or Operating Room experience or training. E #3's file did not contain documentation of clinical orientation or was 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 Pregnancy Termination or Operating Room experience or training. E #4 file did not contain documentation of clinical orientation or was qualified by training or experience as an OR circulating nurse. E #4's file included a letter of resignation dated 10/10/07. 5. These findings were confirmed by the Clinical Director/ Administrator during an interview on 6/6/11 at 2:15 PM.	205.530 (e) cont. 3. The 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 all invasive or operative procedures to comply with 205.530 (e). Clinic director is responsible to hire additional RN with proper qualifications. Medical director and Credentialing Committee responsible to determine any RN hired will fill requirements of 205.530 (e).	On going

DATE OF SURVEY 6/8/11 BY 19843 (Surveyor)

M Parker 6.28.11 (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

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

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

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205.540 (f)	**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: 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 document the person accompanying the patient from the Facility post surgical procedure.	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)**	6.17.11

DATE OF SURVEY 6/8/11 BY 19840 (Surveyor)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

M Parker 6.28 (Provider's Representative)

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, IL 61104

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205.540 (f) Cont.	Findings include: 1. The clinical record of Pt.s' #1-5 were reviewed on 6/6/11 between 1:00 PM and 3:00 PM. The clinical records lacked the name, or relationship of the person accompanying the Pt. 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 accompanying the Pt. upon discharge after surgical procedure.		

DATE OF SURVEY 6/8/11 BY 19840 (Surveyor)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

M Larkin 6.28.11 (Provider's Representative)

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
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205.540 (f) Cont.	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 surgical procedure.		

DATE OF SURVEY 6/8/11 BY 19840 (Surveyor)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

M Lanto 6·28 (Provider's Representative)

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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205.540 (f) Cont.	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. 7. The above findings were confirmed with Administrator during an interview on 6/7/11, at approximately 10:00 AM		

DATE OF SURVEY 6/8/11 BY 19840 (Surveyor)

M Lanton (Provider's Representative) 6.28.1

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
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NAME AND ADDRESS OF FACILITY: Northern Illinois Women's Center. 1400 Broadway, Rockford, IL 61104

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.610 (b)	**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 including…physical 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.	205.610 (b) Updated "surgical form" has section for Physical Exam and documentation of exam clearly stated. Medical and clinic directors' revamped form. CC meeting approved the form. **(See Exhibit 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 Exhibit 2.)**	6.10.11

DATE OF SURVEY 6/8/11 BY 19840 (Surveyor)

M Lanton 6.28.11 (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
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NAME AND ADDRESS OF FACILITY: Northern Illinois Women's Center. 1400 Broadway, Rockford, IL 61104

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205.610 (b) Cont.	Findings include: 1. The clinical record of Pt.s' #1-5 were reviewed on 6/6/11 between 1:00 PM and 3:00 PM. The clinical records lacked documentation of a physical examination. 2. Pt. #1, a 23 year old female, had surgical procedure performed on 4/13/11. The clinical record lacked documentation of a physical examination. 3. Pt. #2, a 22 year old female, had surgical procedure performed on 3/4/11. The clinical record lacked documentation of a physical examination.		6.10.11

DATE OF SURVEY 6/8/11 BY 19840 (Surveyor)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

M Sartin 6.28.11 (Provider's Representative)

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, IL 61104

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205.610 (b) Cont.	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. 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. 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. 7. The above findings were confirmed with Administrator during an interview on 6/7/11, at approximately 10:00 AM.		6·10·11

DATE OF SURVEY 6/8/11 BY 19840 (Surveyor)

M Lanka 6·28·11 (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

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

☒ ASTC SUB ACUTE ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

NAME AND ADDRESS OF FACILITY Northern Illinois Center 1400 Broadway Rockford, Illinois 61104

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205.610 (o)	Clinical Records Accurate and complete records shall be maintained…the record shall include…post 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.	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.	6·17·11

DATE OF SURVEY 6/8/11 BY 07105 (Surveyor)

(Provider's Representative) 6·28·

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

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

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.330 (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:** Based on review of Facility staff personnel files and staff interview, it was determined that for 2 of 2 Registered Nurses (E #3 & 4) who previously worked at the Facility, the Facility failed to ensure a Registered Nurse was on staff to supervise nursing personnel and nursing care, and on the premises when patients were present. Findings include: 1. On 6/6/11 at 10:15 AM, 2 of 2 RN personnel files (E #3 & 4) were reviewed.	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 care of patients. RN shall be on the premises at all 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.	Hired 6.22.11 Search for 2nd RN - ongoing.

DATE OF SURVEY 6/8/11 BY 19843 (Surveyor)

(Provider's Representative) 6.28.11

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Section 205.330 (a)	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 #3 resigned on 4/8/11 and there was no Registered Nurse currently employed at the Facility. The Facility had no RN to supervise nursing staff and on the premises for the past 2 months. 3. 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 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 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		

DATE OF SURVEY 6/8/11 BY 19843 (Surveyor)

(Provider's Representative) 6.28.11

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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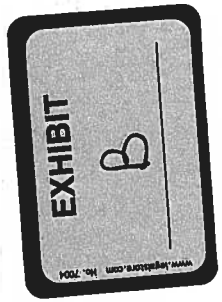
Section 205.330 (a)	Nursing personnel (continued) patient care. On 6/6/11 at 2:15 PM, the Clinical Director stated that 1 of the 3 LPNs (E #4) provided staff supervision. 5. These findings were confirmed by the Clinical Director during the interview on 6/6/11 at 2:15 PM.		

DATE OF SURVEY 6/8/11 BY 19843 (Surveyor)

M Rankin 6.28.11 (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____



ILLINOIS DEPARTMENT OF PUBLIC HEALTH
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PREGNANCY TERMINATION CENTER

NAME AND ADDRES OF FACILITY **PREGNANCY TERMINATION CENTER**

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.230 (2) Corrected	Standards of Professional Work		
205.230 (5) Corrected	Standard of Professional Work		
205.420 (a) Corrected	Sanitary Facility		
205.420 (C)(2) Corrected	Sanitary Facility		
205.540 (f) Corrected	Postoperative Care		
205.610 (b) Corrected	Clinical Records…physical examination		
205.610 (o) Corrected	Clinical records…post counseling notes		

DATE OF SURVEY 9/15/11 BY 19840 (Surveyor) _____ (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
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PREGNANCY TERMINATION CENTER

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

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Repeat deficiencies: **Section 205.530 (e)**	**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 procedure..."** **This requirement was not met as evidenced by:** Based on staff interview and review of Facility personnel files and OR Log review, it was determined that for 1of 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. Findings include: 1. The Clinic Director was interviewed on 9/13/11 at approximately 9:30 AM. The Director stated that a new		

DATE OF SURVEY 9/15/11 BY 19840 (Surveyor) (Provider's Representative)

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PREGNANCY TERMINATION CENTER

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

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Section 205.530 (e) Cont...	**Operative Care (continued)** 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. 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 nursing. E #1's file lacked documentation of training or experience as an OR circulating nurse. 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. 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.		

DATE OF SURVEY 9/15/11 BY 19840
(Surveyor)

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_____
(Provider's Representative)

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
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Section 205.530 (e) Cont...	**Operative Care (continued)** 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.		

DATE OF SURVEY 9/15/11 BY 19840 (Surveyor) (Provider's Representative)

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Section 205.530 (e)	**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:		

DATE OF SURVEY 9/15/11 BY 19843 (Surveyor) (Provider's Representative)

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Section 205.530(e)	**Operative Care (continued)** 1. The clinical record of Pt. #6 was reviewed on 9/14/11 at 1:20 PM. Pt. #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). 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 underwent 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. 3. These findings were confirmed by the Clinical Director during an interview on 9/15/11 at 10:00 AM.		

DATE OF SURVEY 9/15/11 BY 19843 (Surveyor) (Provider's Representative)

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NAME AND ADDRESS OF FACILITY: Northern Illinois Women's Center 1400 Broadway, 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 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.		

DATE OF SURVEY 9/15/11 BY 19840 (Surveyor)

(Provider's Representative)

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

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Section 205.330 (a) Cont...	**Nursing Personnel (continued)** 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 9/15/11 BY 19840 (Surveyor) (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

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

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

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

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
(New Deficiencies) Section 205.230 (a)(4)	**Standards of Professional Work** **Each member of the medical staff granted specific surgical practice privileges shall provide a notarized statement or documentation indicating the name of the Illinois' licensed hospital(s) where they have skilled-equivalent practice privileges. Such statements or 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.** **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 (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.		

