

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7001613111 (X2) MULTIPLE CONSTRUCTION A. BUILDING \_\_\_\_\_ B. WING \_\_\_\_\_ (X3) DATE SURVIV COMPLETED 05/31/95-Revisit

NAME OF PROVIDER OR SUPPLIER ACCESS HEALTH CENTRE LTD. STREET ADDRESS, CITY, STATE, ZIP CODE 1700 75TH STREET DOWNERS GROVE, IL 60516

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

WEND TAG: INITIAL COMMENTS

A 000

SURVIVOR: 07113 TAG 205.1310 Plant & Service Reqt

ALL AMBULATORY SURGICAL TREATMENT CENTERS ARE REQUIRED TO MEET THE FOLLOWING PHYSICAL, PLANT AND SERVICE REQUIREMENTS.

205.1310 (AS AMENDED 12/1/94) SECTION 12-6 AND 13-6 OF NFPA-101 ARE REFERENCED FOR NEW AND EXISTING AMBULATORY SURGICAL TREATMENT CENTERS.

Facility does not comply with the referenced standards as evidenced by:

K21 13-6.2.11.5 Any door with a required fire protection rating, such as stairways, smoke barriers or hazardous areas, if held open, is arranged automatically arranged to close by activation of the fire alarm system.

Facility does not comply

1. The smoke door to the staff

See attached Plan of Correction K21 13-6.2-11.5 Door Closures

6/23/95

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

TITLE

(X6) DATE

*Lisa L. Shyne*  
Statement of Deficiencies and Plan of Correction

RECEIVED

Executive Director 6-14-95

JUN 21 1995

STATE FORM

ILLINOIS DEPARTMENT OF PUBLIC HEALTH FACILITIES STANDARDS

If continuation sheet Page 1 of 1

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

ALL  
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7001613111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/31/95-Revision
---	---	--	--

NAME OF PROVIDER OR SUPPLIER  
ACCESS HEALTH CENTER LTD.

STREET ADDRESS, CITY, STATE, ZIP CODE  
1700 75TH STREET DOWNERS GROVE, IL 60516

1. ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
------------------------	--	---------------------	--	----------------------------

1. 000 1 Continued From Page 1 )  
lounge has a closer, however  
the closing device does not  
always close the door  
automatically and provider's  
staff deliberately prevents the  
door from closing to latch.

2) The mechanical room door does  
not always close to latch.

K15 13-6.3.7.2 Ambulatory Surgical  
Treatment Centers are divided into at  
least two smoke compartments with  
smoke barriers having at least a  
one-hour fire resistance rating.  
Doors (openings) in smoke barriers  
shall have at least a 20-minute fire  
protection rating and are equipped  
with closing devices. Vision panels  
are provided and are fixed wire  
glass.

Facility does not comply

1) The smoke barrier has two  
pass-through windows (steel  
frame with steel glides and  
wire glass horizontal sliding  
panels). The pass-through  
windows are not automatically  
self closing.

The provider currently has an  
interim plan to have staff keep  
the windows closed at all times  
except when items are passing  
through the opening. The  
provider needs to resubmit this  
interim plan with this Plan of  
Correction. This deficiency  
will be reviewed for compliance

See attached Plan of Correction  
K15 13-6.2.7.2 Pass through  
Windows

5/15/94

## ILLINOIS DEPARTMENT OF PUBLIC HEALTH

ALL  
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7001613111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/31/95-Revisit
---	---	--	---

NAME OF PROVIDER OR SUPPLIER ACCESS HEALTH CENTER LTD.	STREET ADDRESS, CITY, STATE, ZIP CODE 1700 75TH STREET DOWNERS GROVE, IL 60516
---	---

1. ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
------------------------	--	---------------------	--	----------------------------

1.000 (Continued From Page 2)

with the interim plan, changes  
in the facility or  
interpretation of the  
requirement at each future  
survey.

K50 31-4.1.3 Fire drills are held at  
unexpected times under varying  
conditions, at least quarterly on each  
shift. The staff is familiar with  
procedures and is aware that drills  
are part of established routine.

Facility does not comply

1) The provider did not follow  
their last proposed plan of  
correction and does not hold  
quarterly drills for each  
shift. Instead, the provider  
holds drills when both shifts  
are present.

a) Drills are not held at  
varying times and are not held  
to simulate situations where  
personnel from only one shift  
is present.

b) Fire alarm must be  
activated and documentary with  
all fire drills.

K51 31-1.3 Fire alarm system is not  
tested, serviced and maintained,  
annually, in accordance with NFPA 72.

Facility does not comply

1) Documentation of fire alarm  
testing was reviewed for the

See attached Plan of Correction  
K50 31-4.1.3 Fire Drill/Alarm  
Inspection Paragraph 1

6/26/95

See attached Plan of Correction  
K50 31-4.1.3 Fire Drill/Alarm  
Inspections Paragraph 2

If continuation sheet Page 3 of 4

## ILLINOIS DEPARTMENT OF PUBLIC HEALTH

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7001613111 (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 05/31/95-REVISI

NAME OF PROVIDER OR SUPPLIER ACCESS HEALTH CENTER LTD. STREET ADDRESS, CITY, STATE, ZIP CODE 1700 75TH STREET DOWNS GROVE, IL 60516

PREVIOUS TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------	--	---------------	---	----------------------

000 (Continued From Page 3)  
past 12 months. While the documentation indicates that "Wells Fargo" is doing something on a regular basis (most likely quarterly), the documentation does not indicate the extent, number of devices or give any indication as to what was performed.

2) Cleaning and servicing other than repairs is not documented.

3) References to NFPA 72 or other recognized standards for testing, etc. is not included.

4) The surveyor cannot verify that every component and device has been tested and/or cleaned in accordance with the identified standard.

K72 31-1.2.2.1 No furnishings, decorations or other objects are placed as to obstruct exits or visibility of exits.

