STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL7001670	A. BUILDING _____ B. WING _____	07/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATIONAL HEALTH CARE SERVICES OF PEO	7405 N UNIVERSITY SUITE D PEORIA, IL 61614

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L 000	Initial Comments Surveyor: 12798 The Illinois Department of Public Health (IDPH) conducted an onsite Life Safety Code inspection on 7/6/11. National Healthcare is a Pregnancy Termination Center (PTC) located at 7405 N. University, Peoria, IL, surveyors #10130 and 12798 met with the administrator and identified the purpose of the visit prior to touring the facility. The building is a one story facility, with no sprinkler protection. 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 8.4. High hazard areas shall comply with 39.3.2.2. This Regulation is not met as evidenced by: Surveyor: 12798 1. Based on observation and staff interview, the facility failed to constructed fire resistant walls that continue through the lay in ceiling to the roof in accordance with NFPA 101, 2000 Edition,	L 029		

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L 029	Continued From page 1 Section 39.3.2 for hazardous areas. This deficient practice could affect patients, as well as an indeterminable number of staff and visitors, if smoke / fire was allowed to move from a room into an exit access corridor. A. Back Storage Room, containing the washer / dryer as well as a gas fired water heater. This room contains shelves of combustible paper products and is considered a hazardous area. The walls to the room do not extend to the deck above and the door is unrated as required by NFPA 101, 8.4. and 39.3.2.2. B. Storage Room off of the handicapped accessible exam room. The room contains several shelves of combustible paper products and 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. C. Front entrance contains (2) large unoccupied storage rooms. The exit corridor wall does not have drywall on the inside which exposes the metal studs to fire and damage. Verify compliance with NFPA 101, 8.4.1, 8.4.3 and 39.3.2.2.	L 029	1. A) Back storage room will have the wall extended to the deck above. This construction will be completed by: Union Construction 611 S.W. Washington Peoria, IL 61602 This door is a solid wood fire rated door and is self closing. This door will be verified by the above listed company. Completion Date: Aug. 10, 2011 B)The walls were verified by Union Construction who did the initial work. The walls are Type X 5/8 inch Gypsum board, this board is on the inside wall of the storage area, and an the other side of the wall that faces the counseling room. The joints were taped and plastered. The door will be replaced by a fire rated, self closing and latching door. See enclosed information. S&S Hardware 917 W. Pioneer Parkway Peoria, IL 61615 Completion Date: Aug 10, 2011 C)The 2 large unoccupied empty rooms will have dry wall put up to protect the metal studs. This will be done by: Union Construction– Michael Morgan 611 S.W. Washington Peoria, IL 61602 Completion Date: Aug 15, 2011	8-10-11 8-10-11 8-15-11
L 046	20.2.9.1/21.2.9.1 Emergency Illumination Emergency lighting shall be provided in accordance with 7.9 and 21.2.9.2. This Regulation is not met as evidenced by: Surveyor: 12798 Based on observation and interview, the facility failed to provide emergency lights for all portions of exit discharges in accordance with NFPA 101 Sections 7.9 and 21.2.9.1. This deficient practice	L 046		

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L 046	Continued From page 2 could affect all patients, as well as an indeterminable number of staff and visitors, if the means of egress was not illuminated during an evacuation. The facility has battery-pack lights scattered throughout the facility providing the required lighting. 1. NFPA 101, 2000, 7-9.3, 7-10.9.2 and 21.2.4. The facility failed to provide documentation as to the emergency and exit lighting testing. A. Monthly visual inspections, and 30 second battery testing of the units. B. Annual battery testing for 90 minutes. 2. The battery operated light in the reception area (back exit) did not function during testing.	L 046	2. 1. A&B) Monthly visual inspection are being done by the Administrator or the Administrative assistant, find enclosed a chart that will verify our inspection and annual testing. Ex #1 2. The lights have been replaced and checked for proper working order. Completed: July 15, 2011	7-15-11 7-15-11
L 048	21.7.1, 4.6.10.1 Written Fire Plan, &/or Interim Measures There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. A simple floor plan, showing the evacuation routes, is posted in prominent locations on all floors. 31.4.1.1 This Regulation is not met as evidenced by: Surveyor: 12798 Based on the review of the facilities documents, it was determined that the facility failed to maintain a written plan for the protection of residents to provide a prompt and effective response in the event of a fire emergency in accordance with NFPA 101, Section 21.7.2. This deficient practice could affect staff, visitors and patients throughout the facility..	L 048		

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L 048	Continued From page 3 A. During the document review of the Fire Safety Plan, the facility document was not complete, direct and explicit with proper procedures. The policy indicates smothering the fire before protecting the safety of the occupants. The facility does not follow the "Fire Safety Plan" as outlined in NFPA 101 Section 21.7. The facility could not produce documentation as to how the facility conducts an "in-service" of fire safety for their existing and new staff.	L 048	3. A new Fire Safety Plan has been re-formulated, a copy is enclosed. We have incorporated R.A.C.E. and P.A.S.S. Documentation provided to assure that existing and new employee have had in-service training. Ex #2	7-14-11
L 050	21.7.1.2 FIRE DRILLS Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift, using the fire alarm system, except at night. The staff is familiar with procedures and is aware that drills are part of established routine. 21.7.1.2 This Regulation is not met as evidenced by: Surveyor: 12798 Based on record review it was determined that the facility failed to maintain provide fire drills as required. Fire drills are to be held at unexpected times under varying conditions, at least quarterly on each shift per NFPA 101, Section 21.7.1.2. This deficient practice could affect staff, visitors as well as patients. 1. The facility was unable to provide documentation as to conducting fire drills. Based on the facility policy, the fire drills are only conducted yearly. The drills must be conducted quarterly, and include who participated, what shift was involved, time drill was conducted, etc. (NFPA 101, 2000, 21-7.1.2.)	L 050	1. The fire drills are conducted quarterly and they are now documented. The Staff who participated are listed and signed off. Completion Date: July 14, 2011 Ex #3	7-14-11

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L 051	Continued From page 4	L 051		
L 051	20.3.4/21.3.2 FIRE ALARM SYSTEM A manual fire alarm system, not a pre-signal type, is provided to automatically warn the building occupants. The fire alarm system is arranged to automatically transmit an alarm to summon the fire department. 20.3.4 and 21.3.4 This Regulation is not met as evidenced by: Surveyor: 12798 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 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. 1. (ASTC. 205.1790(f)). The facility has not provided smoke detection in waiting areas that are open to the egress corridors. 2. 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: A. Bi-annual detector sensitivity calibration testing, NFPA 72, 1999, 7-3.2.1. B. Documentation on visual inspections of the control equipment, batteries, heat / smoke detectors, etc. as specified in NFPA 72, 1999 Table 7-3.1 and required weekly, monthly, semi-annually and/or yearly. C. Documentation of the periodic testing of the battery discharge per NFPA 72, 1999, Table 7	L 051	The safety of my staff and patients is our utmost priority. We keep the doors locked at all times when we are here alone. This allows us protection. On surgical days, the doors are unlocked. The patients can come and go as necessary. After extensive discussion with the Fire Department, Oberlander Security, and Getz Fire Protection we purpose the following: 1. One smoke detector has been installed in the waiting area. 2. a. Biannual detector sensitivity has been done and will be tested bi-annually b. Documentation on visual inspections will be done as required. c. We will do yearly testing of battery discharge, you will find paperwork in the exhibits d. The door hardware will be changed to Securiton Touch Sense Bar; it will be installed on both doors with mag locks. When touched, the mag lock will be released. Extra safety is achieved because in the event of failure, the touch bar will still release. The back door will have complete crash bar installed. PENDING Approval Aug 15, 2011 Completion	

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L 051	Continued From page 5 -3.2. D. Documentation as to how the magnetic door locks function during an emergency. The front lobby door and back door are locked in the direction of egress. NFPA 101, 21.2.2.2 Special locking arrangements are permitted on exterior doors if they comply with 7.2.1.6. The door hardware does not meet the requirements of NFPA 101, 7.2.1.6. 3. The fire alarm control panel located in the storage/ laundry room: A. Was not permanently identified with the location of the circuit disconnect means based on NFPA 72-1-5.2.5. B. NFPA 72-1-5.2.5 requires that the dedicated branch circuit breaker(s), feeding the fire alarm panel and associated equipment, shall have red marking and shall be identified as "FIRE ALARM CIRCUIT". Provide a lock-on device for the circuit breaker.	L 051	See Exhibit 4 See Exhibit 4	8-10-11 8-10-11
L 064	9.7.4.1 FIRE EXTINGUISHERS Portable fire extinguishers are provided. 8.7.4.1 and 9.7.4.1 This Regulation is not met as evidenced by: Surveyor: 12798 1. Based on record review it was determined that the facility failed to properly maintain portable fire extinguishers in accordance with NFPA 1010 2000 Edition 21.3.5.2 and NFPA 10. This deficient practice could affect patients as well as in indeterminable number of staff and visitors if the fire extinguishers failed.	L 064		

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L 064	Continued From page 6 A. The facility was unable to produce documentation that the extinguishers are visually inspected on a monthly basis (NFPA 10, 1998, 4-3.1). B. The facility was unable to produce the annual certified maintenance records for the extinguishers as required by NFPA 10, 1998, 4-4.1. C. The facility was unable to produce the 6 -year hydrostatic testing records for the extinguishers as required by NFPA 10, 1998, 4-4.3.	L 064	5 A) The tags are signed on a monthly basis by the Administrative Assistant and re-checked by the Administrator. Ex # 4 B&C) Please find enclosed the annual maintenance records and a copy of the 6 year hydrostatic testing. Completed: July 18, 2011 Ex #6	7-18-11 7-18-11
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: Surveyor: 12798 1. 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. A. 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 procedure rooms. NFPA 70, 210-8(a)(7) and 517-20 & 21.	L 147	6. A) All outlets that are within 6 feet of a sink have been replaced and are now on a G.F.I. circuit.	7-19-11

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L 147	Continued From page 7 B. Observations determined that multi-prong adapters were used in areas of the facility in the kitchen area and soiled/clean area.	L 147	B)The multi-prong adapter has been removed. The electrical was performed by: Koener Electric 630 S.W. Washington Bartonville, IL 61607 Completion Date: July 19, 2011	7-19-11
L1370	205.1370 Support Services Areas SECTION 205.1370 SUPPORT SERVICE AREAS A control station shall be located to permit visual surveillance of all traffic that enters the operating suite. Sterilizing facilities with high speed autoclaves conveniently located to serve all procedure rooms shall be provided. Approved alternate provisions may be made for replacement of sterile instruments during surgery. A drug distribution station shall be provided for storage and preparation of medication to be administered to patients. Scrub stations with knee, foot or elbow actuated faucets or with automatic electronic actuated faucets shall be provided near the entrances to, but outside of, the procedure rooms. Scrub facilities shall be arranged to minimize splatter on nearby personnel or supply carts. A soiled workroom for the exclusive use of the surgical suite staff shall be provided. The soiled workroom shall contain a work counter, sink equipped for handwashing, waste receptacle, and linen receptacle. This room may be used for cleaning anesthesia equipment. Fluid waste disposal facilities shall be conveniently located with respect to the general procedure rooms. Clean workroom A clean workroom or a clean supply room is required when clean materials are assembled within the surgical suite prior to use. A clean workroom shall contain a work counter, sink	L1370		

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L1370	Continued From page 8 equipped for handwashing, and space for clean and sterile supplies. A clean supply room shall be provided when the narrative program defines a system for the storage and distribution of clean and sterile supplies that would not require the use of a clean workroom. An autoclave shall be incorporated into the clean workroom. Anesthesia storage facilities shall be provided. Flammable anesthetics are prohibited. Medical gas supply storage with space for reserve nitrous oxide and oxygen cylinders shall be provided, with all tanks properly secured. Storage area for equipment and supplies used in the surgical suite shall be provided. Staff and personnel facilities shall be provided for male and female personnel (orderlies, technicians, nurses, and doctors) working within the surgical suite. The areas shall contain lounge, lockers, toilets, lavatories equipped for handwashing, and space for changing clothes. These areas shall be arranged to provide a one-way traffic pattern so that personnel entering from outside the sterile area can change, gown, and move directly into the sterile area. Space for removal of scrub suits and foot covers shall be designed so that personnel using it will avoid physical contact with clean personnel. Change areas where patients can change from street clothes into hospital gowns in privacy, and be prepared for surgery, shall be provided. This shall include lockers, toilets, clothing change or gowning areas, and space for the administration of medications. The stretcher storage area shall be out of the direct line of traffic. A janitor's closet containing a floor receptor or service sink, and storage space for housekeeping supplies and equipment, shall be provided	L1370		