DATE OF SURVEY 9/15/11 BY 19843 _____
(Surveyor) (Provider's Representative)

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Section 205.230 (a)(4)	**Standards of Professional Work (continued)** Findings include: 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 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 SURVEY 9/15/11 BY 19843
(Surveyor)
(Provider's Representative)

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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 SURVEY 9/15/11 BY 19843 (Surveyor) (Provider's Representative)

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Section 205.330 (a)	Nursing personnel (continued) 1. 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..." 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.		

DATE OF SURVEY 9/15/11 BY 19843
(Surveyor) (Provider's Representative)

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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.		

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(Surveyor) (Provider's Representative)

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Section 205.330 (a)	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.		

DATE OF SURVEY 9/15/11 BY 19843 _____
(Surveyor) (Provider's Representative)

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Section 205.350	**Laboratory Services** **(b) Have a written agreement with a laboratory which possesses a valid CLIA certificate to perform any required laboratory procedures which are not performed in the center.** 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 performed at the Facility 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.		

DATE OF SURVEY 9/15/11 BY 19840 (Surveyor) _____ (Provider's Representative)

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Section 205.350 Cont...	**Laboratory Services (continued)** The second certificate was the Facility's internal lab certification for ABO & RH Group, with an expiration date of 1/10/2013. 2. 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 3. The above findings were confirmed with the Clinic Director during an interview on 9/15/11 at approximately 2:00 PM.		

DATE OF SURVEY _____ BY _____ _____
(Surveyor) (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR 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

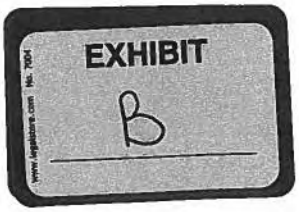
RE: The Department of Public Health v. Northern Illinois Women's Center
Docket No. PTC 11-002

Dear Mr Arnold:

Enclosed you will find the completed Plan of Corrections.

Respectfully,

Meg Larkin
NIWC Administrator



Illinois Department of PUBLIC HEALTH

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

122 S. Michigan Ave., Suite 2000 • Chicago, Illinois 60603-6152 • www.idph.state.il.us

Via Facsimile

Dr. Dennis Christensen
Medical Director
Northern Illinois Women's Center Ltd.
1400 Broadway 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: **NOTICE OF EMERGENCY SUSPENSION**
Northern Illinois 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. **Effective upon the close of business today, Friday, September 30, 2011, the Northern Illinois Women's Center must cease all operations pursuant to the attached Notice.** 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 activities 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.

Sincerely,

Adam V. Abinoja
Deputy General Counsel

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

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 IllinoisWomen's Center 1400 Broadway Rockford, Illinois 61104

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.230 (2)	**Standards of Professional Work** The consulting committee shall review development and content of written policies and procedures of the center…Evidence 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.	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 Signature Sheet in front of P&P manual defines: date, p&p new/changed and Medical Director's signature. (Exhibit B)	6.17.11

DATE OF SURVEY 6/8/11 BY 07105 (Surveyor)

M Larson 6.28.11
(Provider's Representative) Clerical Administrator

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

EXHIBIT A

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

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205.230 (2) Cont.	Standards of Professional Work Findings include: 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. 2. The above findings were confirmed by the Clinic Director during an interview on 6/7/11 at approximately 2:00PM.	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.	6.17.11

DATE OF SURVEY 6/8/11 BY 07105 (Surveyor)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

M Parker 6.28.1 (Provider's Representative)

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
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205.230 (5)	**Standards of professional Work** The consulting committee shall act as a tissue committee and shall review at least quarterly pathological reports…evidence of such review shall be recorded in the 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) 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. 2. The above findings were confirmed with the Clinic Director during an interview on 6/7/11 at approximately 11:50AM.	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 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 tissue 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 MD signature.	6·17·11

DATE OF SURVEY 6/8/11 BY 07105 (Surveyor)

M Lantz 6·28·
(Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
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LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.420 (a)	**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 prevent potential contamination of clean equipment. 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. 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. 2. OR #1 contained a box of opened surgical gloves; the gloves were stained with a dried brown substance. 3. Thirty nine (39) "Medical Rings" (birth 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.	205.420 (a) OR rooms, cabinets and 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 worn for clinic will be cleaned and 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 immediately. Clinic director initiated Weekly OR/Exam Room Cleaning Log. Exhibit C. 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 other refrigerated meds in the lab by the O R's. The fridge 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 fridges' at close of clinic. Exhibit D.	6.17.11

DATE OF SURVEY 6/8/11 BY 07105 (Surveyor)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

M Barton 6.23
(Provider's Representative)

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
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205.420 (C) (2)	**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.	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.	6-13-11

DATE OF SURVEY 6/8/11 BY 19840 (Surveyor)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

M Parker 6-28-11 (Provider's Representative)

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
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205.420 (C) (2) Cont.	Findings include: 1.The 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.	205.420 (C) (2) cont 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.	6-13-11

DATE OF SURVEY 6/8/11 BY 19840 (Surveyor)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

M Kantin 6-28-11 (Provider's Representative)

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Section 205.530 (e)	**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:** Based on review of Facility staff personnel files and staff interview, it was determined that for 2 of 2 Registered Nurses (E #3 & 4) previously 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. Findings include: 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.	205.530 (e) 1. On Wednesday June 22nd, 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 credentials **(See Exhibit A, pg 3)** and found her qualified for the Director of Nursing Position. 2. RN has Operating Room experience. **(Exhibit G)** She will be re-oriented by the doctor, clinic director (approx 2 to 3 wks.) Her performance will be re-evaluated by medical & clinical directors in 3 mos. & documented. Yearly evaluations thereafter. Exhibit Ga	6·22·11 Hired 6·22·11 Orientation 6·22 to 6·15·11 3 mth eval 9·21·11

DATE OF SURVEY 6/8/11 BY 19843 (Surveyor)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

M Carter 6·28·11 (Provider's Representative)

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

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Section 205.530 (e) Cont.	**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 did not include documentation of Pregnancy Termination or Operating Room experience or training. E #3's file did not contain documentation of clinical orientation or was 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 Pregnancy Termination or Operating Room experience or training. E #4 file did not contain documentation of clinical orientation or was qualified by training or experience as an OR circulating nurse. E #4's file included a letter of resignation dated 10/10/07. 5. These findings were confirmed by the Clinical Director/ Administrator during an interview on 6/6/11 at 2:15 PM.	205.530 (e) cont. 3. The 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 all invasive or operative procedures to comply with 205.530 (e). Clinic director is responsible to hire additional RN with proper qualifications. Medical director and Credentialing Committee responsible to determine any RN hired will fill requirements of 205.530 (e).	On going

DATE OF SURVEY 6/8/11 BY 19843 (Surveyor)

M Parker 6.28.11 (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

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

☒ ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

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

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.540 (f)	**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: 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 document the person accompanying the patient from the Facility post surgical procedure.	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)**	6.17.11

DATE OF SURVEY 6/8/11 BY 19840 (Surveyor)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

M Lantz 6.25 (Provider's Representative)

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

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.540 (f) Cont.	Findings include: 1. The clinical record of Pt.s' #1-5 were reviewed on 6/6/11 between 1:00 PM and 3:00 PM. The clinical records lacked the name, or relationship of the person accompanying the Pt. 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 accompanying the Pt. upon discharge after surgical procedure.		

DATE OF SURVEY 6/8/11 BY 19840 (Surveyor)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

M Larson 6.28.11 (Provider's Representative)

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, IL 61104

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205.540 (f) Cont.	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 surgical procedure.		