Facility does not comply

1) The existing surgical suite corridor is 5'-0" wide (min. req'd). However the corridor width is reduced by a shelf unit, a bio-hazard waste box and a wheel chair.

Lynn W. Hanley  
Staff Architect  
5/31/95

See attached Plan of Correction  
K72 31-1.2.2.1 Obstruction of Exits/  
Corridors

6/1/95

**STATEMENT OF DEFICIENCIES NOTED BY STAFF ARCHITECT**  
**PLAN OF CORRECTION**

**K21 13-6.2-11.5      Door Closures**

The state noted the door to the staff lounge which is within the smoke wall, as well as the mechanical room door, have closing devices that do not always close automatically. Too perhaps, center staff may at times deliberately prevent the doors from closing with the use of a door stop. To correct this deficiency the closures shall be readjusted so the doors always close to latch. Also, all door stops will be removed from the facility. This action will occur on or before June 23, 1995. The facility Administrator will oversee this matter and ensure the participation of all staff.

**K15 13-6.2.7.2      Pass through Windows**

As suggested by the surveyors report, the facility is resubmitting the interim plan pertaining to the closure of the pass through windows. This is to be reviewed for compliance and interpretation of this requirement by the architectural department of IDPH. We have continually maintained compliance as stated on the POC dated May 15, 1994, to ensure closure of windows at all times by all staff members when windows are not immediately in use. (Please see Exhibits A & B attached.)

**K50 31-4.1.3      Fire Drill/Alarm Inspections**

The State noted the center failed to comply with protocol requiring that separate fire drills for each staff shift be held. The center in fact held a drill at a time encompassing personnel of both shifts. In order to more efficiently meet compliance, the facility Administrator will ensure quarterly drills be held at varying times (each shift) and will simulate situations where personnel from only one shift are present. Furthermore, beginning at the next scheduled drill the Downers Grove Fire Department will be notified of such, in order to fully activate fire alarm system. The next fire drill will be held on June 26, 1995, at 10:30 a.m. and 2:30 p.m.

State also noted that the facilities quarterly inspections of Alarm systems were not documented with adequate detail. To rectify this citation, the facility Office Manager has supplied the alarm company, Wells Fargo with the NFPA 72 Figure 7-5.1 Inspection and Testing Form as well as an Alarm System and Maintenance Report, and will make sure that future thorough documentation is made upon inspection and cleaning, beginning at the June 2, 1995 inspection. (Please see Exhibit C & D attached.)

**K72 31-1.2.21      Obstruction of Exits/Corridors**

According to the surveyor the surgical suite corridor width is reduced by the following items: shelf unit, biohazard waste box, and a wheel chair. These items have been removed as of June 1, 1995. The Director of Nursing will oversee this area to be sure it remains free from any type of obstruction in the future.

Exhibit A

Plan of Correction submitted to IDPH on May 15, 1994

(1) Two Pass Windows in Smoke Wall had Wood and Aluminum Frames and No Provision for Automatic Closing

The State noted that two pass windows in the smoke barrier wall had frames comprised of wood and aluminum and no provision for self-closing. To rectify this situation, we have contacted a General Contractor regarding replacement of the wood frames and aluminum runners of the windows with steel materials which are more appropriate for existence in a fire wall. The work will be completed by June 30, 1994. An internal memorandum addressing this issue will be circulated by May 15, 1994. Said memorandum will advise staff as to our protocol requiring these windows to remain closed at all times unless they are in immediate use, and each staff member will be required to initial the document as proof of their understanding of its contents.





**Access**  
HEALTH CENTER, LTD.

1700 75th Street • Downers Grove, IL 605  
708-964-0000 • Fax 708-964-00

Exhibit B

MEMORANDUM

To: All Staff  
From: Administration/A.B.  
Date: May 14, 1994  
Re: New Policy

Effective immediately this is to advise all staff of our protocol pertaining to the two (2) sliding glass windows located in the east surgical corridor. They are to remain closed at all times unless they are in immediate use.

Thank you for your cooperation in this matter.

Please initial after reading and understanding.

AB	SD
TV	LT
CW	PP
CA	SS
EA	CG
KBAW	DA
MC	RD
	BN



## INSPECTION, TESTING, AND MAINTENANCE

## INSPECTION AND TESTING FORM

DATE: \_\_\_\_\_

TIME: \_\_\_\_\_

## SERVICE ORGANIZATION

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

REPRESENTATIVE: \_\_\_\_\_

LICENSE NO.: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

## MONITORING ENTITY

CONTACT: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

MONITORING ACCOUNT REF. NO.: \_\_\_\_\_

## TYPE TRANSMISSION

- ☐ - McCulloh  
☐ - Multiplex  
☐ - Digital  
☐ - Reverse Priority  
☐ - RF  
☐ - Other (Specify) \_\_\_\_\_

## PROPERTY NAME (USER)

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

OWNER CONTRACT: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

## APPROVING AGENCY

CONTACT: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

## SERVICE

- ☐ - Weekly  
☐ - Monthly  
☐ - Quarterly  
☐ - Semi-Annually  
☐ - Annually  
☐ - Other (Specify) \_\_\_\_\_

PANEL MANUFACTURE: \_\_\_\_\_

CIRCUIT STYLES: \_\_\_\_\_

NO. OF CIRCUITS: \_\_\_\_\_

SOFTWARE REV.: \_\_\_\_\_

LAST DATE SYSTEM HAD ANY SERVICE PERFORMED: \_\_\_\_\_

LAST DATE THAT ANY SOFTWARE OR CONFIGURATION WAS REVISED: \_\_\_\_\_

MODEL NO.: \_\_\_\_\_

## ALARM INITIATING DEVICES AND CIRCUIT INFORMATION

## QTY OF

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## CIRCUIT STYLE

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MANUAL STATIONS  
ION DETECTORS  
PHOTO DETECTORS  
DUCT DETECTORS  
HEAT DETECTORS  
WATERFLOW SWITCHES  
SUPERVISORY SWITCHES  
OTHER: (SPECIFY) \_\_\_\_\_

Figure 7-5.1 Inspection and Testing Form.