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L1370	Continued From page 9 exclusively for the surgical suite. (Source: Amended at 24 Ill. Reg. 2691, effective February 18, 2000) This Regulation is not met as evidenced by: Surveyor: 12798 1. (205.1370 (b)(12)) The soiled and clean work spaces share the same room. Soiled items from procedure rooms #2 & #3 are taken through the clean side of the room and delivered to the soiled side for processing. The one-way traffic flow, infection control and air flow is not clear for this room. 2. (205.1370(j)& (m)) The back corridor contained storage of a gurney, wheelchair and table. Means of egress shall be continuously maintained free of all obstruction or impediments to full instant use in the case of fire or other emergency based on NFPA 101, 7.1.10.1.	L1370	7. This facility is a Pregnancy Termination Center # 7001670, according to the Administrative Code Section 205.711 (12) allows us to have our clean and soiled utility in the same room. We do not ever utilize the designated clean side for contaminated material. B)The gurney has been removed as has the wheelchair to the recovery area. The hall is clear, for walking.	7-19-11 7-15-11

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{L 000}	Initial Comments Surveyor: 12798 The Illinois Department of Public Health (IDPH) conducted an onsite Life Safety Code inspection on 7/6/11. National Healthcare is a Pregnancy Termination Center (PTC) located at 7405 N. University, Peoria, IL, surveyors #10130 and 12798 met with the administrator and identified the purpose of the visit prior to touring the facility. The building is a one story facility, with no sprinkler protection. 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. A Licensure Follow Up Survey was conducted on 9/12/11, by surveyor 12798. The surveyor finds that all deficiencies were not corrected in accordance with the last submitted Plan of Correction (PoC) dated 7/21/11. A revised PoC was requested. A Licensure Follow Up Survey was conducted on 10/14/11, by surveyor 12798. The surveyor finds that all deficiencies were not corrected in accordance with the last submitted Plan of Correction (PoC) dated 9/12/11. A revised PoC was requested.	{L 000}	RECEIVED OHCR HCF&P 2011 OCT 26 A 11:52	
{L 029}	38.2.1/39.3.2 HAZARDOUS AREAS	{L 029}		

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{L 029}	Continued From page 1 39.3.2.1 Hazardous Areas: Hazardous areas that include, but are not limited to general storage, boiler or furnace rooms, and maintenance shops shall be protected in accordance with Section 8.4. High hazard areas shall comply with 39.3.2.2. This Regulation is not met as evidenced by: Surveyor: 12798 1. Based on observation and staff interview, the facility failed to constructed fire resistant walls that continue through the lay in ceiling to the roof in accordance with NFPA 101, 2000 Edition, Section 39.3.2 for hazardous areas. This deficient practice could affect patients, as well as an indeterminable number of staff and visitors, if smoke / fire was allowed to move from a room into an exit access corridor. A. Back Storage Room, containing the washer / dryer as well as a gas fired water heater. This room contains shelves of combustible paper products and is considered a hazardous area. The walls to the room do not extend to the deck above and the door is unrated as required by NFPA 101, 8.4. and 39.3.2.2. UPDATE 9/12/11: The rating on the doors could not be verified, the tags on the door and frame had been painted. UPDATE 10/14/11: The rating on the doors could not be verified, the tags on the door and frame had been painted. B. Storage Room off of the handicapped accessible exam room. The room contains several shelves of combustible paper products	{L 029}		

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(L 029)	Continued From page 2 and 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. * UPDATE 9/12/11: The rating on the doors could not be verified, the tags on the door and frame had been painted. * UPDATE 10/14/11: The rating on the doors could not be verified, the tags on the door and frame had been painted. C. Corrected 9/12/11	(L 029)	we pulled off tape that covered the plates and the tags are clear and visible Ex #	10-24
(L 046)	20.2.9.1/21.2.9.1 Emergency Illumination Emergency lighting shall be provided in accordance with 7.9 and 21.2.9.2. This Regulation is not met as evidenced by: Surveyor: 12798 Based on observation and interview, the facility failed to provide emergency lights for all portions of exit discharges in accordance with NFPA 101 Sections 7.9 and 21.2.9.1. This deficient practice could affect all patients, as well as an indeterminable number of staff and visitors, if the means of egress was not illuminated during an evacuation. The facility has battery-pack lights scattered throughout the facility providing the required lighting. 1. NFPA 101, 2000, 7-9.3, 7-10.9.2 and 21.2.4. The facility failed to provide documentation as to the emergency and exit lighting testing. * A. Monthly visual inspections, and 30 second battery testing of the units.	(L 046)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL7001670	A. BUILDING _____ B. WING _____	R 10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATIONAL HEALTH CARE SERVICES OF PEO	7405 N UNIVERSITY SUITE D PEORIA, IL 61614

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{L 046}	Continued From page 3 B. Annual battery testing for 90 minutes. UPDATE 9/12/11: Many battery-operated emergency lights and EXIT signs are equipped with a test switch or test button that simulates a power outage and activates the battery. The downside of using this method, however, is that, on older lighting units, the circuitry that ' s supposed to interrupt the normal AC power can fail. In such cases, the use of the test switch or test button really only serves to test the lamps, but does not serve as a valid test of the batteries. It is recommended that the equipment manufacturer be contacted for guidance on acceptable ways to accomplish this without damaging the equipment. UPDATE 10/14/11: The facility was unable to produce any documentation as to the testing of the battery-operated emergency lights and exit signs for 30 seconds and/or 90 minutes. 2. Corrected 9/12/11	{L 046}		
{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: Surveyor: 12798 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	{L 051}		

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{L 051}	Continued From page 4 proper notification to direct patients and visitors to 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. 1. (ASTC, 205.1790(f)). The facility has not provided smoke detection in waiting areas that are open to the egress corridors. * UPDATE 9/12/11: The back patient waiting area (pre-lab / sono) still lacks smoke detection. UPDATE 10/14/11: The back patient waiting area (pre-lab / sono) still lacks smoke detection. 2. 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: A. Corrected 9/12/11 B. Corrected 9/12/11 C. Corrected 9/12/11 D. Documentation as to how the magnetic door locks function during an emergency. The front lobby door and back door are locked in the direction of egress. NFPA 101, 21.2.2.2 Special locking arrangements are permitted on exterior doors if they comply with 7.2.1.6. The door hardware does not meet the requirements of NFPA 101, 7.2.1.6. UPDATE 9/12/11: The new door hardware has been ordered, however it had not been received or installed at the time of this inspection. UPDATE 10/14/11: The new door hardware has been installed, however it was agreed that a sign	{L 051}	The smoke detector has been installed as required. EK 2	10-24

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{L 051}	Continued From page 5 would be placed on the wall indicating the location of the locking device (red button) on the back of the bar. The sign has not been installed. 3. The fire alarm control panel located in the storage/ laundry room: A. corrected 10/14/11 B. corrected 10/14/11	{L 051}	The sign has been printed and hung up by the door. Ex #3	10-24

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	IL7001670	A. BUILDING _____ B. WING _____	R 11/01/2011

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{L 000}	Initial Comments The Illinois Department of Public Health (IDPH) conducted an onsite Life Safety Code inspection on 7/6/11. National Healthcare is a Pregnancy Termination Center (PTC) located at 7405 N. University, Peoria, IL, surveyors #10130 and 12798 met with the administrator and identified the purpose of the visit prior to touring the facility. The building is a one story facility, with no sprinkler protection. 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. A Licensure Follow Up Survey was conducted on 9/12/11, by surveyor 12798. The surveyor finds that all deficiencies were not corrected in accordance with the last submitted Plan of Correction (PoC) dated 7/21/11. A revised PoC was requested. A Licensure Follow Up Survey was conducted on 10/14/11, by surveyor 12798. The surveyor finds that all deficiencies were not corrected in accordance with the last submitted Plan of Correction (PoC) dated 9/12/11. A revised PoC was requested. A desk audit was conducted on 11/1/11, by surveyor 12798. The surveyor finds that all deficiencies previously identified have now been corrected based on the PoC received 10/26/11.	{L 000}		

TITLE (X6) DATE

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

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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

NAME AND ADDRESS OF FACILITY
National Health Care, Inc., Peoria, IL

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

DATE OF SURVEY 06/16/11 BY 26336 & 15162 (Surveyor)

[redacted] (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

Section 205.220 Organizational Plan	An organizational plan shall be known to the staff and available for public information in the facility. The document shall clearly set forth the organization, duties, responsibility, accountability and relationships of professional staff and other personnel... This requirement was not met as evidenced by: A. Based on a review of Pregnancy Termination Center (PTC) organizational chart and staff interview, it was determined the PTC failed to ensure its lines of authority were clearly delineated. Findings include: 1. The PTC organizational chart was reviewed. It indicated "National Health Care (NTC), Inc... Owner to Medical Director to Physicians." Then "Owner to Executive Director to... "It failed to clearly delineate the lines of authority between the physicians, Registered Nurses (RN), Licensed Practical Nurses (LPN), Surgical Technicians (ST), Laboratory staff, Sonogram staff, Counseling staff, or patient. 2. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above finding was confirmed.	A new organizational chart has been designed and a corresponding page with individual staff is listed. This has been reviewed with staff and implemented. Completion Date: June 27, 2011 The Director will be responsible to keep it current. See Exhibit #1
Section 205.230 Standards of Professional Work	(a)A qualified consulting committee shall be appointed in writing... The consulting committee shall meet not less than quarterly and shall document all meetings with written minutes... This requirement was not met as evidenced by: A. Based on a review of PTC policy and staff interview, it was determined the PTC failed to ensure the consulting committee met quarterly and minutes of the meetings were maintained. Findings include: 1. The PTC policy titled "NTC Standards of Professional Work" was reviewed. It indicated "3. The consulting committee	 The consulting committee will meet as documented in September, December, March and June. The minutes will be

	shall meet quarterly to review policy, formulate new procedures, and evaluate clinical problems as they arise. The meetings will be conducted in September, December, March and June. The minutes will be recorded." There was no documentation to indicate the consulting committee met in 2008, 2009, 2010, or 2011. 2. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above finding was confirmed.	recorded and keep in a notebook labeled Consulting committee and will be available for review as needed. We will have a recorded meeting on July 7, 2011, this is first available date due to July 4th holiday. Completion Date: July 7th, 2011 The Director will be responsible to record and track the meeting and its outcome and suggestions. The Director will implement the policy or changes with the appropriate staff members in order to facilitate completion. The medical director will review with staff physicians any medical changes.
Section 205.230 Standards of Professional Work	(a)(2)The consulting committee shall review development and content of the written policies and procedures of the center, the procedures for granting privileges, and the quality of the surgical procedures performed. Evidence of such review shall be recorded in the minutes. This requirement was not met as evidenced by: A. Based on a review of PTC policy manual and staff interview, it was determined the PTC failed to ensure a procedure for granting PTC privileges was established, implemented, and followed. Findings include: 1. The PTC policy manual was reviewed. It failed to include a procedure for granting privileges. 2. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above finding was confirmed.	We have been meeting but my notes were not put in a typed organized fashion, that has been corrected and the director is responsible. The Consulting Committee will initial all meetings. EX A.1 Completion Date: July 7, 2011 Ex. # 20 The Director will follow-up. The manual now includes a procedure for granting privileges, it will be reviewed by the consulting committee and approved Completion date July 7, 2011 The director will be responsible to present new applicants and their documentation to the consulting committee as this situation presents itself
Section 205.230 Standards of Professional Work	(a)(3) Credentials shall be provided by those physicians seeking practice privileges. These credentials shall be reviewed by the credentials committee and specific practice privileges identified and recorded. Record of such accepted practice privileges shall be available for facility staff use and public information within the facility. This requirement was not met as evidenced by: A. Based on a review of PTC policy, a review of Medical Staff credential files, and staff interview, it was determined in 4 of 4	When a physician applies to the P T C for staff privilege the following will be noted and placed in the physician's file The information will be held by the Medical Director 1 Resume 2 Current Illinois License 3 Illinois hospital affiliation 4 Notarized letter stating privileges 5 Outstanding malpractice issues 6 ACLS Certified 7 Applicant's expectations 8 OR skills evaluated by Medical Director 9 Privileges granted Completion Date July 7, 2011 Ex. # 2 The Medical Director will do the interview and review the information, it will be in the physician's file A yearly check will be initiated by the Medical Director The Administrator files the paper work and validates the information

Medical staff credential files reviewed, the PTC failed to ensure specific practice privileges were granted.