DATE OF SURVEY 6/8/11 BY 19840 (Surveyor)

(Provider's Representative) 6·28

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

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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, IL 61104

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205.540 (f) Cont.	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. 7. The above findings were confirmed with Administrator during an interview on 6/7/11, at approximately 10:00 AM		

DATE OF SURVEY 6/8/11 BY_19840 (Surveyor)

M Lanter (Provider's Representative) 6.28.1

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, Rockford, IL 61104

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.610 (b)	**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 including…physical 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.	205.610 (b) Updated "surgical form" has section for Physical Exam and documentation of exam clearly stated. Medical and clinic directors' revamped form. CC meeting approved the form. **(See Exhibit 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 Exhibit 2.)**	6·10·11

DATE OF SURVEY 6/8/11 BY 19840 (Surveyor)

M Lanton 6·28·11 (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.610 (b) Cont.	Findings include: 1. The clinical record of Pt.s' #1-5 were reviewed on 6/6/11 between 1:00 PM and 3:00 PM. The clinical records lacked documentation of a physical examination. 2. Pt. #1, a 23 year old female, had surgical procedure performed on 4/13/11. The clinical record lacked documentation of a physical examination. 3. Pt. #2, a 22 year old female, had surgical procedure performed on 3/4/11. The clinical record lacked documentation of a physical examination.		6.10.11

DATE OF SURVEY 6/8/11 BY 19840 (Surveyor)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

M Sartin 6.28.11 (Provider's Representative)

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, IL 61104

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.610 (b) Cont.	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. 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. 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. 7. The above findings were confirmed with Administrator during an interview on 6/7/11, at approximately 10:00 AM.		6.10.11

DATE OF SURVEY 6/8/11 BY 19840 (Surveyor)

M Lark 6.28.11 (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

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

☐ ASTC SUB ACUTE ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

NAME AND ADDRESS OF FACILITY Northern Illinois Center 1400 Broadway Rockford, Illinois 61104

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.610 (o)	Clinical Records Accurate and complete records shall be maintained…the record shall include…post 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.	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.	6·17·11

DATE OF SURVEY 6/8/11 BY 07105 (Surveyor)

(Provider's Representative) 6·28·

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

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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

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.330 (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:** Based on review of Facility staff personnel files and staff interview, it was determined that for 2 of 2 Registered Nurses (E #3 & 4) who previously worked at the Facility, the Facility failed to ensure a Registered Nurse was on staff to supervise nursing personnel and nursing care, and on the premises when patients were present. Findings include: 1. On 6/6/11 at 10:15 AM, 2 of 2 RN personnel files (E #3 & 4) were reviewed.	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 care of patients. RN shall be on the premises at all 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.	Hired 6.22.11 Search for 2nd RN - ongoing.

DATE OF SURVEY 6/8/11 BY 19843 (Surveyor)

(Provider's Representative) 6.28.11

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) 2. E #3's personnel file included documentation that E #3 was hired on 1/7/11. The Clinical Director stated that E #3 resigned on 4/8/11 and there was no Registered Nurse currently employed at the Facility. The Facility had no RN to supervise nursing staff and on the premises for the past 2 months. 3. 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 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 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		

DATE OF SURVEY 6/8/11 BY 19843 (Surveyor)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

M Lantz 6.28.11
(Provider's Representative)

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 (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 BY 19843 (Surveyor)

M Rankin 6.28.11 (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

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

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PREGNANCY TERMINATION CENTER

NAME AND ADDRES OF FACILITY **PREGNANCY TERMINATION CENTER**

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.230 (2) Corrected	Standards of Professional Work		
205.230 (5) Corrected	Standard of Professional Work		
205.420 (a) Corrected	Sanitary Facility		
205.420 (C)(2) Corrected	Sanitary Facility		
205.540 (f) Corrected	Postoperative Care		
205.610 (b) Corrected	Clinical Records…physical examination		
205.610 (o) Corrected	Clinical records…post counseling notes		

DATE OF SURVEY 9/15/11 BY 19840 (Surveyor) (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

EXHIBIT B

P.27/41

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

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PREGNANCY TERMINATION CENTER

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

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Repeat deficiencies: **Section 205.530 (e)**	**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 procedure..."** **This requirement was not met as evidenced by:** **Based on staff interview and review of Facility personnel files and OR Log review, it was determined that for 1of 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.** Findings include: 1. The Clinic Director was interviewed on 9/13/11 at approximately 9:30 AM. The Director stated that a new	Section 205.530(e) RN, DN (E#1) Is now trained in operating room. See **Exhibit A.** This exhibit documents training in OR and as circulating RN at NHC in Peoria. The RN that trained DN, RN has as many as 30 yrs of OR experience and as circulating nurse. **Exhibit B** Resume of RN BB. Documentation of other training RN's for your review is in RN DN employee file.	10.6.2011

DATE OF SURVEY 9/15/11 BY 19840 (Surveyor)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

M Larkin (Provider's Representative)

FEB-23-1997 22:12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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PREGNANCY TERMINATION CENTER

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

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Section 205.530 (e) Cont...	**Operative Care (continued)** **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.** **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 nursing. E #1's file lacked documentation of training or experience as an OR circulating nurse.** **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.** **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.**	BB, RN (Exhibit B) was hired at NIWC on Sept 28, 2011. RN BB is (2nd) RN on staff @ NIWC. Resume included, documents experience in OR and circulating nurse experience. RN DN or RN BB are present in each OR room during each procedure. Attending physician monitors that RN is present before doing procedure. Evidence of this change will be noted by RN's documentation on bottom section of patient's surgical sheet, and physicians signature on same. **(Exhibit BB)**	10·28·11

DATE OF SURVEY 9/15/11 BY 19840 (Surveyor)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

M Larkin (Provider's Representative)

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
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NAME AND ADDRESS Northern Illinois Women's Center 1400 Broadway, Rockford, IL 61104

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Section 205.530 (e) Cont...	**Operative Care (continued)** 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.	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 C.	9.14.11

DATE OF SURVEY 9/15/11 BY 19840 (Surveyor)

M Larkin (Provider's Representative)

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PREGNANCY TERMINATION CENTER

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

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.530 (e)	**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:**	Section 205.530(e) Operative Care See Exhibit A, B, C. Medical and Clinic Director will assure qualified RN, with operating experience be present in OR during procedures. This will be assured by keeping 2 RN's on staff at all times.	9·28·11

DATE OF SURVEY 9/15/11 BY 19843 (Surveyor) M Larkin (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

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Section 205.530(e)	**Operative Care (continued)** 1. The clinical record of Pt. #6 was reviewed on 9/14/11 at 1:20 PM. Pt. #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). 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 underwent 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. 3. These findings were confirmed by the Clinical Director during an interview on 9/15/11 at 10:00 AM.		

DATE OF SURVEY 9/15/11 BY 1984 (Surveyor) M Larkin (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

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NAME AND ADDRESS OF FACILITY: Northern Illinois Women's Center 1400 Broadway, 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 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.	Section205.330 (a) See Section 205.530 (e) and supporting Exhibits A, B, C	9-28-11

DATE OF SURVEY 9/15/11 BY 19840 (Surveyor)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

M Parkin (Provider's Representative)

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

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Section 285.330 (a) Cont...	**Nursing Personnel (continued)** 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 9/15/11 BY 19840 (Surveyor)

M Parker (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

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

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

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

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
(New Deficiencies) Section 205.230 (a)(4)	**Standards of Professional Work** **Each member of the medical staff granted specific surgical practice privileges shall provide a notarized statement or documentation indicating the name of the Illinois' licensed hospital(s) where they have skilled-equivalent practice privileges. Such statements or 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.** **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 #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.**	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.	ongoing 11-30-11 or Mid-Dec 2011

DATE OF SURVEY 9/15/11 BY 19843 (Surveyor)

M Larkin D (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

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Section 205.230 (a)(4)	Standards of Professional Work (continued) Findings include: 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 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.	Section 205.230 (a)(4) cont. Dr E #3 Documentation of privileges in Wisconsin Hospital, is personnel file for your review.	10·14·11

DATE OF SURVEY 9/15/11 BY 19843 (Surveyor)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

M Lashier (Provider's Representative)

FEB-23-1997 22:14

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LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.330 (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:**	Section 205.330(a) Nursing Personnel Job description of LPN / CNA. has been corrected to conform to the IL Nurse Practice Act. New Job description is in place in NIWC Policy & Procedure book. **Exhibit D.** Staff was educated on change. This Change was made and approved by Medical Director, RN and Clinic Dir. RN on duty will monitor medication distribution each clinic day. Licensed personnel initials med given on designated areas in pt records to insure med was properly administered. Medical and Clinical directors monitor charts daily to ensure meds given were by Licensed Personnel ONLY. **Exhibit E. (2pgs)**	9.14.11

DATE OF SURVEY 9/15/11 BY 19843 (Surveyor)

(Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

P.37/41

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Section 205.330 (a)	Nursing personnel (continued) 1. 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..." 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.	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. Exhibit F. 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.	9.14.11

DATE OF SURVEY 9/15/11 BY 19843 (Surveyor) M Larkin (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

FEB-23-1997 22:15

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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 SURVEY 9/15/11 BY 19843 (Surveyor) M Larkin (Provider's Representative)

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Section 205.330 (a)	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.		