[New figure]

1993 Edition

## ALARM INDICATING APPLIANCES AND CIRCUIT INFORMATION

QTY OF	CIRCUIT STYLE	
_____	_____	BELLS
_____	_____	HORNS
_____	_____	CHIMES
_____	_____	STROBES
_____	_____	SPEAKERS
_____	_____	OTHER: (SPECIFY) _____
_____	_____	_____

NO. OF ALARM INDICATING CIRCUITS: \_\_\_\_\_

ARE CIRCUITS SUPERVISED? ☐ YES ☐ NO

## SUPERVISORY SIGNAL INITIATING DEVICES AND CIRCUIT INFORMATION

QTY OF	CIRCUIT STYLE	
_____	_____	BUILDING TEMP.
_____	_____	SITE WATER TEMP.
_____	_____	SITE WATER LEVEL
_____	_____	FIRE PUMP POWER
_____	_____	FIRE PUMP RUNNING
_____	_____	FIRE PUMP AUTO POSITION
_____	_____	FIRE PUMP OR PUMP CONTROLLER TROUBLE
_____	_____	FIRE PUMP RUNNING
_____	_____	GENERATOR IN AUTO POSITION
_____	_____	GENERATOR OR CONTROLLER TROUBLE
_____	_____	SWITCH TRANSFER
_____	_____	GENERATOR ENGINE RUNNING
_____	_____	OTHER: _____
_____	_____	_____

## SIGNALING LINE CIRCUITS

Quantity and style (See NFPA 72, Table 3-6.1) of signaling line circuits connected to system:

Quantity \_\_\_\_\_ Style(s) \_\_\_\_\_

## SYSTEM POWER SUPPLIES

- a. Primary (Main): Nominal Voltage \_\_\_\_\_, Amps \_\_\_\_\_  
 Overcurrent Protection: Type \_\_\_\_\_, Amps \_\_\_\_\_  
 Location (Panel Number): \_\_\_\_\_  
 Disconnecting Means Location: \_\_\_\_\_

Figure 7-6.1 Inspection and Testing Form. (cont.)

[New Figure]

## b. Secondary (Standby):

Storage Battery: Amp-Hr. Rating \_\_\_\_\_

Calculated capacity to operate system, in hours: \_\_\_\_\_ 24 \_\_\_\_\_ 60 \_\_\_\_\_

\_\_\_\_\_ Engine-driven generator dedicated to fire alarm system:

Location of fuel storage: \_\_\_\_\_

## TYPE BATTERY

☐ Dry Cell☐ Nickel Cadmium☐ Sealed Lead-Acid☐ Lead-Acid☐ Other (Specify) \_\_\_\_\_

## c. Emergency or standby system used as a backup to primary power supply, instead of using a secondary power supply:

\_\_\_\_\_ Emergency system described in NFPA 70, Article 700

\_\_\_\_\_ Legally required standby described in NFPA 70, Article 701

\_\_\_\_\_ Optional standby system described in NFPA 70, Article 702, which also meets the performance requirements of Article 700 or 701.

## PRIOR TO ANY TESTING

## NOTIFICATIONS ARE MADE:

	YES	NO	WHO	TIME
MONITORING ENTITY	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
BUILDING OCCUPANTS	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
BUILDING MANAGEMENT	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
OTHER (SPECIFY)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
AHJ (NOTIFIED) OF ANY IMPAIRMENTS	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

## SYSTEM TESTS AND INSPECTIONS

TYPE	VISUAL	FUNCTIONAL	COMMENTS
CONTROL PANEL	<input type="checkbox"/>	<input type="checkbox"/>	_____
INTERFACE EQ.	<input type="checkbox"/>	<input type="checkbox"/>	_____
LAMPS/LEDS	<input type="checkbox"/>	<input type="checkbox"/>	_____
FUSES	<input type="checkbox"/>	<input type="checkbox"/>	_____
PRIMARY POWER SUPPLY	<input type="checkbox"/>	<input type="checkbox"/>	_____
TROUBLE SIGNALS	<input type="checkbox"/>	<input type="checkbox"/>	_____
DISCONNECT SWITCHES	<input type="checkbox"/>	<input type="checkbox"/>	_____
GROUND FAULT MONITORING	<input type="checkbox"/>	<input type="checkbox"/>	_____

TYPE	VISUAL	FUNCTIONAL	COMMENTS
BATTERY CONDITION	<input type="checkbox"/>	<input type="checkbox"/>	_____
LOAD VOLTAGE		<input type="checkbox"/>	_____
DISCHARGE TEST		<input type="checkbox"/>	_____
CHARGER TEST		<input type="checkbox"/>	_____
SPECIFIC GRAVITY		<input type="checkbox"/>	_____

Figure 7-5.1 Inspection and Testing Form. (cont.)