Findings include:

1. The PTC policy titled "NHC Standards of Professional Work" was reviewed. It indicated "4. When a staff position for a physician... All physicians at the center will have practice privileges available for staff use and public information within the facility.
2. Four out of four Medical staff credential files reviewed failed to include any documentation to indicate PTC specific privileges had been granted, or what the privileges were. There was no documentation to indicate the consulting committee met 2008, 2009, 2010, or 2011 to review medical staff credentials and privileges.
3. The credential file of P-1 was reviewed. P-1's application was dated 5/15/08. There was no documentation to indicate what privileges were being requested at that time or since. There was no documentation to indicate privileges had been reviewed and/or granted.
4. The credential file of P-2 was reviewed. P-2's application was dated 8/19/10. There was no documentation to indicate what privileges were being requested at that time or since. There was no documentation to indicate privileges had been reviewed and/or granted.
5. The credential file of P-3 was reviewed. P-3's application was dated 4/10/07. There was no documentation to indicate what privileges were being requested at that time or since. There was no documentation to indicate privileges had been reviewed and/or granted.
6. The credential file of P-4 was reviewed. There was no application for P-4. The filed indicated a letter from Aurora Health Care dated 9/30/03. There was no documentation to indicate what privileges were being requested at that time or since. There was no documentation to

We have always had the physician information available for staff and public information

We are changing credentialing policy and the Administrator will provide in each physician's file a short synopsis for any one's review at the facility

Completion Date: July 27, 2011 Ex 2

Administrator will follow-up with the individual physician input

Asked and answered
Ex 2

Asked and answered
P1 is no longer here. If he is used, he will be re-certified.
Ex # 2

Asked and answered
Ex # 2

Asked and answered
Ex # 2

Asked and answered
Ex # 2

	indicate privileges had been reviewed and/or granted. 7. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above findings were confirmed.	
Section 205.230 Standards of Professional Work	(a)(4) 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... As used in this subsection, "skilled- equivalent" means... This requirement was not met as evidenced by: A. Based on a review of Medical staff credential files and staff interview, it was determined in 4 of 4 Medical staff credential files reviewed, the PTC failed to ensure notarized documentation indicating the name of the Illinois' licensed hospital(s) where the physician had skilled- equivalent practice privileges was maintained in the credential file. Findings include: 1. Four out of four Medical staff credential files reviewed failed to include notarized documentation indicating the name of the Illinois' licensed hospital(s) where the physician had skilled- equivalent practice privileges. 2. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above findings were confirmed.	We have on file 2 hospital letters for Dr. Allen Palmer and Dr. Mandy Gittler. The doctors will provide notarized statements and a copy of the hospital face sheet. Completion Date: July 7, 2011 Dr. Smith is re-applying for staff privileges in Chicago. The Medical Director will follow and the Administrator will keep them current.
Section 205.230 Standards of Professional Work	(a)(5) The consulting committee shall act as a tissue committee and shall review at least quarterly pathological reports from procedures performed by each physician on the staff. Evidence of such review shall be recorded in the minutes. This requirement was not met as evidenced by: A. Based on a review of PTC policy and staff interview, it was determined the PTC failed to ensure tissue pathological reports	

	were reviewed, and documentation of the review, by the consulting committee quarterly. Findings include: 1. The PTC policy titled "NHC Standards of Professional Work" was reviewed. It indicated "6. The consulting committee shall review tissues quarterly and the review will be recorded in the minutes. All physicians performing procedures at the center will have their tissue reports evaluated." There was no documentation to indicate the consulting committee met in 2008, 2009, 2010, or 2011 or that tissue pathology reports were reviewed. 2. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above finding was confirmed.	The tissue reports are checked by the staff RN and signed off. All reports that are under 10gms are followed up by the Administrator and reviewed with the physician, he then initials the report. Any tissue reports that are inconsistent with the ultrasound and doctors findings are also reviewed. The tissue reports are then placed in the individual patient's chart. H.8 This is currently being done and has been done for the last 25 years Completion Date: July 7, 2011 Administrator will follow-up
Section 205.230 Standards of Professional Work	(b)(1) The Medical Director shall secure compliance with the policies and procedures pertaining to medical and surgical procedures, approved by the consulting committee. This requirement was not met as evidenced by: A. Based on a review of PTC policy manual and staff interview, it was determined the PTC failed to ensure compliance with the policies and procedures pertaining to medical and surgical procedures approved by the consulting committee. Findings include: 1. The PTC policy manual was reviewed. Policy and Procedure Review documentation indicated "Review of Policy and Procedure will be done on a semi-annual basis..." There was no documentation to indicate the policies and procedures had been approved by the consulting committee. The review sheet indicated review completed by the Administrator only. 2. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above finding was confirmed.	Approval sheet with Medical Director initials. Completed: July 7, 2011 I 9 Ex I 9 Administrator will follow-up Exhibit #3 Re-typed and resubmitted.
Section 205.230	(b)(2) The Medical Director shall be responsible for	

Standards of Professional Work	the implementation of medical policies and procedures contained in the facility's policies and procedures manual (Section 205.240) governing the professional personnel involved directly in the care of patients undergoing surgical procedures... This requirement was not met as evidenced by: A. Based on observation, clinical record review, a review of Medical Practice Act of 1987, a review of Part 1300 Nurse Practice Act, a review of Staff Nurse job description, and staff interview, it was determined in 10 of 20 (Pts #2, #4, #5, #7, #10, #11, #14, #17, #19, #20) clinical records reviewed, in which the patient required Intravenous (IV) moderate sedation, the PTC Medical Director failed to ensure delegation of IV moderate sedation was to staff practicing within their scope of practice. Findings include: 1. During a tour of the PTC, conducted on 6/16/11 at 10:15 AM with the Administrator, it was verbalized by E-1 that Intravenous (IV) moderate sedation was performed by E-1, who is an LPN. It was further confirmed by the Administrator that LPNs administer IV moderate sedation. 2. Ten out of twenty clinical records reviewed (Pts #2, #4, #5, #7, #10, #11, #14, #17, #19, #20), in which the patient required IV moderate sedation, documentation indicated it was administered by an LPN. 3. The 225 ILCS 60/) Medical Practice Act of 1987 was reviewed. It indicated "Section 54.2. (b) In an office or practice setting and within a physician- patient relationship, a physician may delegate patient care tasks or duties to an unlicensed person who possesses appropriate training and experience provided a health care professional, who is practicing within the scope of such licensed professional's individual licensing Act, is on site to provide assistance."	Intravenous (IV) moderate sedation was done with the physician present in the operating suite. The L.P.N. has been IV certified, but after review from the department, that will no longer be done at this facility. Completed: June 23, 2011 Wanda Ball RN head nurse will follow-up. The Director will oversee head nurse. Policy changed. Completed June 23, 2011, Wanda Ball RN head nurse will follow-up. The Director will oversee head nurse. The Medical Practice Act of 1987 (225 ILCS 60) was reviewed by the staff physician and all duties that are delegated to unlicensed personnel will be initialed and kept in a log and signed off by the corresponding health care professional. The head nurse in the department will be responsible. Log book created. Completion date: June 30, 2011 Administrator will follow-up and do a random check.

	4. Part 1300 Nurse Practice Act was reviewed. It indicated "Section 1300.240 Standards for Pharmacology/ Administration of Medication Course for Practical Nurses... g) The curriculum shall not include the following procedures: ...3) Administering medications via intravenous push or administering heparin in heparin locks." 5. The Staff Nurse job description was reviewed. There was no delineation between the requirements and duties of an RN or LPN. 6. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above findings were confirmed.	This has been corrected and the new curriculum will not include administering medications via intravenous push by an L.P.N.. Completed: June 30, 2011 Wanda Ball, RN will supervise. The Director will oversee head nurse. Staff nursing job description is currently being revised; delineation between the LPN and RN has been completed. Completion Date: June 30, 2011 Wanda Ball, RN will supervise. The director will oversee head nurse and do job description on a yearly basis.
Section 205.230 Standards of Professional Work	B. Based on observation, a review of Medical Practice Act of 1987, a review of personnel file, and staff interview, it was determined PTC Medical Director failed to ensure delegation of compounding of parenteral medications was to staff practicing within their scope of practice. Findings include: 1. During a tour of the PTC, conducted on 6/16/11 at 10:15 AM with the Administrator, E-4 was observed drawing up syringes of Lidocaine 5 ml with 0.2 ml Vasopressin. It was verbalized by E-4 and the Administrator that E-4 adds 5 ml 8.4% Sodium Bicarbonate just before use, due to instability of the medication. When E-4 was asked what her title was, E-4 stated "a certified nursing assistant (CNA) and one of the duties performed is the preparation of the above syringes for procedures. 2. The 225 ILCS 60/) Medical Practice Act of 1987 was reviewed. It indicated "Section 54.2. (b) In an office or practice setting and within a physician- patient relationship, a physician may delegate patient care tasks or duties to an unlicensed person who possesses appropriate training and experience provided a health care professional, who is practicing within the scope of such licensed professional's individual licensing	We now have two (2) people trained to assist the staff nurse in loading the Lidocaine Mix. This staff was trained by Wanda Ball, RN and is documented in the Lidocaine Log. A staff nurse is always present and they are the only people allowed to compound the medication. Each bottle is mixed, dated and initialed by the nurse. When the assistant draws up the mixture, the syringe is then labeled. J10 I have included the new daily log sheet to be signed off by the nurse who was compounding the mix and supervising the loading of the syringes. Completed and documented June 30, 2011 This will be monitored by the Administrator daily, by initialing the log sheet at the days end. These logs will be reviewed by the Q.I. committee ~~monthly~~ quarterly. K11

	Act, is on site to provide assistance." 3. The personnel file of E-4 was reviewed. There was no documentation to indicate E-4 had been instructed and/or demonstrated competency in the compounding of parenteral medications. 4. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above findings were confirmed.	Ms. Young and any other personnel that will be filling, the compounded Lido mixture will have technique training recorded in their employee charts and verified by the Head O.R. nurse Wanda Ball RN. Completed: June 30, 2011 Wanda Ball, RN will follow-up. The Director will oversee head nurse.
Section 205.230 Standards of Professional Work	C. Based on observation, a review of personnel files, a review of the Sonogram Technician job description, and staff interview, it was determined the PTC Medical Director failed to ensure sonogram procedures were performed by personnel with knowledge and demonstrated competency in performing the procedure. Findings include: 1. During a tour of the PTC, conducted on 6/16/11 at 10:30 AM, E-5 was observed assisting patients into and out of the sonogram room. It was verbalized by E-5 that she performs the sonograms to determine the age of the fetus prior to the procedure. When asked what training had been provided, E-5 verbalized that the Administrator had instructed her in performing sonograms. 2. The personnel file of E-5 was reviewed. There was no documentation to indicate E-5 had been instructed and/or demonstrated competency in performing sonograms. 3. The Sonogram Technician job description was reviewed. There was no documentation to indicate what education and/or qualifications were required for the position. It indicated "The Sonogram Technician is directly responsible to the Director of the Clinic and the physician." 4. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above findings were confirmed.	All sonographers have been under the direction since 1999 of Jolette Cole RT(ARDMS). She is an X-ray technologist that specializes in ultra sonography. We have her qualification and training records in the sonography binder. We will now add them to each employee verified to perform ultra sound. Completion Date: July 1, 2011 The Administrator and Ms. Cole will follow-up. Ex # 5 Ex # 25 The Sonogram Technician job has been re-written to reflect what is required for the position. Completed July 1, 2011 Responsible physician of the day and the Administrator I did not confirm this; I was not asked or consulted.
Section 205.240 Policies and	The management/ owner of the ambulatory surgical treatment center shall formulate a written	

Procedures Manual	policies and procedures manual. This shall be done in cooperation with the medical and professional staff and shall be approved by the consulting committee. These procedures shall provide for the acceptance,... This requirement was not met as evidenced by: A. Based on a review of PTC policy manual and staff interview, it was determined the PTC failed to ensure its policies and procedures were approved by the consulting committee. Findings include: 1. The PTC policy manual was reviewed. There was no documentation to indicate the consulting committee had approved the manual. 2. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above finding was confirmed.	New form written and placed in PTC manual for Consulting Committee approval. #3 Completed: July 15, 2011 Administrator will follow-up
Section 205.310 Personnel Policies	Each ambulatory surgical treatment center shall have written personnel policies including... There shall be a documented procedure for orientation of new employees to the facility's policies and procedures as well as the personnel policies including a copy of the appropriate job description. This requirement was not met as evidenced by: A. Based on a review of PTC personnel policy manual, a review of personnel files, observation, and staff interview, it was determined the PTC failed to ensure it established, implemented, and maintained a staff orientation program to ensure demonstrated competency in the respective job description. Findings include: 1. The PTC personnel policy manual was reviewed. There was no documentation to indicate a program to ensure orientation of each staff member to their respective positions and ensure demonstrated competency in the provision of services for that position had been established,	We will re-do all orientation by July 23, 2011 and it will be noted and signed by the supervisor. Completion Date: July 7, 2011 Followed-up by immediate supervisor. The Director will oversee orientation.