DATE OF SURVEY 9/15/11 BY 19843 (Surveyor) M Larkin (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

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PREGNANCY TERMINATION CENTER

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

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.350	**Laboratory Services** **(b) Have a written agreement with a laboratory which possesses a valid CLIA certificate to perform any required laboratory procedures which are not performed in the center.** **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 performed at the Facility** **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.**	Section 205.350 Laboratory Svs Attached you will find a written agreement with SAH Laboratory. CLIA certificate expiration date 2/27/2013. Exhibit G. The contract has been signed by this administrator and sent to SAH Lab. Was informed this could be approx a two week process. SAH Lab CLIA certificate and Laboratory Accreditation certificate is filed in Policy & Procedure for your inspection. Administrator will be responsible to renew this contract yearly. Medical Director will follow-up as well to assure continued agreement with SAH Lab remains current. Exhibit G - 4 pgs.	Pending - Completion Date (Estm) 10.28.11

DATE OF SURVEY 9/15/11 BY 19840 (Surveyor)

(Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

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PREGNANCY TERMINATION CENTER

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

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG		COMPLETION DATE
Section 205.350 Cont...	**Laboratory Services (continued)** The second certificate was the Facility's internal lab certification for ABO & RH Group, with an expiration date of 1/10/2013. 2. 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 3. The above findings were confirmed with the Clinic Director during an interview on 9/15/11 at approximately 2:00 PM.		

DATE OF SURVEY _____ BY _____ _____
(Surveyor) (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

National Health Care, Inc.

7405 N. University Street, Suite 1
Peoria, Illinois 6161
309-691-907
(Illinois) 800-322-162
(Iowa) 800-322-544
www.abortionaccessnhc.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 [redacted], R.N. As of October 3rd, 2011 she has completed 96 cases with my staff nurses.

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,

Margaret Van Duyn
Administrator

Exhibit A

[redacted]

Education: Methodist School of Nursing, Peoria, IL - Registered Nurse
graduated 1972

Employment: [redacted] (2003 to present)
Labor and Delivery Registered Nurse

[redacted] 972 to 2007)
Labor and Delivery Registered Nurse

[redacted] (1981 to present)
Registered Nurse

[redacted]
Registered Nurse

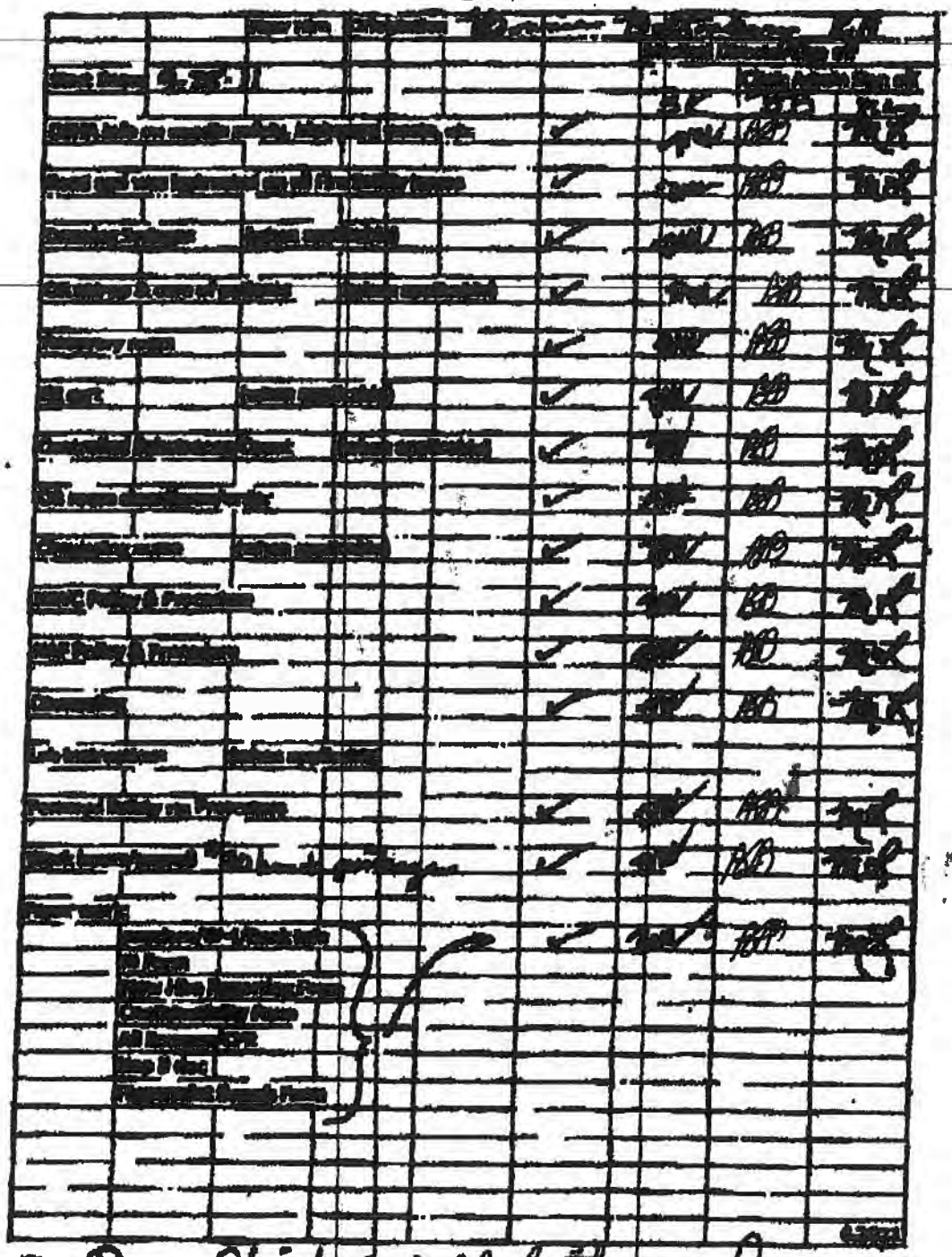
Experience: Counseling patients, Circulating in procedure rooms, insertion and administration of intravenous sedation and fluids, monitoring vital signs, recovering postsurgical patients, and various other nursing functions.

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

References: Available upon request

Exhibit B
1 of 2

BB RN



Dr. Dennis Christensen

BB Christensen, MD
Signature

[redacted]

Exhibit B

LAB

Pt #_____ Name _____ Age _____ Date ____/____/____

1. Preg test (NS)_____ Height _____ Weight _____ BP ____/____ Pulse_____ Hgb _____

Rh _____ Rho-gam _____ Leuk _____ Nitr _____ Prot _____ Glu _____ Initials _____

SONO

2. LNMP ____/____/____ Calc EGA _____ Gravida _____ Para _____ Prior Cesarean? (yes / no)

Sac _____ CRL _____ BPD _____ Gest. Age (U/S) _____ Cardiac Activity. (yes / no)

☐ **Long** ☐ **Transverse** **Placenta:** ☐ **Anterior** ☐ **Posterior** ☐ **yolk sac identified?**

☐ ectopic precautions given Sens preg test: _____ fetal number _____ sonographer initials ____

Physical exam

EGA: _____ Uterine position: Ant _____cm Mid _____cm Post ____cm Adnexa: nl___ abnl ___

Abnormalities noted: Heart _____ Lungs _____ Abd _____Pelvis _____

Procedure/ Post AB / Tissue Check

Start _____ Finish _____ Block _____

Paracervical Block: 1. 1% Lidocaine w/ atropine, buffered + 1 u vasopressin (up to 12 + 6 weeks)

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** laminaria ____inserted ____ removed Rhogam lot #_____

(exp. date: ____/____)

☐ Rhogam, micro ☐ Rhogam, full ☐ Atropine 0.4 mg ☐ Pitocin 10 u (I.C.) ☐ Methergine 0.2 mg IM

Location:_____ by: _____ int.

Total Volume _____	☐ Placenta	FF _____	Other _____
Tissue _____	☐ Fetus	LMP wks _____	_____
Fluid Est. _____	☐ Villi	Equivocal _____	_____
Measured _____	☐ Sac	Histologic _____	_____
EBL _____	☐ micro		

Impression: ☐ **Complete** ☐ **Scant tissue** ☐ **scant protocol initiated**

Patient tolerance: Good Easy Satisfactory Difficult Poor Complication

Comments: _____

_____

(Signature here indicates entire form has been reviewed and approved) _____ M.D./ D.O.