[New figure]

TRANSIENT SUPPRESSORS  
 REMOTE ANNUNCIATORS  
 NOTIFICATION APPLIANCES  
 AUDIBLE  
 VISUAL  
 SPEAKERS  
 VOICE CLARITY

☐  
☐  
☐  
☐  
☐  
☐

## INITIATING AND SUPERVISORY DEVICE TESTS AND INSPECTIONS

LOC. & S/N	DEVICE TYPE	VISUAL CHECK	FUNCTIONAL TEST	FACTORY SETTING	MEAS. SETTING	PASS	FAIL
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

COMMENTS: \_\_\_\_\_

## EMERGENCY COMMUNICATIONS EQUIPMENT

PHONE SET  
 PHONE JACKS  
 OFF-HOOK INDICATOR  
 AMPLIFIER(S)  
 TONE GENERATOR(S)  
 CALL IN SIGNAL  
 SYSTEM PERFORMANCE

VISUAL

FUNCTIONAL

COMMENTS

☐  
☐  
☐  
☐  
☐  
☐  
☐

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## INTERFACE EQUIPMENT

(SPECIFY) \_\_\_\_\_  
 (SPECIFY) \_\_\_\_\_  
 (SPECIFY) \_\_\_\_\_

VISUAL

DEVICE OPERATION

SIMULATED OPERATION

☐  
☐  
☐

☐  
☐  
☐

## SPECIAL HAZARD SYSTEMS

(SPECIFY) \_\_\_\_\_  
 (SPECIFY) \_\_\_\_\_  
 (SPECIFY) \_\_\_\_\_

☐  
☐  
☐

☐  
☐  
☐

Figure 7-5.1 Inspection and Testing Form. (cont.)

[New figure]

SPECIAL PROCEDURES: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_COMMENTS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ON/OFF PREMISES MONITORING:	YES	NO	TIME	COMMENTS
ALARM SIGNAL	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
ALARM RESTORAL	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
TROUBLE SIGNAL	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
SUPERVISORY SIGNAL	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
SUPERVISORY RESTORAL	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

NOTIFICATIONS THAT TESTING IS COMPLETE:

	YES	NO	WHO	TIME
BUILDING MANAGEMENT	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
MONITORING AGENCY	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
BUILDING OCCUPANTS	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
OTHER (SPECIFY)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

THE FOLLOWING DID NOT OPERATE CORRECTLY: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SYSTEM RESTORED TO NORMAL OPERATION: DATE \_\_\_\_\_ TIME \_\_\_\_\_

THIS TESTING WAS PERFORMED IN ACCORDANCE WITH APPLICABLE NFPA STANDARDS.

NAME OF INSPECTOR: \_\_\_\_\_

TIME: \_\_\_\_\_

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

NAME OF OWNER OR REPRESENTATIVE: \_\_\_\_\_

TIME: \_\_\_\_\_

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

Figure 7-5.1 Inspection and Testing Form. (cont.)

{New figure}

DEPARTMENT OF HEALTH SERVICES  
DIVISION OF HEALTH FACILITIES STANDARDS  
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

P195

☒ ASTC ☐ IHA ☐ IHO ☐ HOSPICE ☐ HOSPITAL

NAME AND ADDRESS OF FACILITY: *Academy Street Center, 1708 W 75th St, Duquesne, PA 15116*

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 a)	<p><i>Having Personnel</i></p> <p><i>Found in a review of personnel files that the facility failed to ensure that the professional nurse has the qualifications for the position she is currently engaged.</i></p> <p><i>Findings include</i></p> <p><i>1 B.S. is an L.P.N. Her personnel file contains the job description "The Clinical Nurse Coordinator." The job description is signed by "B.S."</i></p> <p><i>The job description for Clinical Nurse Coordinator included the necessary qualifications for graduate of a</i></p>	<p>Our clinical coordinator job description has been revised to reflect the qualifications of our Staff Licensed Practical Nurse, B.S.</p>	October 2, 1998

DATE OF SURVEY: *10-01-98* by *Wayne J. Gant, R.N.* SURVEYOR

IF PLY. INDICATE DATE OF PRIOR SURVEY: *10/19/98* DATE

*Wayne J. Gant, R.N.*  
PROVIDER'S REPRESENTATIVE

DEPARTMENT OF HEALTH & HUMAN SERVICES  
 DIVISION OF HEALTH FACILITIES STANDARDS  
 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

1275

<input checked="" type="checkbox"/> LTC <input type="checkbox"/> HHA <input type="checkbox"/> IPFO <input type="checkbox"/> NURSING HOME <input type="checkbox"/> HOSPITAL	
NAME AND ADDRESS OF FACILITY <u>Greenwood Senior Center, 1700 W 45th St, Duquesne, Pa 15116</u>	
LIST RULE VIOLATED 265.33g of	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG <p>           Prepared School of Nursing &amp; Health Science in W. R.N., at least one year of nursing supervisory experience. NRS has none of the qualifications.            3) The administrator stated that an incorrect job description was placed in the file &amp; it should have been "Clinical Coordinator". On 10-1-98 the job description for "Clinical Coordinator" could not be found &amp; was not submitted.            3. "I, the nurse practitioner, does not have a valid current CPR credential. Faculty policy requires staff to have current CPR         </p>
PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE 2. New Clinical Coordinator job description is attached as exhibit III. <span style="float: right;">October 2, 1998</span>  3. A "CPR" re-certification class has been scheduled for October 26, 1998. <span style="float: right;">October 26, 1998</span>

DATE OF SURVEY 10-01-98 by Maureen O'Connell  
 SUPERVISOR  
 IF PLY. INDICATE DATE OF PRIOR SURVEY: 10-9-98  
 1/87

PROVIDER'S REPRESENTATIVE  
[Signature]  
 DATE 10-9-98



INSTRUCTIONS FOR SURVEILLANCE OF A PUBLIC HEALTH  
DIVISION OF HEALTH FACILITIES STANDARDS  
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

P. 395

<input checked="" type="checkbox"/> ASTC	<input type="checkbox"/> HHA	<input type="checkbox"/> IDHO	<input type="checkbox"/> HOSPICE	<input type="checkbox"/> HOSPITAL
NAME AND ADDRESS OF FACILITY <i>Deer Creek Health Center, Ltd. 1740 W 75th St. Downers Grove, IL 60516</i>				
LIST RULE VIOLATED  305.710(b)	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG  <i>Limited Procedures Specialty Center Not less than 3 recovery -- chairs shall be required for each procedure room. --- furnished as more than 2 procedures per hour will be performed per procedure room -- there only two chairs will be required per room. This requirement is not met: Based on an interview with the administrator she stated that they have 2 and 1/2 procedure rooms. They need 6 chairs. She also stated that the procedure room allowed them to do 1 procedure per hour in the big room. --- Furniture include</i>	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE	