	implemented, and/or maintained. 2. Nine of 12 personnel files (E-1 thru E-4, E-6 thru E-10) failed to include documentation of orientation and/or demonstrated competency in the provision of services for the position in which each served. 3 of 12 (E-5, E-11, E-12) failed to have a personnel file. 3. During a tour of the PTC, conducted on 6/16/11 at 10:30 AM, E-5 and E-11 were observed providing care to PTC patients. It was verbalized by the Administrator that E-12 was an employee who provided "respiratory" and laboratory services. 4. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above findings were confirmed.	We had a form that was in the employee chart. We are all redoing them and they will complete all training. Ex #6 Completed: June 30, 2011 The Administrator will follow-up This is completely incorrect. E-12 was not here on the day of the inspection. E-5 and E-11 were doing their correct jobs. The employee you are referring to as E-12 is a CNA who is currently studying respiratory therapy. She was walking patients and works as a receptionist while being a full time student in respiratory therapy.
Section 205.320 Presence of Qualified Physician	A qualified physician shall be present at the facility until all patients are medically discharged. The discharge criteria shall be defined by the qualified consulting committee. This requirement was not met as evidenced by: A. Based on a review of PTC policy manual and staff interview, it was determined the PTC failed to ensure discharge criteria were established and approved by the consulting committee. Findings include: 1. The PTC policy manual was reviewed. There was no documentation of discharge criteria. 2. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above finding was confirmed.	We are re-doing the patient recovery sheet to provide a more detailed discharge. This will need Consulting Committee approval and printing. Ex D4 Completion Date: July 15, 2011 Follow-up by the Administrator.
Section 205.330 Nursing Personnel	(b) Nursing care may be provided by student nurses and LPNs who have been trained in observation and emergency techniques for preoperative and postoperative care of surgical patients and who are under the direct personal supervision of a RN at all times. This requirement was not met as evidenced by: A. Based on a review of personnel files and	Could be extended a few days due to the printing company.

	staff interview, it was determined the PTC failed to ensure LPNs were trained in observation and emergency techniques for preoperative and postoperative care of surgical patients. Findings include: 1. Three out of three LPN personnel files reviewed failed to include documentation of training in observation and emergency techniques for preoperative and postoperative care of surgical patients. 2. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above finding was confirmed.	All new employees will go through the emergency training and this will be documented in their file. The staff will go through this re-check every year. The Q I. team will review this training and the Administrator will follow-up. The physicians will be available to discuss any new medical situation that may arise. The nursing staff will have an inservice about emergency techniques pre and post operative. The topics will be covered and Dr. Mandy Gittler will review the emergency situations. Completion Date: July 7, 2011 Follow-up and charted by Recovery Head Nurse. The director will oversee the head nurse.
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. This requirement was not met as evidenced by: A. Based on a review of PTC agreements and staff interview, it was determined the PTC failed to ensure it had a written agreement with a CLIA certified laboratory for procedures which are not performed in the center. Findings include: 1. The PTC agreements were reviewed. There was no agreement with a CLIA certified laboratory for procedures which are not performed in the center. 2. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above finding was confirmed. A form was presented with a Methodist Medical Center of Illinois laboratory sheet and a stamp of National Healthcare Services name on the top. It was verbalized that this form was what was utilized and no formal agreement was in place.	We have a current written agreement from Methodist Medical Center Laboratory. This has been a 30+ year agreement. I have included their CLIA certificate and the agreement Ex # 7 Completed June 17, 2011 Followed by the Administrator.
Section 205.410 Equipment	Equipment shall be in good working order... This requirement was not met as evidenced by: A. Based on observation, a review of PTC	

policy manual, a review of PTC sterilizer information book, and staff interview, it was determined the PTC failed to ensure it established, implemented, and maintained an ongoing preventative maintenance program for equipment utilized in the provision of patient care.

Findings include:

1. During a tour of the PTC, conducted with the Administrator on 6/16/11 at 10:45 AM, the following items were observed with no documentation to indicate when preventative maintenance had been performed: In Room #3, one Berkly Model VC-II, one Gleamer Light, and one Welch-Allyn Blood pressure machine; in the sterilization area, one Pelton-Crane and two Tuttrauer Sterilizers; in the Sonogram room, the sonogram machine; and in the laboratory room, the centrifuge; in the hallway next to the crash cart, one portable oxygen tank with a sticker which indicated last check was 10/16/2000 and when the tank was turned on it indicated "Need refill line". It was verbalized by the Administrator and E-5 that equipment did not undergo preventative maintenance. Both verbalized that "If we have a problem, we just call the company and they come repair whatever it is."
2. The PTC sterilizer information book was reviewed. It indicated one Pelton-Crane and two Tuttrauer Sterilizers. The Pelton-Crane requisition type form was dated 1994 and the Tuttrauer requisition type form was dated 1995. It was verbalized by the Administrator that this was the last time the sterilizers were maintained, as "we call if we have any problems."
3. The PTC policy manual was reviewed. There was no policy to address the preventative maintenance of patient care equipment.
4. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above findings were confirmed.

Ex 015

A preventative maintenance log has been established for all equipment. This will include Sterilizers Welch Allyn Blood Pressure, Berkley VCII, SONO and the centrifuge.

Kirk Medical Equipment Medical Repair Service
705 E Lincoln #114
Normal, IL 61761

He has the above equipment in his possession at this time. They will all be checked and returned before clinic on June 30, 2011.

Completed: June 28, 2011

The Gleamer Lights: if the bulb burns out it is replaced, if it does not function correctly we call the company.

The Welch Allyn is self testing and routinely checked and when Richmark is here. They will be checked and signed off.

Completed June 28, 2011

The machine manual will be checked and signed yearly and is added to the crash cart list.

The Oxygen Tank was refilled and checked.

Completed June 28, 2011

Ex 8

Oxygen tank will be added to crash cart list. Followed by head OR nurse. The Administrator will oversee the head nurse.

New policy will be written on machine maintenance.

H 8

Completion Date: June 30, 2011

The Administrator will oversee this and sign off yearly.

The Q.I. team will review quarterly.

Ex 15
17

Equipment	assure the safety in storage and use of all narcotics and medications in accordance with state and federal law. This requirement was not met as evidenced by: A. Based on observation, a review of PTC policy manual, and staff interview, it was determined the PTC failed to ensure drugs were stored in a locked cabinet, as per PTC policy. Findings include: 1. During a tour of the PTC, conducted with the Administrator on 6/16/11 at 10:45 AM, the following medications were observed unsecured, and/or unlabeled: a) In the Handicap counseling room: 10 stacked unlabeled medication cups with 2 tablets of Aleve sitting on the lamp stand. b) In the Recovery Room: 1 unopen and 1 open bottle of 100 tablets of Misoprostol 200 micrograms per tablet in an unlocked drawer. All open vials, in each area, failed to indicate when they were opened. c) In Procedure Room #1: 1 unopen and 1 open vial of Fentanyl 50 micrograms per ml; 1 open vial of Midazolam 5mg per 10 ml, and 1 unopen vial of Atropine 0.4 mg per ml on the procedure stand inside the door. d) In Procedure Room #2: 1 open vial of Fentanyl, 1 unopen and 1 open vial of Midazolam, and 1 unopen vial of Atropine on the procedure stand inside the door. e) In Procedure Room #3: 1 open vial of each Fentanyl and Midazolam and 1 unopen vial of Atropine on the procedure stand inside the door. 2. The PTC policy titled "Medication Handling Protocol" was reviewed. It indicated "All medications are to be stored in a locked cabinet in the Recovery Room and will... All narcotics are stored under lock and key..." 3. During a staff interview, conducted with	Aleve will no longer be left in cups, they will be directly given by the counselor Completed June 30, 2011 Recovery Nurse will implement and follow-up. The Administrator will oversee. The med drawer in Pre-Op was left unlocked, the staff nurse has been reprimanded. We have had a staff in service, all bottles will be labeled when opened, and drawer will be locked at all times. Completed: June 30, 2011 Recovery Nurse will follow-up. The Administrator will oversee. All Procedure Room drugs will be locked in individual boxes, the nurse in the operating room will sign in and out in recovery Completed June 23, 2011 Recovery Head Nurse responsible and will follow-up. Reviewed on clinic days by the Administrator and signed off as checked as correct after the head nurses. The narcotics are now totally secured and locked. Completed: June 23, 2011 Head Recovery Nurse is accountable for signing drugs out and checking them back in. Each nurse will count with the head nurse. Checked end of procedure days as complete by the Administrator.

	the Administrator on 6/16/11 at 2:30 PM, the above findings were confirmed.	
Section 205.410 Sanitary Facility	(a)The Ambulatory surgical treatment center shall insure maintenance of a sanitary facility with all equipment in good working order. Written procedures shall include provision for... This requirement was not met as evidenced by: A. Based on observation, a review of PTC Sterilizer Monitoring log, and staff interview, it was determined the PTC failed to ensure sterilizers were cleaned monthly, as per its monitoring log requirement. Findings include: 1. During a tour of the PTC, conducted on 6/16/11 at 10:45 AM, 1 Pelton Crane and 2 Tuttnauer sterilizers were observed in the sterilizer area. On the Sterilizer Monitoring log, it indicated all 3 sterilizers were to be cleaned on 6/7/11. There was no documentation to indicate 3 out of 3 sterilizers had been cleaned on that day or since. 2. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above findings were confirmed.	The sterilizers are at Kirk Repair, they are being cleaned and maintenance performed. 4 8 Completed: June 28, 2011 Lead surgical technician is responsible and cleaning of the sterilizers will be documented. They are cleaned monthly. A log is already established and current. 4 9 Completed: Current to June 28, 2011 Lead surgical technician is responsible. Followed and checked by the Administrator.
Section 205.410 Sanitary Facility	B. Based on Policy review, observation, and staff interview, it was determined the PTC failed to ensure infection control processes were maintained to prevent the potential for cross-contamination of patient care items. Findings include: 1. The Facility policy indicated "all laundry is processed on site and requires no special labeling of contaminated linen provided that Universal precautions are adhered to when handling." There was no documentation to indicate the linens were laundered and water temperatures were monitored, as necessary to prevent the potential for cross contamination of	Laundry is processed on site. All linen used is out in a yellow contaminated laundry bag as was explained. There was a laundry handling procedure in the OSHA Policy Book. Meister Plumbing is coming to see about a higher temperature setting. Laundry Precautions will be reinforced by the Administrator As of June 30, 2011, we will be using paper gowns until this issue is resolved Completion Date: July 18, 2011 Administrator will follow-up

	contagions. 2. During a tour of the PTC, conducted on 6/16/11 at 10:45 AM with the Administrator, the following items were observed: On the crash cart, 2 cups of snack nuts and packages of prepackaged cookies. In 3 out of 3 procedure rooms, emesis basins with open packages of bandaids and open 2x2 gauze squares. In the Medication Closet, 4 or more boxes of various birth control medications and patient care items were stored on the floor. It was verbalized by the Administrator that these were to be picked up by a disposal company today. These boxes were open and there was nothing to indicate that these were not available for patient use. 3. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above findings were confirmed.	(a) There are no snacks on the crash cart shelf (b) Band-Aids will not be opened before they are to be applied. (c) Boxes of pills were taken by Medical Waste as I stated. All patient supplies have been elevated off the floor (d) No open 2x2 in emesis basins Completed: June 22, 2011 Administrative Assistant along with Head OR nurse will follow-up. The Administrator will oversee Administrative Assistant.
Section 205.510 Emergency Care a) b)	a)Each facility shall have a written plan of procedure to be followed in case of fire, explosion, or non-patient medical emergency... b)Each facility shall be prepared to manage those emergencies which may be associated with procedures performed there. These requirements were not met as evidenced by: A. Based on a review of the policy and procedural manuals, a review of personnel files and staff interview, it was determined the Facility failed to ensure staff training for emergency or non-emergency situations were conducted. Findings include: 1. The PTC policy and procedural manual was reviewed. Policies related to emergency preparedness and/or non-medical emergencies were present; however, 12 of 12 personnel files failed to indicate staff was trained in handling emergencies of any type. The Administrator indicated training had taken place, but training was not	On June 29-30, 2011, we will repeat emergency preparedness, Pathogens, P P E, TB and will be recorded and available for inspection. The Administrator and Head OR nurse are both OSHA certified trainers and our re-certificate is in Bloomington in August. Completed: June 29-30, 2011 The Administrator is responsible The Q.I. team will review monthly.