Nursing Notes

L.O.C Alert and responsive ☐ ☐ Stable to Recovery Walked to RR with assistance ☐

BP _____/_____ Pulse _____

Nursing Comments: _____

_____

_____

_____ Initials

Exhibit BB

NIWO

New Hire Orientation				Medical Director Sign off	
Start Date: 9-7-11			Staff Int	Med Dir	Clinic Admin Sign off
OSHA info on needle safety, bio-hazard waste, etc		✓	[illegible]	[illegible]	MK
Read and was instructed on all Fire Safety issues		✓	[illegible]	[illegible]	MK
Drawing Syringes	(when applicable)	✓	[illegible]	[illegible]	MK
OR set-up & care of patients	(when applicable)	✓	[illegible]	[illegible]	MK
Recovery room		✓	[illegible]	[illegible]	MK
ER cart	(when applicable)	✓	[illegible]	[illegible]	MK
Controlled Substances/Count	(when applicable)	✓	[illegible]	[illegible]	MK
OR room cleanliness/order		✓	[illegible]	[illegible]	MK
Circulating nurse	(when applicable)	✓	[illegible]	[illegible]	MK
NWC Policy & Procedure		✓	[illegible]	[illegible]	MK
NAF Policy & Procedure		✓	[illegible]	[illegible]	MK
Counseling		—			
Lab Instructions	(when applicable)	—			
Personal Safety etc Protections		✓	[illegible]	[illegible]	MK
Work hours/payroll	[illegible]				MK
Paper work:					
	Employee/W-4/Bank Info	✓	[illegible]	[illegible]	MK
	I9 Form	✓			MK
	New Hire Reporting Form	✓			MK
	Confidentiality Form	✓			MK
	All licenses/CPR	[illegible] ✓	[illegible]		
	Hep B doc	✓		[illegible]	MK
	Fingerprint Search Form	✓ [illegible]		[illegible]	MK
					6.2011

Dr Dennis Christensen [signature] MD

Signature

Exhibit C

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.

C N A

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 THE PATIENT'S CHOICE TO BE HERE TODAY? YES_____ NO_____** Staff Intl _____

Any Known Allergies: None ☐ List:_____

Medication Currently Taking: None ☐ _____

Is patient certain of Decision? ☐Yes ☐No If **NO** document _____

Children:_____ Vaginal_____ C-Section_____Complications? _____

Any Previous Abortions? #_____ Date of Last One:_____ Any Complications?_____

_____

_____

_____

Who accompanied you today? _____ Do they support you?_____

Birth Control: What birth control were you using? _____

Choice for birth control today? _____

On the signed order of the physicians, please give the following for surgical abortions only (circle ordering physician):

Dennis Christensen, MD	**Stewart Kernes, DO**		
✔ Misoprostol 200 mcg #2	Misoprostol 200 mcg #2	☐ **Laminaria consent**	Time Given: _____
12.0 weeks or greater	12.0 weeks or greater	☐ **Misoprostol consent**	Given by: _____
Route: Vaginally	Route: Vaginally		

✔ ☐ **Naproxen Sodium 220 mg #2** ☐ **ibuprofen suspension (100mg/5cc) 40 cc** Time Given: _____ Given by: _____

☐ Dr ☐ Preg ☐ Surg/Medical consent ☐ Alternative ☐ Procedure ☐ Rh ☐ After care +meds ☐ BC ☐ Emerg

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

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_____

Date_____ Counselor's signature_____

Suction D Ver 6/11

POST COUNSELING NOTES

Date: ___/___/___

Patient # _____ Patient Name: _____

MEDICATIONS / PT. ASSESSMENT

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

☐ Ergotrate 0.2 mg #9: Directions: First dose with next meal then three times daily until gone
Lot # _____ Exp Date _____ INITIALS: _____

☐ Scant/ Ectopic Precautions, if indicated ☐ Pregnancy Test

☐ Doxycycline 100 mg #6 Directions: Take one twice daily until gone
Lot # _____ Exp Date _____ INITIALS: _____

☐ Ampicillin 500 mg #_____ ☐ Bactrim DS #_____
Lot # _____ Exp Date _____ INITIALS: _____

Directions: _____

☐ Other _____ INITIALS: _____

BIRTH CONTROL / AFTERCARE

What BC does patient want to use: _____

_____

☐ Birth control pill: _____ Other: _____

_____

☐ LoEstrin 24 ☐ Lo-Loestin 24 ☐ BC Review ☐ Aftercare questions answered _____ **pt.initials**

☐ Nuva Ring #_____

☐ samples given with 6 months written refill

Comments: _____

_____

_____

DISCHARGE

Discharge Consent

I believe that I am ready to leave Northern Illinois Women's Center. I have received written instructions concerning my care, what to do concerning emergency care if a problem arises. I have received advice about contraception and follow-up. I will have a check-up and pregnancy test between 2 and 3 weeks. I agree to call the clinic if additional care is needed. **I will be leaving this facility with** _____

Patient Signature: _____

Discharged on the order of the attending physician. Patient ambulating without assistance.

_____ Physician Signature _____ Staff Initials

Exhibit F Rx 2 of 2

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. **Initial**
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. **Initial**

Recovery/Post Counseling

1. 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. **Initial**

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
1 of 4

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 G
2 of 4

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: M Larkin
Signature

Meg Larkin
Print Name

10·12·11
Date

10·12·11
Sent Signed copy to SAH Labs
10·12·11. Was advised she could take a few weeks for them to process & get back to us. Completed. MH

Exhibit G
4 of 4

APPLICATION FOR EMPLOYMENT

Equal Opportunity Employer

mileage to Peoria 133 miles.

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 [redacted] [redacted] [redacted]

(Last) (first) (Middle)

ADDRESS [redacted] CITY Rockford

STATE IL ZIP [redacted] TELEPHON [redacted]

(Area Code/Number)

Are you legally authorized to work in the US: Yes X No _____

POSITION DESIRED

POSITION R.N. SALARY/WAGES EXPECTED negotiable

DATE YOU CAN START Now

ARE YOU EMPLOYED NOW? No CAN WE QUESTION YOUR PRESENT EMPLOYER? —

HAVE YOU EVER APPLIED TO THIS COMPANY BEFORE? No

IF SO, WHERE? — WHEN? —

(Cont.)

EXHIBIT C

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.

EMPLOYMENT HISTORY

DATES	EMPLOYER AND ADDRESS	JOB TITLE/DESCRIPTION OF DUTIES
1. 07/05 TO 07/10	[redacted]	RN. intakes, lists, chart, Triage, office hysteroscopy, EMB, pap's etc.
2. 03/99 TO 04/2000		RN. intakes, assist c colpo cryo endo biopsy, chart Triage, lab.
3. 05/97 TO 05/99		Customer relations in person + via Telephone. Ob Gyn. guide + emotional supporter.
4. 03/1996 TO 09/1996		CNA - direct care of Nursing c-section, V.S. assist ADL's - lab draws.

EDUCATION ___ (Complete only if marked by prospective employer as required for position)

NAME OF SCHOOL	LOCATION	COURSE/DEGREE
Rock Valley College grad.	Rockford Rd. Rkfd, Il.	Assoc. in applied Science Nursing
Resume - attached.		

TRAINING OR SPECIAL STUDY ___ (Complete only if marked by prospective employer as required for position)

REFERENCES

Give the names of three persons not related to you, that you have known for at least one year.

NAME	ADDRESS	PHONE NO.	OCCUPATION	YEARS KNOWN
[redacted]	Rkfd, Il.	[redacted]	Receptionist	12 yrs
[redacted]	Rkfd, Il.	[redacted]	RN	17 yrs.
[redacted]	Rkfd, Il.	[redacted]	Instructor	3 yrs.

(Cont.)

LIST OF ESSENTIAL JOB-RELATED FUNCTIONS (These will be filled in by the prospective employer)

1. _____

2. _____

3. _____

4. _____

I CERTIFY THAT THE FACTS CONTAINED IN THIS APPLICATION ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND THAT, IF EMPLOYED, FALSIFIED STATEMENTS ON THIS APPLICATION SHALL BE GROUNDS FOR DISMISSAL.

I AUTHORIZE INVESTIGATION OF ALL STATEMENTS CONTAINED HEREIN AND THE REFERENCES LISTED ABOVE TO GIVE ANY AND ALL INFORMATION CONCERNING MY PREVIOUS EMPLOYMENT.