DATE OF SURVEY 10-31-98 BY Mary J. Grand  
IF PLAN INDICATE DATE OF PRIOR SURVEY: 11/87  
PROVIDER'S SIGNATURE [Signature]  
DATE 10-9-98

ILLINOIS DEPARTMENT OF CORRECTIONS

DIVISION OF HEALTH FACILITIES STANDARDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

P495

☒ ASTC ☐ IDMC ☐ HOSPICE ☐ HOSPITAL

NAME AND ADDRESS OF FACILITY  
*Deerwood Health Center, Inc.  
 1705 W 75th St  
 Duquoin, Ill. 62516*

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
705.711(b) ant. 2	<p>1. On 10-1-98 - there (3) procedure rooms were set up &amp; ready for use for terminative procedure.</p> <p>2. On 10-1-98 the facility staff were unable to present a narrative program that provided that no more than two procedure per hour would be performed per procedure room.</p> <p>3. The recovery room has 7 lounge chairs for the 3 procedure room.</p> <p>4. One of the chairs is placed immediately next to another recovery chair, side of chairs touching. That the adjacent space requirement was not present in 10-1-98</p> <p>5. The recovery chairs were</p>	<p>1. Based on correspondence with Don Jardine of the Illinois Department of Public Health on November 25, 1991 and again on December 3, 1991, our facility is licensed with one (1) full time and two (2) part time Operating Rooms. See Exhibits II and III attached.</p> <p>2. By part time Operating Rooms, we only perform an average of two (2) procedures per hour in these rooms.</p> <p>3. Seven (7) lounge chairs in the Recovery Room are adequate in the Recovery Room per Illinois Department of Public Health code 205.710b-7.</p> <p>4. Recovery Room chairs have been re-arranged to meet the states spacing requirements.</p>	<p>October 1, 1998</p> <p>October 1, 1998</p> <p>October 1, 1998</p> <p>October 1, 1998</p>

DATE OF SURVEY \_\_\_\_\_ by SURVEYOR \_\_\_\_\_  
 IF PLY, INDICATE DATE OF PRIOR SURVEY: \_\_\_\_\_  
 10/1/87

*Don R. Skure*  
 PROVIDER'S REPRESENTATIVE  
 10-9-98  
 DATE

INSTITUTIONS PROVIDING SERVICES OF THERAPEUTIC NATURE  
DIVISION OF HEALTH FACILITIES STANDARDS  
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

P. 875

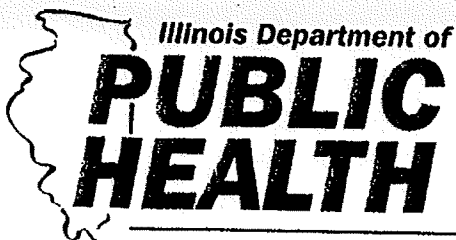
☒ ASTC ☐ INH ☐ JMO ☐ HOSPICE ☐ HOSPITAL

NAME AND ADDRESS OF FACILITY: *Amesbury Senior Center, 1705 W 175th St, Amesbury, IL 60516*

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.70(b) 7	<i>placed in a semi-circle. The seventh chair partially obstructed the fire exit.</i>	5. Recovery Room chairs have been re-arranged. Currently, there is no obstruction of any fire exit.	October 1, 1998
CR23	<i>NOT placed as in the approved sketch presented for state approval in 1992, but are close together as the current arrangement.</i>	6. Recovery Room chairs have been re-arranged to display the layout approved by the IDPH in 1992.	October 1, 1998
		The Administrator, Kathleen Henricks will ensure the above policies are adhered to.	

DATE OF SURVEY: *May 17, 1998*  
BY: *Mary J. Gorman* SURVEYOR  
IF PLV, INDICATE DATE OF PRIOR SURVEY: *10-9-98* DATE  
1/87

*Kathleen Henricks*  
PROVIDER'S REPRESENTATIVE  
10-9-98  
DATE



17001613

Pat Quinn, Governor

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • [www.idph.state.il.us](http://www.idph.state.il.us)

January 17, 2012

Jenny Mitchell, Administrator  
Access Health Center, Ltd.  
1700 75th Street  
Downers Grove, IL 60516-

Re: Access Health Center, Ltd.  
Downers Grove  
Licensure survey

Dear Jenny Mitchell:

On July 12, 2011 a life safety code inspection was conducted for the purpose of determining compliance with the requirements of the "Ambulatory Surgical Treatment Center Licensing Requirements" (77 Ill. Adm. Code 205) and the 2000 Edition of NFPA 101, Life Safety Code. Based on monitoring visit January 13, 2012, we find that the previously cited deficiencies have been corrected and the facility is no longer under monitoring for physical environment.

If you have any questions about this approval, please do not hesitate to call us at 217-785-4264. The Department's TTY number is 800/547-0466, for use by the hearing impaired.