Ex 16

recorded.

2. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM.

Section 205.520 b) Pre-operative care

b) A complete medical history shall be obtained and the physical examination shall be complete. A pre-anesthetic evaluation shall be completed specifically identifying any patient sensitivity or contraindications to anesthesia.

This requirement was not met as evidenced by:

Findings include:

A. Based on a review of twenty clinical records and staff interview, it was determined the Facility failed to ensure medical histories and complete physical examinations were reviewed by the physician prior to the procedure.

1. Twenty clinical records were reviewed on survey date 06/16/11. None of the records contained documentation to indicate the histories (completed by the patient), nor the physical examinations (laboratory work, pelvic, and sonogram completed by the nurse, laboratory, and/or sonographer) were reviewed by the physician prior to the procedure. There was no documentation to indicate a pre-anesthetic evaluation was conducted, prior to the administration of IV moderate sedation, on any patients records reviewed.

2. An interview was conducted with the Administrator on 06/16/11. It was verbalized that the patients fill out their own histories. There was no documentation to indicate the physician or nurses administering IV sedation reviewed the medical histories. The Administrator indicated the

We are re-writing the chart to include an area for the documentation to indicate physician review of all the pertinent information and pre-sedation evaluation. Spacing will be provided for nurse evaluation also. During our Consulting Committee meeting, we will discuss how to implement more of a physical exam.

Completion Date: July 20, 2011.

The Administrator and Medical Director will be responsible.

The Q.I. team will review on a quarterly basis. This will be done the last clinic day of the month. If any problems are discovered the issue involved will be discussed with the appropriate staff and how to correct the situation.

Completion date: August 31, 2011

E-17

	only examination completed was a pelvic exam, a sonogram and laboratory work-up. 3. During a staff interview, conducted with the Administrator on 6/16/11 at 2:30 PM, the above findings were confirmed.	
Section 205.530 a) b) 2) E) i) ii) iii) Operative Care	a)Surgical procedures shall be performed only by a qualified physician within the limits of the defined specific practice privileges that have been granted..... b)Administration of Anesthesia 2) Anesthesia may be administered only by the following persons, each having been granted specific anesthesia privileges by the consulting committee or a committee designated by the consulting committee. E) A registered nurse. If the ASTC policy allows the registered nurse to deliver moderate sedation ordered by a physician licensed to practice medicine in all its branches the following are required: i) The registered nurse must be under the supervision of physician.... ii) The registered nurse must attain ACLS certification.... iii) The supervising physician licensed to practice medicine in all its branches,...must have training and experience in delivering and monitoring moderate sedation and possess clinical privileges at the ASTC to administer moderate sedation or analgesia..... These requirements were not met as evidenced by: A. Based on policy review and a review of physician credentials and files, it was determined the Facility failed to ensure any physician had defined specific privileges granted.....	Asked and answered Completed
	Findings include: 1. The Facility policy titled "Standards of Professional Work," indicated: #4. When a staff position for a physician becomes available, all applications will be reviewed by the committee. All physicians at the	Asked and answered Ex # 2

	center will have practice privileges available for staff use and public information within the Facility. 2. Four of four physician files were reviewed on survey date 06/16/11. There was no documentation to indicate surgical and/or anesthesia privileges had been applied for and/or granted to any physician by a consulting or designated committee. 3. The above findings were verified with the Facility Administrator on 06/16/11 at 10:00 am	All physicians will be renewing credentials at the Consulting Committee meeting. The meeting will be on July 7th, depending on the ability to get everyone together. This meeting will include practice privilege and sedation privileges. Completion Date: July 7, 2011 Ex # 2 Administrator will follow-up
Section 205.530 Operative Care b) 2) E) i) ii) iii)	B. Based on a review of the IL Nurse Practice Act, a review of clinical records, a review of personnel files, and staff interview, it was determined that the Facility failed to ensure personnel administering intravenous sedation were qualified in the State of IL to administer anesthesia. Findings include: 1. The Illinois Nurse Practice Act, part 1300.240 "Standards for pharmacology/administration of medication course for practical nurses," indicates: f) This (LPN) curriculum shall prepare the LPN to start peripheral intravenous therapy that consists of a short catheter inserted through the skin into a peripheral vein. g) The curriculum shall not include: #3) Administering medications via intravenous push or administering heparin in heparin locks. 2. Ten (Pt. #'s 2, 4, 5, 7, 10, 11, 14, 17, 19, &20) of twenty clinical records contained documentation that an LPN had administered the IV sedation prior to the pregnancy termination procedure. All patients received the standard ordered Fentanyl, 50mcg and Midazolam (Versed) 2.5mg, intravenous push, (IVP). 3. There was no documentation in three of three LPN files reviewed to indicate any LPN had been "IV certified." There was no documented evidence in the LPN credential files to indicate the LPNs possessed IV certification certificates. The	The L.P.N, who is IV certified and the certificate was in her folders, is not longer doing IV sedation. The physician was present in the room at the time. There will be an R.N. in the room; I am placing an Ad for a new RN in room 2. At this time we will not use the 3rd OR room. Completed: June 30, 2011 The Head OR nurse will follow this and no L.P.N. will give IV medication. This will be checked by the Administrator on a random basis.

	LPN files contained current licensure, applications, as well as, confidentiality statements. 4. During an interview with the Facility Administrator conducted on 06/16/11 at 3:00 pm, the above findings were verified.	
Section 205.530 E) i) ii)iii)&v)	A registered nurse. If the ASTC policy allows the registered nurse to deliver moderate sedation ordered by a physician licensed to practice medicine in all its branches the following are required: i)The registered nurse must be under the supervision of a physician licensed to practice....and have no other responsibilities during the procedure. ii)The registered nurse must maintain current Advanced Cardiac Life Support (ACLS) certification.... iii)The supervising physician licensed to practice...must have training and experience in delivering and monitoring moderate sedation and possess clinical privileges at the ASTC to administer moderate sedation or analgesia. v)The supervising physician licensed to practice medicine in all its branches... must maintain current ACLS certification as appropriate to the age of the patient. These requirements were not met as evidenced by: A. Based on observation, a review of personnel credential files and staff interview, it was determined the RNs administering moderate sedation had multiple clinical responsibilities, were not ACLS certified and the physicians were not privileged to administer moderate sedation. Findings include: 1. During a tour of the PTC it was observed that the RNs were performing many tasks other than continual observation of the patients receiving IV sedation. The duties included but were not limited to, laboratory/ phlebotomy, counseling,	I have no nursing personnel that have ever done laboratory or phlebotomy procedures. They do counseling pre-op, operating room and recovery as needed and within their scope of training. Completed June 23, 2011 Administrator will follow-up

	prepping other patients, preparing medications and post recovery. 2. The credential files of all RNs, (3), and physicians, (4), were reviewed on survey date 06/16/11. There was no indication any of the RNs were ACLS certified. There was no documentation to indicate 3 of 4 physicians (P-1, P-2, P-4) were ACLS certified. 3. The above findings were verified with the Facility Administrator on 06/16/11 at 3:00pm.	The patient is never alone and the physicians are giving all IV medications. The physician does not leave the room until the procedure is over. They are all ACLS certified. The R.N.s are taking the exams as this is written. We have received one back and the R.N. passed. The patient is taken to recovery by the R.N. Since the physician is giving the IV sedation the R.N. is there and will monitor the patient completely. Completion Date: July 20, 2011 Checked by the Medical Director and filed in chart by Administrator
Section 205.530 e)	e) A registered nurse, qualified by training and experience in operating room nursing, shall be present in the operating room and function as the circulating nurse during all invasive or operative procedures.... This requirement was not met as evidenced by: A. Based on observation and staff interview, it was determined the Facility failed to ensure all RNs were present in the procedural area at all times during the termination of the pregnancy. Findings include: 1. During a tour of the Facility conducted on survey date 06/16/11, it was observed that RN performed multiple tasks, or was not present at all during the invasive procedures performed. Documentation indicated LPNs were, at times, solely, the only nursing staff in the patient procedural rooms. All staff members performed multiple tasks and the 2 different, non - current, personnel sheets indicated all staff were performing multiple tasks daily from clerical work, performing sonography, patient preparations, recovery, counseling, drawing pre-filled medications, assisting the physician, etc. 2. During an interview with the Facility Administrator conducted on survey date, 06/16/11 at 2:00 pm, the Administrator indicated she was not aware of the new regulations and that they "had always	The charts are reviewed by the Administrator and the Q.I. team. The chart is the record for the R.N. that was in the operating room. All staff have multiple tasks, the RN will always be present in the operating room. No LPN will be in the operating room without an RN during an invasive procedure. As to multiple tasks you implied that just anyone is doing anything. I have validated all positions you questioned. Followed by OR head nurse and the Administrator will oversee. I have no answer; everyone is trained to perform multiple tasks. Completed June 30, 2011 Administrator will follow along with the appropriate supervisor, this will be documented if necessary

R 18
5 19

205.620 Statistical Data (a) 3), 4), 5)	performed this way." a)Each ambulatory surgical treatment center shall collect, compile and maintain the following clinical statistical data..... 3) the number and type of complications reported, including specific procedure associated with each complication; 4) the number of patients requiring transfer to a licensed hospital for treatment....list the procedure performed... 5) the number of deaths, including the specific procedure that was performed. These requirements were not met as evidenced by: A. Based on a review of the comprehensive data sheets presented and staff interview, it was determined the Facility failed to ensure all administrative statistical data including report entries and error reports were conducted as required, quarterly. Findings include: 1. There was no actual data presented or reviewed for the center. The documentation presented included reported numerical counts of procedures performed per month. The last counted statistics was dated March of 2011. The statistical data report failed to include the specific procedures conducted, any or no complications, specific procedures utilized, medical or surgical abortions, the number of transferred patients, or the number of adverse reactions or deaths. 2. The Administrator indicated in an interview on 06/16/11 at 10:00 am that "we've had no problems in the last 36 yrs." It was indicated that there had never been an adverse event, a transfer out or a death. The above findings were verified with the Administrator on 06/16/11 at 2:30 pm.	We have made a new form to accommodate the regulation. It is included and the information is available for inspection. This form will include all the information required. Ex: 11 SAME AS Ex 11 Ex T-20 Completed: June 28, 2011 Followed by Head Receptionist. Reviewed by Administrative Assistant. This clinic has never had a death or serious life threatening issue as a result of any procedure done. We have had transfer out on a couple of occasions but they were not surgical incidence related. Completed: June 30, 2011 Followed-up by the head receptionist and Administrator.