DATE: 08/31/[redacted] SIGNATURE: [redacted]

DO NOT WRITE BELOW THIS LINE - FOR EMPLOYER USE ONLY

INTERVIEWED BY: _____ DATE: _____

COMMENTS: _____

_____

_____

_____

HIRE: YES _____ NO _____

POSITION: _____ DEPARTMENT: _____

SALARY/WAGE: _____ REPORT DATE: _____

APPROVED: 1._____ 2._____ 3._____

Manager Dept. Head General Manager

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 alien, 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).

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent . . . . . A [redacted]

B Enter "1" if:
- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,000 or less. . . B [redacted]

C Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . . C [redacted]

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . . . D [redacted]

E Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . E [redacted]

F Enter "1" if you have at least $1,500 of **child or dependent care expenses** for which you plan to claim a credit . . F [redacted]
(**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G **Child Tax Credit** (including additional child tax credit). See Pub 972, Child Tax Credit, for more information.
- If your total income will be less than $57,000 ($85,000 if married), enter "2" for each eligible child.
- If your total income will be between $57,000 and $84,000 ($85,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have 4 or more eligible children. G [redacted]

FAXED By: IK Date: 7.9.11

H Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▶ H [redacted]

For accuracy, **complete all worksheets that apply.**
- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($25,000 if married) see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Cut here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4** — Department of the Treasury, Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074 20[redacted]

1 Type or print your first name and middle initial. [redacted] Last name [redacted]

2 Your social security number [redacted]

Home address (number and street or rural route) [redacted]

3 ☒ Single ☐ Married ☐ Married, but withhold at higher Single rate.
Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.

City or town, state, and ZIP code [redacted]

4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ ☐

5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2) 5 [redacted]

6 Additional amount, if any, you want withheld from each paycheck . . . . . 6 $ [redacted]

7 I claim exemption from withholding for 2007, and I certify that I meet **both** of the following conditions for exemption.
- Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability **and**
- This year I expect a refund of all federal income tax withheld because I expect to have **no** tax liability.

If you meet both conditions, write "Exempt" here . . . . . ▶ 7

Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature (Form is not valid unless you sign it.) ▶ [redacted] Date ▶ 09/07/11

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.) NIWC Rhnd, IL 61104

9 Office code (optional)

10 Employer identification number (EIN)

For Privacy Act and Paperwork Reduction Act Notice, see page 2. Cat. No. 10220Q Form **W-4** (2007)

2083

OMB No. 1615-0047; Expires 06/30/08

Department of Homeland Security
U.S. Citizenship and Immigration Services

Form I-9, Employment Eligibility Verification

Please read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins.

Print Name: Last	First	Middle Initial	Maiden Name
[redacted]	[redacted]	[redacted]	[redacted]

Address (Street Name and Number)	Apt. #	Date of Birth (month/day/year)
[redacted]		[redacted]

City	State	Zip Code	Social Security #
[redacted]	IL	[redacted]	[redacted]

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):
- [x] A citizen or national of the United States
- [ ] A lawful permanent resident (Alien #) A _____
- [ ] An alien authorized to work until _____

(Alien # or Admission #) _____

Employee's Signature	Date (month/day/year)
[redacted]	09/07/11

Preparer and/or Translator Certification. *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature	Print Name
M Larkin - NIWC	Meg Larkin - NIWC

Address (Street Name and Number, City, State, Zip Code)	Date (month/day/year)
1400 Broadway - Rkfd, IL 61107	9.7.11

Section 2. Employer Review and Verification. To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s).

List A	OR	List B	AND	List C
Document title:		Drivers License		SS card
Issuing authority:				
Document #:				
Expiration Date (if any):				
Document #:				
Expiration Date (if any):				

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* 9.7.11 **and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative	Print Name	Title
M Larkin	Meg Larkin	Director

Business or Organization Name and Address (Street Name and Number, City, State, Zip Code)	Date (month/day/year)
Northern IL Women's Center 1400 Broadway Rkfd 61104	9.7.11

Section 3. Updating and Reverification. To be completed and signed by employer.

A. New Name (if applicable)	B. Date of Rehire (month/day/year) (if applicable)

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.

Document Title: _____ Document #: _____ Expiration Date (if any): _____

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Date (month/day/year)

State of Illinois
Department of Employment Security

New Hire Reporting Form

Employers must report each new hire within 20 days. **Assistance: 1 800 327-HIRE (4473)**

Please print or type

EMPLOYER NAME AND ADDRESS

Federal Employer ID Number - FEIN [redacted]

Company Name Northern IL Women's Center

Street Address 1400 Broad Way

Street Address

City Rockford *State* IL *Zip Code* 61104 -

EMPLOYER ADDRESS FOR CHILD SUPPORT WAGE WITHHOLDING ORDERS

Street Address SAME

Street Address

City *State* *Zip Code* -

NEW EMPLOYEE NAME AND ADDRESS

Social Security Number [redacted] *Date of Hire (MM-DD-YYYY)* 09 - 07 - 2011

First Name [redacted] *MI* [redacted] *Last Name* [redacted]

Street Address [redacted]

City [redacted] *State* IL *Zip Code* [redacted] -

NEW EMPLOYEE NAME AND ADDRESS

Social Security Number *Date of Hire (MM-DD-YYYY)* - -

First Name *MI* *Last Name*

Street Address

City *State* *Zip Code* -

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

FAXED By: IK Date: 9.9.11

ALHF® Contact_us@CPRandFirstAid.net

Instructor

Student

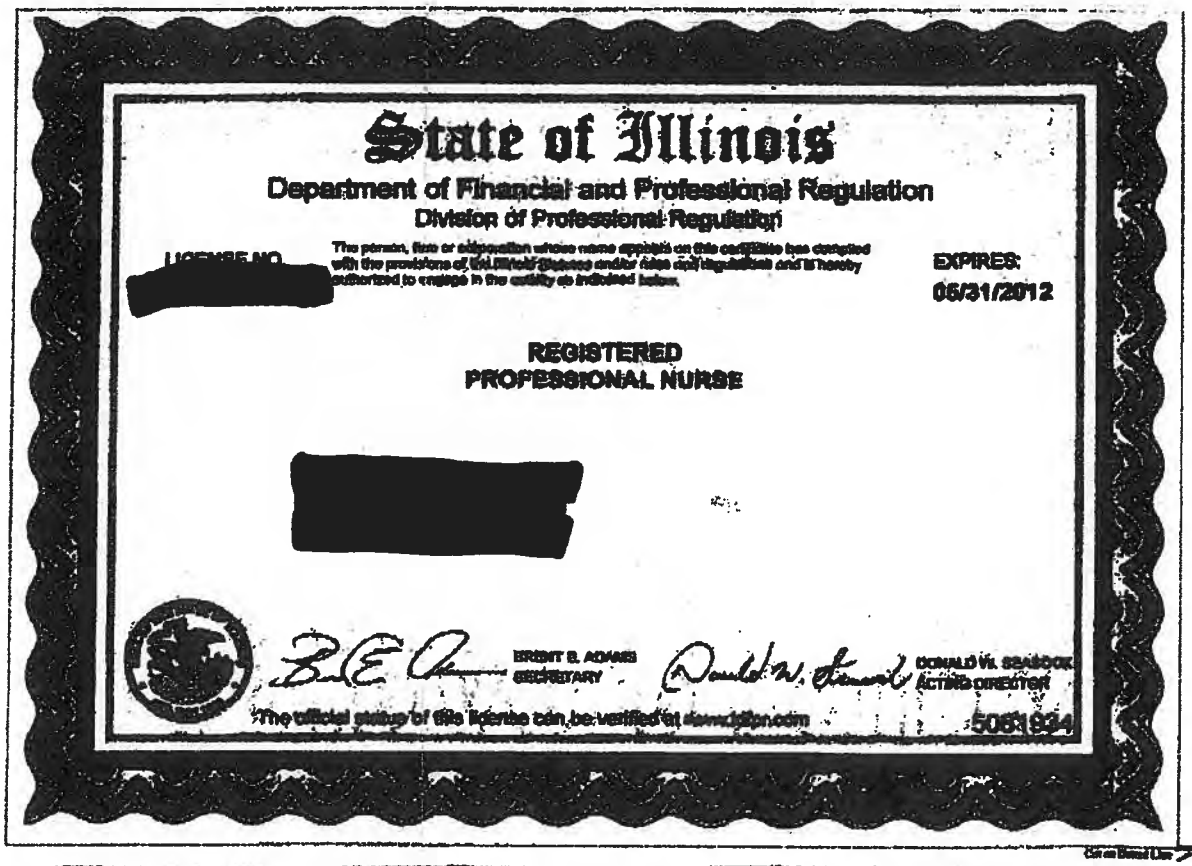
Online course presented by www.CPRandFirstAid.net