Sincerely,

Henry Kowalenko, Supervisor  
Design Standards Unit  
Division of Health Care Facilities & Programs

Cc: Karen Senger, Supervisor  
Central Office Operations Section, IDPH

*Improving public health, one community at a time*

*printed on recycled paper*

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>7001613</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>01/13/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>ACCESS HEALTH</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1700 - 75TH STREET DOWNERS GROVE, IL 60516</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 000}	<p><b>Initial Comments</b></p> <p>The Illinois Department of Public Health (IDPH) conducted an onsite Life Safety Code inspection on 7/12/11. Access Health is a Pregnancy Termination Center (PTC) located at 1700 75th Street, Downers Grove, IL. Surveyor #12798 met with the facility assistant administrator and consultant to identify the purpose of the visit prior to touring the facility.</p> <p>The building is a one story facility, with sprinkler protection of hazardous rooms only, all other areas are equipped with heat and/or smoke detection. The building appears to be Type II (000) construction. The PTC is the only occupant in the building, and was inspected under the Illinois Ambulatory Surgical Treatment Center (ASTC) Licensing Requirements and the Life Safety Code (2000).</p> <p>The following deficiencies were identified by document review, staff interview or direct observation. We have included the deficient code section(s) for your convenience.</p> <p>Surveyor 12798: On January 13, 2012 a follow up inspection was conducted at Access Health, Downers Grove, Illinois. The Surveyor finds all deficiencies have now been corrected and the facility is now compliant.</p>	{L 000}		

Illinois Department of Public Health

TITLE

(X6) DATE

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

STATE FORM

6898

EP2512

If continuation sheet 1 of 1

## Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  7001613	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/12/2011
NAME OF PROVIDER OR SUPPLIER  ACCESS HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 - 75TH STREET DOWNERS GROVE, IL 60516		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	Initial Comments  The Illinois Department of Public Health (IDPH) conducted an onsite Life Safety Code inspection on 7/12/11. Access Health is a Pregnancy Termination Center (PTC) located at 1700 75th Street, Downers Grove, IL. Surveyor #12798 met with the facility assistant administrator and consultant to identify the purpose of the visit prior to touring the facility.  The building is a one story facility, with sprinkler protection of hazardous rooms only, all other areas are equipped with heat and/or smoke detection. The building appears to be Type II (000) construction. The PTC is the only occupant in the building, and was inspected under the Illinois Ambulatory Surgical Treatment Center (ASTC) Licensing Requirements and the Life Safety Code (2000).  The following deficiencies were identified by document review, staff interview or direct observation. We have included the deficient code section(s) for your convenience.	L 000		
L 029	38.2.1/39.3.2 HAZARDOUS AREAS  39.3.2.1 Hazardous Areas: Hazardous areas that include, but are not limited to general storage, boiler or furnace rooms, and maintenance shops shall be protected in accordance with Section B.4.  High hazard areas shall comply with 39.3.2.2.  This Regulation is not met as evidenced by: A. Based on observation and staff interview, the facility failed to maintain fire resistant walls or provide sprinkler protecting for hazardous areas in accordance with NFPA 101, 2000 Edition,	L 029		

Illinois Department of Public Health

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

STATE FORM

TITLE

(X5) DATE

6900

EP2811

If continuation sheet 1 of 8

## Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  7001613	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/12/2011
NAME OF PROVIDER OR SUPPLIER  ACCESS HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 - 75TH STREET DOWNERS GROVE, IL 60516		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 029	Continued From page 1  Section 39.3.2. This deficient practice could affect patients, as well as an indeterminable number of staff and visitors, if smoke / fire was allowed to move from the room into an exit access corridor. (see also L-0117, building services)  1. Storage Room, contains shelves of combustible paper products and is considered a hazardous area. The walls to the room extend to the deck above but are not sealed and the door is unrated as required by NFPA 101, 8.4 and 39.3.2.2. This room contains a sprinkler head, however the inspector was informed that it was non-functional. The room either needs to meet the construction requirements OR the sprinkler needs to be functional.  2. Mechanical room off of recovery. The room is considered a hazardous area. Verify compliance with the wall construction ( 1 hour rated), and the door must be fire rated, self closing and latching as specified in NFPA 101, 8.4 and 39.3.2.2 OR the sprinkler head located in this room needs to be functional.	L 029	1. & 2. Storage Room and Mechanical Room sprinkler heads will be inspected by SimplexGrinnell within the next 30 days and will be functioning within the next 90 days. Annual inspections will continue every year.	10/28/201
L 051	20.3.4/21.3.2 FIRE ALARM SYSTEM  A manual fire alarm system, not a pre-signal type, is provided to automatically warn the building occupants. The fire alarm system is arranged to automatically transmit an alarm to summon the fire department. 20.3.4 and 21.3.4 This Regulation is not met as evidenced by: A fire alarm system with approved components, devices or equipment is installed and maintained according to NFPA 101, and NFPA 72. Non-functioning equipment may not provide staff proper notification to direct patients and visitors to	L 051		



## Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  7001613	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/12/2011
NAME OF PROVIDER OR SUPPLIER  ACCESS HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 - 75TH STREET DOWNERS GROVE, IL 60516		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	<p>Continued From page 2</p> <p>a means of egress without crossing or entering the area of fire origin. This deficient practice could affect all patients as well as an indeterminable number of staff and visitors.</p> <p>1. The following documentation was unavailable at the time of this inspection of the fire alarm system as required by NFPA 101, 21.3.4.1:</p> <p>a. Since the building is considered "not fully sprinklered", public areas (corridors, waiting areas, bathrooms, etc) are to be equipped with single station battery-operated smoke detector or smoke detectors tied to the fire alarm system. Battery operated smoke detectors require testing, maintenance and battery replacement programs to ensure proper operation. Hard-wired smoke detectors will require annual testing with the fire alarm system and sensitivity testing every two years in order to comply with NFPA 72, 1999, 7-3.2.1. No previous Sensitivity Tests could be produced for review. This information is required to confirm that each device was tested and activated within the required manufacture's range.</p> <p>b. Documentation of visual inspections of the control equipment, batteries, heat / smoke detectors, etc. are required weekly, monthly, semi-annually and/or yearly as specified in NFPA 72, 1999 Table 7-3.1</p> <p>c. Documentation of the periodic testing of the battery discharge (90 minute) per NFPA 72, 1999, Table 7-3.2. was not available for review.</p> <p>d. The fire alarm system had been inspected by an outside testing company. The testing document was unclear as to how many devices were tested indicating only "100%". The test</p>	L 051	<p>a.</p> <p>Sensitivity Test will be completed with the annual fire alarm system inspection by Affiliated Customer Services on August 24, 2011. In the future, sensitivity testing will be completed during alternate year annual inspection.</p> <p>b.</p> <p>Per NFPA 72, 1999, 7-3.1, Exception No. 2, because automatic inspections are performed via a remotely monitored fire alarm control unit by ADT, visual inspection frequency is permitted to be annually. The annual visual inspection is completed Affiliated Customer Service.</p> <p>c.</p> <p>A new Preventive Maintenance/Inspection Log has been created to properly document the annual 90 minute battery discharge. A memo has been sent out informing the manager of the changes and the maintenance staff has been trained on how to perform tests/inspections.</p> <p>The center's manager will be responsible for making sure that the documentation of the tests/inspections is current. (See Enclosure)</p>	8/31/201

## Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  7001613	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  07/12/2011
NAME OF PROVIDER OR SUPPLIER  ACCESS HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1700 - 75TH STREET DOWNERS GROVE, IL 60516		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
L 051	Continued From page 3  contained devices tested (smoke, heat, pull stations, etc.) without including a total number of each device and location of each tested device. It was impossible to determine if the entire system has been properly inspected in the past 12 months. Failure to properly inspect the fire alarm system could lead to a system failure or a possible malfunction in the event of an emergency situation. Fire alarm system testing in accordance with NFPA 101, 2000 Edition, Section 9.6 as well as NFPA 70 and NFPA 72.  e. It is unclear based on the information provided if smoke detection is provided at the main fire alarm panel in accordance with NFPA 101 Section 9.6.1.4 and NFPA 72, 1999, Section 1-4 and 1-5. The report failed to identify the location of each of the 14 heat detectors and 4 smoke detectors.	L 051	d. & e.  Affiliated Customer Service, the fire alarm testing company, has been made aware that the location and quantity of all fire alarm system devices are to be documented in their report. Affiliated Customer Service confirmed that all devices in the fire alarm system were tested during the annual inspection in September 2010 and for future inspections the location and quantity of each device will be noted.  (See Enclosure)		
L 076	Medical Gas 4.3.1.1.2, 20.3.2.4, 21.3.2.4  Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities, and NFPA 101.  (a) Oxygen storage locations of greater than 3,000 cu. ft. are enclosed by a one hour separation.  (b) Locations for supply systems of greater than 3,000 cu. ft. are vented to the outside.  4.3.1.1.2, 20.3.2.4, 21.3.2.4  This Regulation is not met as evidenced by: A. Based on observations it was determined that the facility failed to provide proper storage of	L 076			

## Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  7001613	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  07/12/2011
NAME OF PROVIDER OR SUPPLIER  ACCESS HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1700 - 75TH STREET DOWNERS GROVE, IL 60518		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
L 078	Continued From page 4 portable oxygen containers in accordance with NFPA 99, Section 8-3.11.2. This deficient practice could affect an indeterminable number of patients, staff and visitors.  1. The Recovery Room, contained a portable liquid oxygen container sitting on the vinyl tile floor unsupported. NFPA 99, Section 8-3.11.2 (h).  2. Recovery Room, liquid oxygen containers (3) were less than 20 feet from combustible items such as recovery chairs, trash cans, etc. Based on conversation with the facility staff the liquid oxygen is normally kept at this location. NFPA 99, Section 8-3.1.11.2(c)(1).	L 078	1. & 2. A memo has been released advising the staff of the proper storage of the O2 Tanks. (See Enclosure)  The Nurse Supervisor and Manager will be responsible to ensure compliance.	7/28/2011	
L 117	Building Services 21.5.1, 9.1., NFPA 70, 110  This Regulation is not met as evidenced by: A. Building services including utilities, heating, venting and air conditioning meet the requirements of NFPA 101, 21.5.  PLUMBING:  1. All fixtures for use by medical and nursing staff shall be trimmed with valves which can be operated without the use of hands. Improper infectious control procedures may affect all patients, staff and visitors.  a. Scrub sinks for surgery shall be trimmed with valves which are aseptically operated (i.e., knee or foot or elbow actuated) without the use of hands. Wrist blade handles are not acceptable based on LSC 205.1620(c)(2).  2. The facility contains 2 sprinkler heads, one serving the storage room and one located in the	L 117	a. We will be replacing the scrub sink faucets with aseptically operated faucets. We are currently obtaining options and quotes from plumbers.  The Administrator will be responsible for compliance within 6 months.	1/28/2012	

## Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  7001613	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  07/12/2011
NAME OF PROVIDER OR SUPPLIER  ACCESS HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1700 - 75TH STREET DOWNERS GROVE, IL 60516		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
L 117	Continued From page 5  mechanical room. The facility indicated that the sprinklers were non-functional. No documentation was available as to the servicing of these heads or when they were taken out of service. The sprinklers do not constitute a "system" and appear to be installed off of the domestic water supply and must comply with the Illinois Plumbing Code, 890.1130(d). Identification of the backflow, check valves, air gaps, etc. were unknown by the facility staff. A improperly installed system may contaminate the water supply at this facility.(see also 029, protection of hazardous areas).	L 117	2. Sprinklers will now be functional. (See L 029 1. & 2.)	10/28/201	
L 147	Electrical wiring 9.1.2, 20.5.1  Electrical wiring and equipment are in accordance with NFPA 70, National Electrical Code 9.1.2, 20.5.1  This Regulation is not met as evidenced by: A. Based on the observation and staff interview, the facility failed to install electrical wiring in accordance with NFPA 101, 2000 Edition, Section 9.1.2 and NFPA 70, 1999 Edition, National Electrical Code. This deficient practice could affect staff that would come in contact with deficient electrical wiring and water or be affected by an electrical fire from overloading electrical circuits, if improper electrical wiring started a fire.  1. Observations determined that certain outlets within 6 feet of the edge of a sink basin were not GFI manufactured devices and were not on a GFI circuit as observed in the the sterile processing room or the POC lab. NFPA 70, 210-8(a)(7) and 517-20 & 21.  2. Observations determined that multi-prong	L 147	1. All outlets within 6 feet of edge of a sink basins have been replaced with GFI manufactured devices by an electrician.  2. A memo has been sent out advising staff not to use multi-plug adaptors.	7/30/2011	

## Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  7001613	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  07/12/2011
NAME OF PROVIDER OR SUPPLIER  ACCESS HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1700 - 75TH STREET DOWNERS GROVE, IL 60516		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
L 147	Continued From page 6 adapters were used in areas of the facility including sterile processing.	L 147			
L136A	205.1306 a) Examination Room (s)  SECTION 205.1360 CLINICAL FACILITIES  a) Examination rooms  1) Each examination room shall have a minimum clear floor area of 80 square feet, and a minimum dimension of 8 feet, exclusive of vestibule, toilet, closet, and work counter (whether fixed or movable). A minimum clear dimension of 2'6" on each side and at both ends of the examination table shall be provided.  2) A lavatory or sink equipped for handwashing with electronic or knee or foot control shall be provided.  3) A counter or shelf space for writing shall be provided.  (Source: Amended at 24 Ill. Reg. 2691, effective February 18, 2000)  This Regulation is not met as evidenced by: A. Areas designated for patient care, exam rooms, treatment rooms, etc. where patients may be touched, hand washing facilities are required to reduce the risk of infections from patient to staff and from staff to patients. Improper infectious control procedures may affect all patients, staff and visitors.  1. The Examination room contains a hand	L136A			

## Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  7001613	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  07/12/2011
NAME OF PROVIDER OR SUPPLIER  ACCESS HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1700 - 75TH STREET DOWNERS GROVE, IL 60516		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
L136A	Continued From page 7 washing sink, however it was not equipped with hands-free operation hardware as required by ASTC 205.1360(a)(2).	L136A	1.  See response for L117 1. a.		1/28/201

Illinois Department of Public Health  
STATE FORM

EP2511

If continuation sheet 8 of 8

**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 Access Health Center 1700 75<sup>th</sup> Street Downers Grove IL 60516

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)	<p><b>Sanitary Facility</b> The ambulatory surgical treatment center shall insure maintenance of a sanitary facility...</p> <p>This requirement is not met as evidenced by:</p> <p>Based on Facility policy review, observation and staff interview, it was determined that for 1 of 2 operating rooms (OR2) observed, the Facility failed to ensure a sanitary environment.</p> <p>Findings include:</p> <p>1 On 5/18/11 at approximately 11:30AM, Facility policy titled, "Terminal Cleaning of the Operating Suite" was reviewed.</p>	See Next Page	

BY

RECEIVED

JUN 08 2011

BY 07105  
(Surveyor)

(Provider's Representative)

DATE OF SURVEY 5/18/11

11/9/19 JH



**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    Access Health Center 1700 75<sup>th</sup> Street Downers Grove, IL 60516

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) Cont	<p>Sanitary Facility</p> <p>The policy included, "...cleaning of the operating suite will occur at the end of every surgery day."</p> <p>2. On 5/18/11 at approximately 11:15AM OR #2 was inspected and observed with loose debris on the floors, a red stain on a wall and standing water in a small bucket. The last surgical day was on 5/16/11.</p> <p>3. The above findings were confirmed by the Nurse Manager during an interview on 5/18/11 at approximately 11:15AM.</p>	<p>The Administrator has contacted the cleaning company which is responsible for terminal cleaning at the end of the day. Their supervisor has discussed the situation with their cleaning staff.</p> <p>The Nursing Supervisor will be responsible to monitor and ensure compliance by the cleaning company. In addition, they will also assign the medical assistants to do "spot-cleaning" as well as "spot-checks" between patients and at the end of the day prior to terminal cleaning.</p>	06/30/2011

Date of survey    5/18/11    By    07105    (Surveyor)

(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 Access Health Care 1700 75<sup>th</sup> Street Downers Grove IL 60519LIST RULE  
VIOLATEDENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY  
WHAT IS WRONGPROVIDER'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 6 of 10 records reviewed (Pt. #s 1-6), the Facility failed to ensure patients received post operative counseling.

Findings include:

06/30/2011

Due to the nature of the procedures, many of our patients explicitly express that they do not want to be contacted post procedure for confidentiality reasons. Also, many of our patients return to their own physicians for post-op care and/or counseling and some patients are simply non-compliant and do not respond to any type of follow up.

Therefore, with this in mind we have created a "Post Counseling Progress Notes" Form (see enclosure). This Form will be used to document the post counseling status of each patient:

1. Whether or not the patient can be contacted
2. Where the patient will be going for follow up:
  - a. Own Physician, who?
  - b. Our Facility, when?
  - c. No Follow Up/Non-Compliance/Wrong Contact, etc.

Assigned staff will make an attempt to contact the patient regarding post counseling. Notes will be added to the patient's chart. The administrator will monitor compliance.

DATE OF SURVEY 5/17/11

BY 07105  
(Surveyor)

(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**

Access Health Care 1700 75<sup>th</sup> Street Downers Grove IL 60519

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 (c) Cont	<b>Clinical Records</b>  1. On 5/17/11 clinical records were reviewed between 10:00AM and 12:30PM. The clinical records for Pt. #s 1-6 lacked post operative counseling notes.  2. The above findings were confirmed by the Chief of Operations during an interview on 5/17/11 at approximately 1:30PM.		

**DATE OF SURVEY**    5/17/11

**BY**    07105  
(Surveyor)

(Provider's Representative)

### POST COUNSELING PROGRESS NOTE

[illegible]