Ex # 1

DEPARTMENT ORGANIZATIONAL CHART

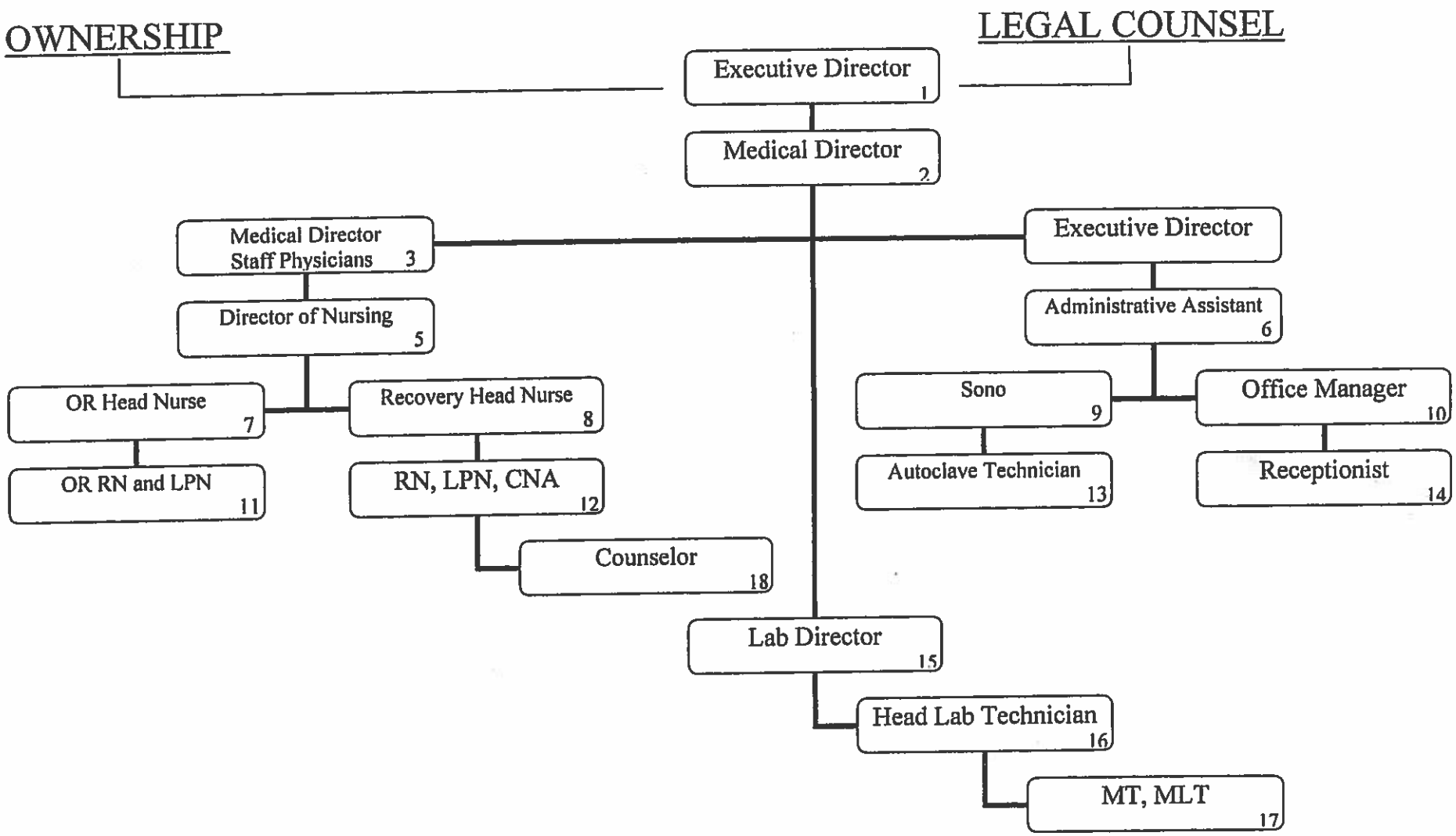


Exhibit #20

July 7, 2011
Consulting Committee

Attending:

1. Bernard Smith, M.D.—Medical Director
2. Allen Palmer, D.O.—Senior Staff OB-Gyn
3. Mandy Gittler, M.D.
4. Margaret Van Duyn, Administrator

The meeting commenced at 1:00pm. We will be reviewing policy, procedures and a review of pathology reports.

The committee will meet quarterly: September, December, March, and June.

On June 16, 2011, the Illinois Department of Public Health surveyed our P.T.T. A Plan of Correction was submitted to us.

We have instituted a procedure for granting privileges at the P.T.C. for a new staff physician:

1. Resume
2. Current Illinois License
3. Illinois Hospital Affiliation
4. Notarized letter stating privileges
5. Outstanding malpractice issues
6. ACLS certified
7. Applicant's expectation
8. OR skills evaluated by the Medical Director
9. Type of privilege granted

Should any concerns arise they will be discussed and reviewed by the Medical Director. All staff physicians are being reviewed and brought up to current requirements. Dr. Stewart Kernes is not on staff at this time. If he needs to be reinstated, his credentials will be reviewed and privileges applied for will be evaluated.

Discussion was held about a circulating nurse. The requirement is that an R.N must be in the OR during invasive procedures. We will drop down to 2 procedure rooms. We only have 3 R.N.s on staff, so we will have to try some other options.

The physician will now give all intravenous sedation.

All medication will be secured in a locked box in the individual operating rooms. The R.N. will be responsible for checking the medications in and out with the recovery room nurse. The count shall be done before and after surgery.

Discussion was held in depth about ACLS certification and how that will be accomplished. The physicians are looking into dates and courses. Certification will be documented as the course.

Chart pages were reviewed and changes are being discussed as how to validate that the physician and nurse have reviewed the chart. The physicians will review the chart as changes are made and printed. The Consulting Committee will review the final chart pages in question.

We now have a document that requires the staff physicians to sign off semi-annually after the Policy and Procedure Manual has been reviewed.

The new transfer agreement, and laboratory acceptance from Methodist Medical Hospital was reviewed and accepted.

20 Path reports and charts were reviewed.

5 Path reports—Dr. Bernard Smith
8 Path reports—Dr. Allen Palmer
7 Path reports—Dr. Mandy Gittler

All charts were accepted.

Meeting adjournment: 3:05

Respectfully Submitted,

[redacted]

Margaret A. Van Duyn
Administrator

Bernard Smith, M.D.

Allen Palmer, D.O.

Mandy Gittler, M.D.

Ex-2

205.230
a(2)

A.

1. When a physician applies to the P.T.C. for staff privilege the following will be noted and placed in the physician's file. The information will be held by the Medical Director.

1. Resume
2. Current Illinois License
3. Illinois hospital affiliation
4. Notarized letter stating privileges
5. Outstanding malpractice issues
6. ACLS Certified
7. Applicant's expectations
8. OR skills evaluated by Medical Director
9. Privileges granted

Completion Date: July 7, 2011

The Medical Director will do the interview and review the information, it will be in the physician's file. A yearly check will be initiated by the Medical Director. The Administrator files the paper work and validates the information.

Exhibit #21

Re-Credentialing Review
July 27, 2011

, M.D., our current Medical Director today, will review M.D., our staff physician for compliance in regards to staff privileges.

reviewed:

1. Resume
2. Current Illinois License
3. Illinois Hospital Affiliation, Illinois Masonic current and on active staff
4. Notarized letter stating privileges
5. No outstanding malpractice issues
6. ACLS certification will be completed August 5, 2011. Will follow-up for completion.
7. Dr. Gittler had her operating skills reviewed previously and again today.
8. Privileges granted for pregnancy termination and intravenous sedation.

I found the above requirements satisfied and current.

_____ _____

Date

_____

Margaret Van Duyn, Administrator

Physician Tissue Review

Month _____ Year_____

Surgery Date: _____ Charts Review Date _____ Physician_____

Comments: _____

_____

Surgery Date: _____ Charts Review Date _____ Physician_____

Comments: _____

_____

Surgery Date: _____ Charts Review Date _____ Physician_____

Comments: _____

_____

Surgery Date: _____ Charts Review Date _____ Physician_____

Comments: _____

_____

Surgery Date: _____ Charts Review Date _____ Physician_____

Comments: _____

_____

Surgery Date: _____ Charts Review Date _____ Physician_____

Comments: _____

_____

Surgery Date: _____ Charts Review Date _____ Physician_____

Comments: _____

_____

End of Month Review

_____
Benard Smith, M.D
Medical Director

_____
Margaret Van Duyn
Administrator

Revised July 12, 20111

Policy Procedure and Procedural Change

The Policy and Procedure Manual will be reviewed yearly. A comment section will be provided.

Incorporated in this section is also a procedural change. Whenever a change is made in the clinic, it will always be discussed by the Consulting Committee but in addition will be reviewed and signed off by the Medical Director. This will also be noted in the Q.I.

The Administrator will check this for completion yearly and whenever there is a procedural change.

Revised July 12, 2011

EX
I 9

Procedure Policy Review
Yearly Review

January 2011

Date: _____ _____
Medical Director

Comments: _____
_____
_____
_____
_____

January 2012

Date: _____ _____
Medical Director

Comments: _____
_____
_____
_____
_____

January 2013

Date: _____ _____
Medical Director

Comments: _____
_____
_____
_____
_____

Procedure Change

Date: _____

Describe Change: _____

_____

_____

_____

_____

_____
Medical Director

_____
Administrator

Revised July 13, 2011

Ex. 3

Policy and Procedure Review

Review of Policy and Procedure will be done on a semi-annual basis. Anytime a procedure is changed it will be noted in the comment section and dated.

Director	Dr. Palmer	Dr. Smith	Dr. Gittler	
_____	_____	_____	_____	January 2011
_____	_____	_____	_____	June 2011
_____	_____	_____	_____	January 2012
_____	_____	_____	_____	June 2012
_____	_____	_____	_____	January 2013
_____	_____	_____	_____	June 2013
_____	_____	_____	_____	January 2014
_____	_____	_____	_____	June 2014

Comments: _____

J 10
K 11

Lidocaine Medication Log

All bottles will be labeled and initialed by the compounding nurse.

The compounding nurse will oversee the drawing up of the medication and she will initial the following log.

Personnel trained to draw up the Lidocaine Mix will also be listed. The Administrator will be responsible to follow.

Date	# Drawn	# Discarded	RN/LPN	Assistant/Administrator

Revised 8-02-11

Ex # 5

[redacted]

Joette Cole

Objective

Registered Diagnostic Medical Sonographer, RDMS (ARDMS Certified)

Experience

July 1992 – August 1994 | Carle Clinic Association | Urbana, IL

Diagnostic Medical Sonographer

- OB/GYN

August 1994 – March 2000 | Dr. Carolyn Garcia | Bloomington, IL

Diagnostic Medical Sonographer

- OB/GYN
- Abdomen

March 2000 - Present | Sonultra | Bloomington, IL

Diagnostic Medical Sonographer

- Application Specialist
- Quality Assurance
- Sonography Consulting

March 2000 - Present | Downstate Diagnostics | Bloomington, IL

Diagnostic Medical Sonographer

- OB/GYN
- Abdomen
- Urology

Education

July 1991-July 1992 | University of Iowa | Iowa City, IA

Diagnostic Medical Sonographer

- ARDMS Certified – National Boards Taken August 1992
- Certified in Abdomen, OB, Physics

References

References are available on request.

Ex #5

ARDMS

The globally recognized standard of excellence in sonography 2011

ARDMS® HAS AWARDED CREDENTIALS TO

JOETTE L. COLE

CREDENTIALS

RDMS(AB OB/GYN)

ARDMS #	REGISTERED SINCE	STATUS	EXPIRES ON
29933	1982	ACTIVE	12/31/2011

Check for up-to-date status at www.ARDMS.org/MYARDMS.

#21 cont..

New Employee Orientation

_____ Initial interview and discussion of clinic policy, salary, workdays and time off.

_____ Privacy statement

_____ W-4 with birthday

_____ I-9

_____ Personnel Policy, Job Description

_____ Fire Drill, Disaster Training

_____ OSHA Testing

_____ Walk Through

_____ Hep. Vac.

_____ Lic.

_____
Date Completed

_____
Date Completed

_____ _____
Date Employee

Comments: _____

_____

_____

_____

_____

_____

_____ _____
Director

J 10

Job Orientation and Certification

Filed in Employee Chart

Employee: _____

Position: _____

Training Start Date: _____

Facilitator: _____

Comments: _____

_____

_____

_____

_____

_____

Training Completion Date: _____

_____ _____
Employee Signature Facilitator

_____ _____
Date Administrator

This will be filed in the employee record. Every task the employee is assigned will be evaluated in this manner.

Revised 7-13-11

ET #6

New Employee &
Employee Yearly Check

This will be done in June of each year.

Current Year _____

_____ 1. Privacy Statement

_____ 2. W-4 with birthday

_____ 3. Yearly Evaluation

_____ 4. Fire Drill, Disaster Training, OSHA

_____ 5. License, CPR, or certification

_____ Date _____ Employee

Comments on orientation and job competency: _____

_____

_____

_____

_____

_____

_____ Supervisor

_____ Administrator

#7Le cont...

National Health Care, Inc.

Title: Surgical Technician

Reports To: Staff Physician, Clinic Director

Education Requirements:

- High School Diploma or GED
- A person that has the ability to work within the guidelines of the clinic

Position Summary:

1. Ability to function as a team member
2. Be self-motivated
3. Able to assess a situation and act accordingly
4. Follow medical guidelines
5. Follow directions from professional staff in case of an emergency

Duties:

1. Check all supplies before procedure days so that anything needed can be made before procedures start
2. Set up each OR room
    a. Place bottles in the machine and hook up hoses
    b. Unwrap instruments and place a sterile towel over them
3. Ensure that RN has compounded Lidocaine mixture and drawn up syringes for patient procedures
4. During procedures:
    a. Remove dirty instrument packs and POC
    b. Check POC
    c. Wash and rewrap instrument packs, wrapping should be snug against contents
    d. Soak MVA's in OPA for 9-12 minutes, rinse, dry and put back in OR room (if used)
    e. Set up OR room for next patient procedure
    f. Sterilize instruments
5. End of day:
    a. Remove and wash all instrument packs, bottles, and hoses from OR
    b. Wrap and sterilize all instruments
        i. Date packs with month and day
    c. Place hoses back in OR rooms after cleaning
    d. Spray all surfaces with Cavicide and wipe down
    e. Pack products of conception for pick up and shipping

Physical and Emotional Requirements:

- Be in good health
- Able to lift and transfer a patient if needed
- Able to handle an emotionally demanding atmosphere

Revised July 13, 2011

National Health Care, Inc.