American Life & Health Foundation®

[redacted]

Has Satisfied the Requirements for Training Course in

Adult/Child/Infant CPR



State of Illinois

Department of Financial and Professional Regulation

Division of Professional Regulation

LICENSE NO. [redacted]

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

EXPIRES: 05/31/2012

REGISTERED PROFESSIONAL NURSE

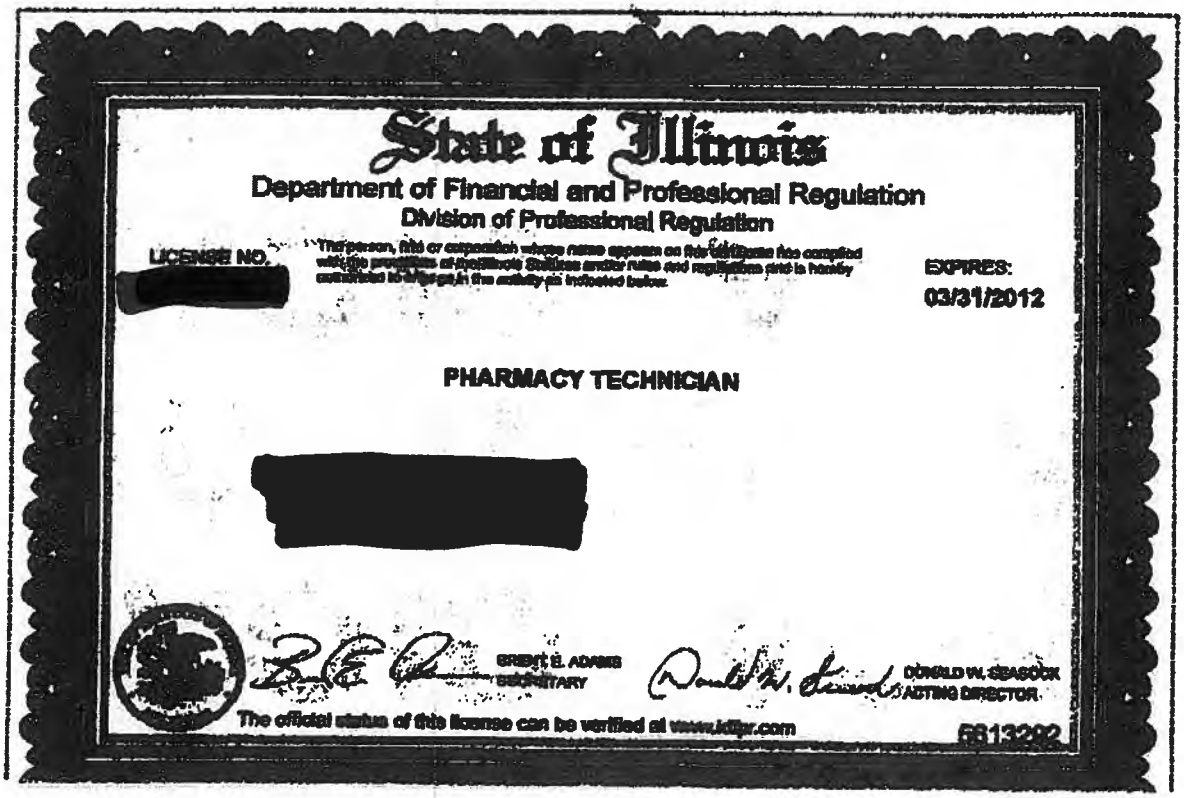
[redacted]

BRENT B. ADAMS SECRETARY

DONALD W. SEABOCK ACTING DIRECTOR

The official status of this license can be verified at [illegible].com

5061934



State of Illinois

Department of Financial and Professional Regulation

Division of Professional Regulation

LICENSE NO. [redacted]

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

EXPIRES: 03/31/2012

PHARMACY TECHNICIAN

[redacted]

BRENT B. ADAMS SECRETARY

DONALD W. SEABOCK ACTING DIRECTOR

The official status of this license can be verified at www.idfpr.com

6613292

Employment Application

Programs, services and employment are equally available to everyone. Please inform the Human Resources Department if you require reasonable accommodation for the application or interview.	Date of Interview (Month/Day/Year): 09/28/2011
Applicant Data	Position Applied for: RN.
How were you referred to us: National Health Care Peoria IL	

Full Name: [redacted]

Address [redacted] City: [redacted] State: IL [redacted]

Phone: Mobile/Pager/Other: [redacted] mail:

Date Available to Start: 9/28/11 Social Security Numbe [redacted] y Requirements: 30^{00}/hr + mileage

If you are under 18 years of age, can you provide a work permit? ☐ Yes ☐ No If no, please explain:

Have you ever worked for this company? ☒ Yes ☐ No If yes, when? The fall Dr. R passed

Are you a citizen of the United States? ☒ Yes ☐ No

If not, are you legally allowed to work in the United States? ☐ Yes ☐ No

Type of employment desired: ☐ Full-Time ☒ Part-Time ☐ Temporary ☐ Seasonal

Have you ever pleaded guilty, no contest or been convicted of a crime? ☐ Yes ☒ No If yes, give dates and details:

Answering yes to these questions does not constitute an automatic rejection for employment. Date of the offense, seriousness and nature of the violation, rehabilitation and position applied for will be considered.

Driver's license number (if applicable to position): State.

Summarize Your Special Skills or Qualifications

Worked counseling O.R., Recovery for National Health Care since 05/81
Circulated for deliveries & Caesarean Sections since 1972 to present
Vaginal

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 alien, 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).

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A 1
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,000 or less.	B 0
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C 0
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D 0
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E 1
F	Enter "1" if you have at least $1,500 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F 0
G	**Child Tax Credit** (including additional child tax credit). See Pub 972, Child Tax Credit, for more information. • If your total income will be less than $57,000 ($85,000 if married), enter "2" for each eligible child. • If your total income will be between $57,000 and $84,000 ($85,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have 4 or more eligible children.	G 0
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▶	H 2

For accuracy, complete all worksheets that apply.

- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($25,000 if married) see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

Cut here and give Form W-4 to your employer. Keep the top part for your records.

Form **W-4** — Department of the Treasury, Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2007

1 Type or print your first name and middle initial. [redacted] Last name [redacted] 2 Your social security number [redacted]

Home address (number and street or rural route) [redacted]

City or town, state, and ZIP code [redacted]

3 ☒ Single ☐ Married ☐ Married, but withhold at higher Single rate.
Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.

4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ ☐

5	Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)	5 2
6	Additional amount, if any, you want withheld from each paycheck	6 $ —
7	I claim exemption from withholding for 2007, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▶	7

Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature (Form is not valid unless you sign it.) ▶ [redacted] **Date** ▶ 9/29/11

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.) [redacted] | 9 Office code (optional) | 10 Employer identification number (EIN)

For Privacy Act and Paperwork Reduction Act Notice, see page 2. Cat. No. 10220Q Form **W-4** (2007)

OMB No. 1615-0047; Expires 06/30/08

Department of Homeland Security
U.S. Citizenship and Immigration Services

Form I-9, Employment Eligibility Verification

Please read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins.

Print Name: [redacted] Middle Initial [redacted] Maiden Name Same

Address (Street Name and Number) [redacted] Apt. # Date of Birth (month/day/year) [redacted]

City [redacted] State IL Zip Code [redacted] Social Security # [redacted]

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- [X] A citizen or national of the United States
- [ ] A lawful permanent resident (Alien #) A _____
- [ ] An alien authorized to work until _____ (Alien # or Admission #) _____

Employee's Signature [redacted] Date (month/day/year) 9/28/11

Preparer and/or Translator Certification. *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature | Print Name

Address (Street Name and Number, City, State, Zip Code) | Date (month/day/year)

Section 2. Employer Review and Verification. To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s).

List A	OR	List B	AND	List C
Document title:		license (DL) Or		
Issuing authority:		Voters Card		
Document #:				
Expiration Date (if any):				
Document #:				
Expiration Date (if any):				

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) 9-28-11 and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative | Print Name: Meg Larkin | Title: Clinic Director

Business or Organization Name and Address (Street Name and Number, City, State, Zip Code): Northern IL Women's Center, 1450 Broadway, Rockford 61104 | Date (month/day/year): 9-28-11

Section 3. Updating and Reverification. To be completed and signed by employer

A. New Name (if applicable) | B. Date of Rehire (month/day/year) (if applicable)

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.

Document Title: | Document #: | Expiration Date (if any):

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative | Date (month/day/year)

State of Illinois
Department of Employment Security

New Hire Reporting Form

Employers must report each new hire within 20 days. **Assistance: 1 800 327-HIRE (4473)**

Please print or type

EMPLOYER NAME AND ADDRESS

Federal Employer ID Number - FEIN [redacted]

Company Name Northern IL Women's Center

Street Address 1400 Broadway

Street Address

City Rockford *State* IL *Zip Code* 61104 -

EMPLOYER ADDRESS FOR CHILD SUPPORT WAGE WITHHOLDING ORDERS

Street Address SAME

Street Address

City *State* *Zip Code* -

NEW EMPLOYEE NAME AND ADDRESS

Social Security Number [redacted] *Date of Hire (MM-DD-YYYY)* 9 - 28 - 11

First Name [redacted] *MI* [redacted] *Last Name* [redacted]

Street Address [redacted]

City [redacted] *State* IL *Zip Code* [redacted] -

NEW EMPLOYEE NAME AND ADDRESS

Social Security Number *Date of Hire (MM-DD-YYYY)* - -

First Name *MI* *Last Name*

Street Address

City *State* *Zip Code* -

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

FAXED By: M
Date: 10-3-11

[redacted]

Healthcare Provider

American Heart Association.

PEEL HERE

[redacted]

This card certifies that the above individual has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association BLS for Healthcare Providers (CPR and AED) Program.

8-22-2011
Issue Date

8-2013
Recommended Renewal Date

Training Center Name IVCH

TC Info Pe[redacted] 9[redacted] 61354

Course Location IVCH - OB

Instructor Name [redacted]

Holder's Signature [redacted]

© 2011 American Heart Association Competing with this card will alter its appearance. 90-1891

This card contains unique security features to protect against forgery.

90-1891 3/11


State of Illinois
Department of Financial and Professional Regulation
Division of Professional Regulation
REGISTERED
PROFESSIONAL NURSE
LICENSE NO.
EXPIRES
5216134

ACLS Training Center

Advanced Cardiac Life Support

[redacted]

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

Aug 24, 2011
Date

Aug 24, 2013
Expiration Date

Region: US N1

Training Center: ACLS Training Center

Site: Northwest

Candidate's Signature:

ACLS Training Center

LabCorp
Laboratory Corporation of America

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,

[redacted]

Laboratory Corporation of America Holdings
Contracts Department, Central Division

Enclosures

[redacted]

LABORATORY SERVICES AGREEMENT

THIS AGREEMENT made this 1st day of December, 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.

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

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: Meg 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

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").

19. MODIFICATION

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: [redacted]

Print Name: [redacted]

Date: 12/6/11

CLIENT:
Northern Illinois Women's Center, LTD.

By: M Larkin

Print Name: Meg Larkin

Date: 12 · 1 · 11

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

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

Dear [redacted]

Laboratory Corporation of America, in Dublin, Ohio under the direction of [redacted] is accredited by the College of American Pathologists' Laboratory Accreditation Program.

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.

Sincerely,

[redacted]
Laboratory Accreditation Programs
College of American Pathologists

Ref: STILACCRED

CENTERS FOR MEDICARE & MEDICAID SERVICES

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF ACCREDITATION

LABORATORY NAME AND ADDRESS

LABORATORY CORPORATION OF AMERICA
6370 WILCOX ROAD
DUBLIN, OH 43016

CLIA ID NUMBER
36D0327333

EFFECTIVE DATE
06/14/2011

EXPIRATION DATE
06/13/2013

LABORATORY DIRECTOR
[redacted]

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

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

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

157 certs2_052111

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

LAB CERTIFICATION (CODE)	EFFECTIVE DATE
BACTERIOLOGY (110)	06/14/1995
MYCOBACTERIOLOGY (115)	06/14/1995
MYCOLOGY (120)	06/14/1995
PARASITOLOGY (130)	06/14/1995
VIROLOGY (140)	06/14/1995
SYPHILIS SEROLOGY (210)	06/14/1995
GENERAL IMMUNOLOGY (220)	06/14/1995
ROUTINE CHEMISTRY (310)	06/14/1995
URINALYSIS (320)	06/14/1995
ENDOCRINOLOGY (330)	06/14/1995
TOXICOLOGY (340)	06/14/1995
HEMATOLOGY (400)	06/14/1995
ABO & RH GROUP (510)	06/14/1995

LAB CERTIFICATION (CODE)	EFFECTIVE DATE
ANTIBODY TRANSFUSION (520)	06/14/1995
ANTIBODY NON-TRANSFUSION (530)	06/14/1995
ANTIBODY IDENTIFICATION (540)	06/14/1995

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.

Advancing Excellence

Accredited Laboratory

The College of American Pathologists

certifies that the laboratory named below

Laboratory Corporation of America
Dublin, Ohio

[redacted]

LAP Number: 1635001
AU-ID: 1182090
CLIA Number: 36D0327333

has met all applicable standards for accreditation and is hereby fully accredited by the College of American Pathologists' Laboratory Accreditation Program. Reinspection should occur prior to September 20, 2013 to maintain accreditation.

Accreditation does not automatically survive a change in director, ownership, or location and assumes that all interim requirements are met.

Frank R Rudy
Chair, Commission on Laboratory Accreditation

Stephen M Bacon MD FCAP
President, College of American Pathologists

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: [redacted]

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**
SPECIALTY:	**GYNECOLOGY**
APPOINTMENT DATE:	**APRIL 1994 - PRESENT**
STAFF CATEGORY:	**ACTIVE**

[redacted] 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,

[redacted]

Medical Staff Coordinator

[redacted]

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.Sinai 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: [redacted]

ISMIE
Mutual Insurance Company
Twenty North Michigan Avenue
Suite 700 Chicago, Illinois 60602
Telephone 312-782-2949
Toll Free 800-782-4767
Fax 312-782-3023
Web www.ismie.com

Policyholder: [redacted]
Policy Number: [redacted]
Billing Period: 10/01/2011 - 01/01/2012
Invoice Type: Installment
Due Date: 10/01/2011
Date prepared: 08/29/2011

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	$66,488.00
Part Time Amount	-$26,595.00
Adjusted Base Premium	$39,893.00
Loss Free Discount	-$7,779.00
Total Annual Premium	$32,114.00

Total Annual Premium	$32,114.00
Total billed to date for this policy period	$8,028.50
Balance to be billed	$24,085.50

Current Quarterly Installment:(2 of 4)	$8,028.50
Total Due:	**$8,028.50**

ISMIE Tip: Did you know that online premium payments are now available? To pay your premiums online simply log onto www.ismie.com - go to your MyISMIE screen and select the "Pay My Premium" option. Should you encounter difficulties during the process or have questions, please contact our Underwriting Division at 800-782-4767 or underwriting@ismie.com

State of Illinois
Department of Financial and Professional Regulation
Division of Professional Regulation

LICENSE NO. [redacted]

LICENSED PHYSICIAN AND SURGEON
CONTROLLED SUBSTANCE
IIN II III IV V IIIN

[redacted]

EXPIRES:
07/31/2014

BRENT E. ADAMS
SECRETARY

DONALD W. SEASOCK
ACTING DIRECTOR

The official status of this license can be verified at www.idfpr.com

5770758

State of Illinois
Department of Financial and Professional Regulation
Division of Professional Regulation

LICENSE NO. [redacted]

LICENSED
PHYSICIAN AND SURGEON

[redacted]

EXPIRES:
07/31/2014

SIGN [redacted]

BRENT E. ADAMS
SECRETARY

DONALD W. SEASOCK
ACTING DIRECTOR

The official status of this license can be verified at www.idfpr.com

5769618

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	01-31-2012	Paid

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2,2N,3 3N,4,5	PRACTITIONER	12-04-2008

[redacted]

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 Credentia[redacted], MD[redacted]me to our facility on October 29th. He brought with him the following documentation.

Current Illinois License
DEA Number

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

On October 31, 2011[redacted]xed his Resume and his Malpractice insurance. Then on November 1, NIWC received a letter from Methodist Hospital in Chicago stating he has surgical privileges and is in good standing with them.

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

Credentialing Meeting Adjourned @ 2:30 pm.

Nov 1, 2011
Date

Dennis Christensen, MD

Stewart Kernes, DO

Meg Larkin