Title: Laboratory Technician

Reports To: Lab Supervisor, Lab Director, Clinic Director

Education Requirements:

- Graduate of a certified laboratory program or Military Field Service School and possess a certificate of completion
- Possess current CPR certification
- Have experience in Blood Bank

Position Summary:

1. Ability to perform laboratory testing
2. Ability to pass CAP proficiency test with a 100%
3. Be self-motivated
4. Ability to be respectful of patients

Duties:

1. Respect patient individuality
2. Follow accepted laboratory procedures
3. Perform and record daily controls
4. Chart and record laboratory results
5. Provide support if needed in the clinic
6. Recognize that if the patient is not tolerating the procedure well, provide support and call for help

Physical and Emotional Requirements:

- Be in good health
- Able to lift and transfer patient if needed
- Able to handle an emotionally demanding atmosphere

Revised July 13, 2011

Exhibit #25

National Health Care, Inc.

2011

Title: Sonogram Technician

Reports To: Staff Physician, Nursing Staff, Clinic Director

Education Requirements:

- RT, RN, LPN or Sonogram Trained
- Trained in Sonogram Techniques for gestational dating
- Able to be evaluated by our consulting RT for competency
- Possess current CPR certification (if requested)

Position Summary:

1. Perform ultrasounds, be aware that a vaginal probe can be stressful
2. Able to chart and record sonogram findings accurately
3. Respectfully acknowledge the need for patient privacy
4. Can demonstrate knowledge and understanding of NHC policy and procedures

Duties:

1. Determine positive pregnancy
2. Determine gestational age
3. Rule out ectopic pregnancy
4. Inform the proper staff person or staff physician of any abnormalities noted

Physical and Emotional Requirements:

- Be in good health
- Able to lift and transfer patient if needed
- Able to handle an emotionally demanding atmosphere

Revised July 13, 2011

Title: Staff RN

Reports To: Nurse Supervisor, Staff Physician, Clinic Director

Education Requirements:

- Graduate from an accredited school of nursing
- Possess a current Illinois Nursing License
- Possess current CPR certification
- Able to take ACLS if necessary
- Experienced in Surgical Nursing or Post Partum

Position Summary:

1. Ability to perform all nursing duties within the scope of the Nursing Practice Act
2. Able to assess a situation and act accordingly
3. Follow direction of the supervising nurse
4. Ability to function as a team member
5. Work with and support ancillary staff

Duties:

1. Perform all duties within the scope of the held nursing license
2. Demonstrate proper care of patients
3. Comfort and support patients while withholding judgment
4. Assist physicians in the procedure room
5. Provide emotional and physical support to patients
6. Perform physical assessments
7. Demonstrate skill in completing patient charts
8. Perform venapuncture
9. Give medications as needed
10. Operate basic emergency medical equipment and utilize medications on the crash cart (as directed by the staff physician)
11. Be accountable at the end of the day for any narcotics used
12. Dismantle and re-stock the OR

Physical and Emotional Requirements:

- Be in good health
- Able to lift and transfer patient if needed
- Able to handle an emotionally demanding atmosphere

Ex 4

National Health Care, Inc.

Job Descriptions

2011

Title: Staff LPN

Reports To: Nurse Supervisor, Staff Physician, Clinic Director

Education Requirements:

- Graduate of an accredited school of nursing
- Possess a current Illinois Nursing License
- Possess current CPR certification

Position Summary:

1. Ability to perform all nursing duties within the scope of the Nursing Practice Act
2. Ability to assess a situation and act accordingly
3. Take directions from Nurse Supervisor
4. Ability to function as a team member

Duties:

1. Talk with women in regards to their expectations about the procedure, pain relief, recovery, etc.
2. Ensure proper care of patients in a pre-surgical, surgical, or recovery phase (according to the policy and procedures of the clinic)
3. Comfort and support patients while withholding judgment
4. Demonstrate effective communication skills
5. Demonstrate excellent patient assessment skills
6. Demonstrate skill in completing patient charts
7. Exhibit basic nursing and aseptic techniques
8. Operate and understand basic emergency equipment use under a physicians direction

Physical and Emotional Requirements:

- Be in good health
- Able to lift and transfer patient if needed
- Able to handle an emotionally demanding atmosphere

Ex D4

Recovery Room
Admitting and Discharge Criteria

Each woman requires assessment immediately after the abortion to ensure that the uterus is contracting, bleeding is not excessive, and she is clinically stable.

All patients will be checked upon arrival, blood pressure, pulse and respiration. If the patient is overly sleepy, an O_2 saturation will be done. This information will be compared to the OR notes.

Routine Assessment:

1. Alertness and mental state
2. Degree of pain and disability
3. Admitting and discharge vital signs
4. Uterine seize and tone, usually assessed by abdominal examination
5. Amount of bleeding
6. Any other concerns the patient may have.

Pain management is essential. The pain is assessed and written in the chart upon Admit and Discharge along with vital signs. The recovery is responsible. Most pain results from uterine cramping, but all atypical pain, and pain in another area, shall be documented. This type of cramping should decrease in 15 minutes.

Severe pain is unusual after an abortion, if pain continues a hematometra may be forming.

Normal bleeding varies by gestational age. Passing clots can be considered normal; more may pass in larger gestation.

Excessive bleeding requires assessment by the clinician if bleeding does not respond to uterine massage or low dose uterotonic medication.

Discharge Criteria:

Patient is discharged on the written order of the physician. The following criteria will be met before discharge:

1. Vital signs are within normal limits (documented)
2. Bleeding is controlled (documented) must be moderate or less
3. Pain is less than 2 (1-5) and is documented
4. All paperwork, prescriptions, questions and aftercare will be reviewed and checked off.
5. Who is with the patient, if the patient has not had I.V. sedation, she may drive.
6. If I.V. sedation is administered, who is driving will be documented and the patients driver will be present before release.
7. Time of release will be documented.

Ex.
D4

Recovery Room Patient Care

1. Once OR nurse has placed patient in recliner, situate patient.
    a. Have blue pad already placed on chair
    b. Elevate feet by placing chair in reclined position
    c. Place white blanket over patient
    d. Give patient an ice pack to put over abdomen
    e. Give patient cup of Sierra Mist and cookies
    f. Ask if ride is already waiting for them (call if necessary)
    g. Ask how patient is doing and inform that cramping will calm down in about 15 minutes.

2. Patient's blood pressure is immediately taken and assessed.

3. Patient's initial post-op charting
    a. Write chair number in tab by name
    b. Write time patient arrived to post-op
    c. Write down blood pressure and pulse
    d. Indicate patient's pain level.

4. Visual assessment of patient is completed. Review patient IV site for redness. Apply ice on injecting site if needed. Document in chart if abnormal.

5. Recovery Time:
    a. No anesthesia and ride = at least 30 minutes
    b. Anesthesia and ride = at least 40 minutes
    c. No anesthesia and no ride = at least 45 minutes
    d. Patient is not allowed to have anesthesia if driving themselves
    e. Patient time may increase if patient has an abnormal assessment

6. Blood pressure is reassessed 5 minutes before discharge.

7. Medications are administered by nurse in post-op per Physicians orders.

8. Review patients chart for known allergies and daily medications before dispensing medications.

9. All patients receive and antibiotic. Standard is Doxycycline, 100mg, dispense #6 take twice a day with water and food and informed to avoid sunlight and antacids. If allergy to Doxycycline or other antibiotic then substitute Amoxocillin 500mg #15 for 5 days or another as instructed by the Physician.

10. All patients that are 12 weeks gestation or further received Methergine 0.2mg #6 one at dinner and bedtime today then three times a day until gone per standing order.

11. RH card is given to patients with negative blood types that received the RhoGam shot during the procedure.

12. Doctor's notes to excuse from work or school are given as indicated on post-op orders. Doctor notes state patient is able to resume normal activities after three days.

13. Birth control information is given as directed per Physician.

14. Any other information is given as directed by the Physician.

15. Abnormalities in Post-Op:

    a. Nausea/vomiting/restlessness/diaphoreses. Retake patient's blood pressure for possible drop from pre-procedure blood pressure. If low blood pressure is discovered and symptomatic, patient may receive 0.4 Atropine IM x 1 dose to elevate blood pressure symptoms. Patient is educated about need of medication due to blood pressure dropping and informed they will feel better in 5-10 minutes. Caffeine beverages are given as needed to assist in raising blood pressure.
    b. If patient has extreme nausea/vomiting that does not ease after vomiting, give patient Tigan 200mg IM per direct order of the Physician.
    c. Increased abdominal pain that does not ease after 10 minutes fundal massage to check for fundal bogginess. Possible return to Sono and possible return to procedure room for recheck and/or re-suction by Physician.
    d. Patients that did not receive any anesthesia but are having severe cramping/also those who have had anesthesia may have Toradol 30mg Po/IM as directed by the physician. Patients are informed the use of non-narcotic anti-inflammatory that helps with cramping.
    e. Patients who received anesthesia and are very drowsy and hard to arouse Spo_2 is assessed if low then 90% patient encouraged to deep breath if very drowsy and decreased reaction to sternal rub, standing orders to reverse anesthesia with Romazicon, after physician evaluation.
    f. All abnormal situations in post-op are relayed to physicians for orders.

16. Patients are released from Post-op, and then RN does not leave until the last patient has left the premises.

EX17

Pt. # _____ Pt. Name _____ Date____/____/____

SONO

1. LMP _____ Calc WK _____ Gravida ____ Para ____ SONO WEEKS_____

Sac Seen _____ Yolk Sac_____ Fetal Pole _____ CRL _____ B.P.D. _____

Other_____ _____Int.

LAB

2. Preg Test Sens: _____ Hgb _____Rh _____

Rho-Gam_____ Tech _____

PRE-OP

3. Time _____ B.P._____ Pulse _____

Misoprostol info: ☐ _____ Pt. Int. Misoprostol 200 mcg#2 ☐ _____Int.

P.E.

4. Gest_____ Ant_____ Mid_____Post_____Adnexa_____

Abnormalities were noted in the following areas: Heart_____ Lungs_____ Abd_____ Pelvis_____

OR NOTES

Admit Time _____ B.P. _____ Pulse _____ O_2 Sat _____

A. Paracervical block, Lidocaine HCL 1% 15 ml 20 ml Additives in block: 5cc 8.4% Sodium Bicarbonate 0.2 ml Vasopressin per 45cc Lidocaine

☐ Fentanyl 50 mcg given I.V. Midazolam HCL 2.5 mg ☐ 2.0 mg ☐ Time _____ _____ M.D./RN

B. Cervix dilated to _____ Uterine Depth _____ Cannula _____ mm Blood Loss: _____ mL Tissue to P.L.S.

Rho - GAM: Cervical ☐ IM ☐ Mini 50ug ☐ Full 300ug ☐ Methergine 0.2 mg/cervical ☐ Pitocin 10 units / cervical ☐

C. L.O.C. Alert & Responsive ☐ Easily Arousable ☐ Other:_____

_____

_____

_____

I have reviewed the patient's medical history, performed a physical exam and found them to be within the clinic's guidelines.

_____RN

_____ M.D.

Discharge: Satisfactory ☐ Walked to RR c assist. ☐

Ex 04

Pt. # _____ Pt. Name _____ Date _____ / _____ / _____

RECOVERY ROOM

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

MEDICATIONS

I.V. medication given: _____ SONO _____

____ Ergonovine 0.2mg 1 P.O. upon admit
____ Doxycycline 100 mg 1 B.I.D. #6
____ Ergonovine 0.2 mg T.I.D. #6
____ Ergonovine 0.2 mg #2 Take 1 @dinner 1 @ bedtime
____ Tri-Cyclen Lo 28-Day Disp 1 Rx Ref x 2
____ Ibuprofen 800 mg #10

Scant Tissue - check up explained _____Staff/Intitial
____ Rh Immune Card: given with explanation
____ Postcare emerg. # B.C. and medications
____ Work / School Excuse
____ Femcon Fe Disp 1 Ref x 2
____ Loestrin 24 Fe 28 Disp 1 Ref x 2
____ Nuva Ring Disp 1 Ref x 2

NURSES NOTES/POST-OP INSTRUCTIONS

Other: _____

_____

_____

_____

Discharged to Driver:_____ _____ RN/LPN

Patient discharged on the written order of the physcian. Condition at discharge is satisfactory and pt. ambulating with out assistance.

Time _____ _____RN/LPN _____ M.D.

PATH REPORT

Date _____ Fax ☐ Reg ☐ GMS: _____ Diag: _____

Follow up: _____

_____

_____

CHECK UP

Date _____ Preg. Test _____ Hgb _____ Sono _____

Follow Up _____

_____

Medication _____

_____ M.D.

Revised 08/11

Ex E5

OSHA, Fire Drill, Disaster, and Emergency Training

DATE:

OSHA TRAINER: MARGARET VAN DUYN LMT

PATIENT EMERGENCY TRAINER: P.1 + P3

POLICY/PROCEDURE TRAINER: " "

	(Name)	July 14 (date)	July 27 (date)
1.	[redacted]	OSHA / Emerg Fire/Bomb	Post Op. Em.
2.	[redacted]		
3.	[redacted]		
4.	[redacted]		
5.	[redacted]		
6.	[redacted]		
7.	[redacted]		
8.	[redacted]		
9.	[redacted]		
10.	[redacted]		
11.	[redacted]		
12.	[redacted]		
13.	[redacted]		
14.			
15.			
16.			
17.			
18.			
19.			
20.			

[redacted]
Administrator

P1
Staff Physician

EXHIBIT #27

OSHA, Fire Drill, Disaster, and Emergency Training

DATE: OSHA TRAINER:

PATIENT EMERGENCY TRAINER: POLICY/PROCEDURE TRAINER:

	(Name)	_____ (date)	_____ (date)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

_____ Administrator

_____ Staff Physician

EX E5

PROVISION FOR FIRST AID AND EMERGENCY

Any medical emergencies occurring during a procedure at the Clinic will be dealt with as follows:

1. The Emergency Telephone Number 911 will be called for transporting the patient to the Emergency Room of Methodist Hospital of Central Illinois where we maintain a transfer agreement. If necessary, the patient will be admitted.

Should an emergency arise while the patient is at home, the following is the Clinic's procedure:

1. The patient will call the Clinic number which is a 24-hour answering service. Her call will be immediately referred to the staff person or doctor on call who will advise her to go to the Methodist Hospital Emergency entrance. She will be met there by the Clinic Coordinator, nurse, or other Clinic Representative who will stay with her until all emergency services have been provided and the patient returns home. If hospital admittance is required, the Clinic Representative will help also with this process.

FAINTING

Vaso depressor syncope, the most common type of fainting episode, is usually characterized by a sudden fall in blood pressure and a slowing of the heart. The causative stimuli may be fear, anxiety, or pain. In the early phase, there may be motor weakness, epigastric distress, perspiration, restlessness, yawning and sighing respirations. The patient may appear anxious with a pale face and cold, moist extremities. After several minutes, light-headedness, blurring of vision, and sudden loss of consciousness may occur.

The patient should be placed in the recumbent position with his head lower than the rest of his body. Airway should be maintained. Inhalation of aromatic spirits of ammonia may help revive the patient.

1. Apply O_2 at 6 LPM per mask to re-oxygenate.

CONVULSIVE SEIZURES

Paroxysmal disorders of cerebral function sudden in onset and of brief duration, characterized by recurrent attacks involving changes in the state of consciousness, motor activity, or sensory phenomena.

Signs and symptoms

Rigidity of body muscles, usually lasting from a few seconds to perhaps a half a minute, followed by jerky movements. During the period of rigidity the patient may stop breathing, bite his tongue severely, and become incontinent. There is a gradual subsidence of all symptoms.

Treatment

1. Prevent patient from hurting himself. Remove all objects from the vicinity which could cause injury. Loosen clothing if possible.

2. Turn patient on side to clear airway. Apply oxygen at 6 LPM per mask to aid in respirations. Monitor pulse ox. Observe for respiratory failure. If respiratory failure occurs, call 911, insert oral airway if no gag reflex or if gag reflex still present, use ambu bag that is connected to oxygen tank to aid respirations.

3. If convulsions continue with no apparent diminishing, call the emergency squad for transportation to the hospital. If convulsions continue administer 10 mg Valium IM.

If patient has history of seizures or epilepsy, request Valium orders from doctor and reevaluate with physician.

SHOCK: ANAPHYLACTIC

Signs and Symptoms

Typically, in 1 to 15 minutes, the patient complains of a sense of uneasiness and becomes agitated and flushed. Palpitation, parasthesias, pruritus, throbbing in the ears, coughing, sneezing, and difficulty breathing are other typical complaints. The patient is flushed and has a rapid pulse. The patient with vasovagal syncope (common faint) develops pallor and a slow pulse. NOTIFY THE PHYSICIAN IMMEDIATELY.

Treatment

1. LACTATED RINGERS SOLUTION IV should be started immediately with an 18 gauge needle if possible (20 gauge at least), running wide open.

2. ADRENALINE 1:1000 (0.5 mgm) - 0.5 cc in 10 cc of saline injected into IV as a bolus - slowly - 10.5 in 45 to 60 seconds.

3. DECADRON (Dexamethasone) - 25 mgm injected into IV as a bolus.

4. PHENERGAN (Antihistamine) - 25 mgm (1/2 of tubex) injected into IV as bolus, slowly 45 to 60 seconds. Remainder of tubex given IM.

Pulse should be monitored constantly. If possible, one person with stethoscope should be listening to chest.

Blood pressure should be checked every two to three minutes if possible.

The patient's airway status should be evaluated. If possible, an airway which keeps the tongue up and forward should be placed in the mouth during the early stages of treatment. An endotracheal tube should be available to use if needed.

Oral airway should be inserted then use the ambu bag connected to oxygen at 15 LPM - oral airway can be only used if no gag reflex. Otherwise, assist respirations with ambu bag making sure head and neck are positioned properly. To check for proper airway management monitor chest rise and fall NOT abdomen rise and fall.

If it is suspected the anaphylactic shock is from the Versed then Romazicon (Flumazenil) 0.2 mg should be administered IVP over 15 seconds after approval from doctor.

Note time of all events including administration of original drug. Prepare complete record for patient record and transfer.

ABRASIONS, CONTUSIONS AND LACERATIONS

If abrasions, contusions, and lacerations occur and are of a minor nature, the wound should be cleaned and bandaged if necessary. If wound occurred in a fall, check for signs of fracture (pain, swelling, disfigurement, loss of motion).

Should the wound not be of a minor nature, or if signs of fracture exist, the emergency squad will be called to transport the patient to the hospital for treatment. Checking for signs and symptoms of fracture and check for distal and proximal pulses.

While waiting for the emergency squad and if the bleeding is severe, the following procedures are recommended:

1. Direct pressure

   Hold a thick dressing over the wound and apply firm pressure. If bleeding is controlled, do not remove the dressing. If bleeding continues and soaks through the dressing, add additional dressings and apply pressure even more firmly.

2. Elevation

   Unless there is evidence of fracture, a severely bleeding wound of the hand, neck, arm, or leg should be elevated. Direct pressure should be continued.

3. Pressure on the Supplying Artery

   If direct pressure plus elevation does not control the bleeding, it may be necessary to apply pressure to the supplying artery - the brachial artery for control of the arm wound and the femoral artery for control of the leg wound.

4. CAUTION!

   Usage of the pressure points to control bleeding should be used only when necessary and only from the length of time it takes to control the bleeding. Prolonged pressure in effect acts as a tourniquet with the resulting danger of loss of limb.

5. Head Injury

   In the event of head injury, evaluate pupil status, immobilize head and neck, keep the patient immobile, and check for changes in consciousness, (drowsiness, confusion, agitation), vomiting or loss of motion in extremities. If above changes occur, transport patient to hospital by emergency squad for evaluation.

EMERGENCY SURGICAL PROCEDURES

PERFORATIONS

If the operating physician believes or suspects he has perforated the uterus, he will inform the patient of the possible problem and determine correct follow-up.

LACERATIONS OF THE CERVIX

Operating physician's decision - may pack the vagina with 2" sterile packing or suture if necessary.

ATONY

In cases of uterine relaxation with more than a normal amount of bleeding, notify the physician immediately.

DRUG LIST

Current and up-to-date drugs are listed on the crash cart.

OTHER EMERGENCIES

Clinic staff is currently trained in C.P.R. and trained in shock, respiratory failure, cardiac arrest, etc.

EMERGENCIES

1. Patient Tracking

2. First Aid & Emergency

3. Protocols
    a. Fainting
    b. Convulsive Seizures
    c. Shock: Anaphylactic
    d. Abrasions, Contusions, Lacerations

4. Emergency Surgical Procedures

5. Emergency Transfer and Reporting

6. CPR Instructions/Crash Cart

7. Emergency Eyewash Instructions

8. Fire Drill Procedure

9. Fire/Bomb/Tornado Emergency Procedure

10. Extremist Activity Protocols

11. Evacuation Plan

12. Clinic Diagram

13. Reporting Threats or Acts of Violence

14. Incident Report

PROCEDURE FOR A FIRE DRILL

1. All of the major rooms contain a fire extinguisher. Locate these so you know where they are ahead of time. Read the instructions so you know how to use them if necessary. Attempt to extinguish fire with fire extinguisher or by smothering with pillow.

2. There is a fire alarm in the hallway on the way to the recovery room. Pull this to alert the fire station of the fire..

3. There are exits through the front door, utility room hall, recovery room and the back procedure hallway has an exit door.

4. First priority is to protect yourself and the patients. Get them out through the closest door. Do not worry about purses, etc. You and the patients are more important.

5. All employees will have a practice fire drill yearly.

6. All new employees will be advised of the fire drill procedure.

EMERGENCY EVACUATION PLAN FOR NATIONAL HEALTH CARE INC.

IN THE EVENT OF A FIRE, BOMB THREAT, CHEMICAL SPILL, MASS DISASTER OR OTHER EMERGENCY, THE CLINIC DIRECTOR IS RESPONSIBLE FOR DETERMINING THAT AN EMERGENCY EXISTS AND MANAGEMENT OF EMERGENCY PROCEDURES. IF THE CLINIC DIRECTOR IS NOT PRESENT, THE SUPERVISOR OF THE DAY SHALL ASSUME THIS RESPONSIBILITY. STAFF WHO BELIEVE AN EMERGENCY SITUATION EXISTS SHOULD NOTIFY THE NURSING SUPERVISOR.

1. Clinic director will designate staff person as runner to alert all areas of the clinic that an emergency is in progress and that the evacuation plan is to be implemented. In the clinic director's absence, the nursing supervisor will designate a runner.

2. The clinician is responsible for patients in the examination rooms. The medical assistant assisting the clinician will evacuate patients from the bathroom nearest to examination rooms.

3. Recovery room nurse and medical assistant are responsible for patients in their areas as well as the recovery bathroom. Non-ambulatory patients to be transferred to ambulance gurneys, covered with extra blankets and exited by way of the recovery room exit. Ambulatory patients to be wrapped in blankets and exited through recovery.

4. Patient advocates and/or medical assistants checking in patients are responsible for patients awaiting or receiving check-in services. Medical assistant working in the laboratory is responsible for removing patients from holding room and then for assignment to recovery.

5. O.R. Technician is responsible to physician and/or nurse anesthetist for removing patient in surgery and for further instructions such as emergency equipment.

6. Receptionist/phone person is responsible for calling local emergency services at 911 and for evacuating waiting room and bathroom. Assist nursing supervisor in clearing patients.

7. Supervisor of the day is responsible for verifying that all staff have been informed of the emergency in progress. This individual will check all rooms including bathrooms after all persons have been evacuated.

8. Supervisor of the day shall take a list of patients scheduled for the day to aid in accounting for patients after evacuation. The supervisor shall also account for all employees following evacuation.

ALL EVACUEES TO MOVE OUT INTO THE PARKING LOT AWAY FROM THE BUILDING IN A LOCATION THAT DOES NOT BLOCK ACCESS FOR EMERGENCY VEHICLES. PATIENTS ARE TO BE ATTENDED TO ACCORDING TO THEIR NEEDS AND ARE NOT TO BE LEFT ALONE. EMERGENCY EQUIPMENT AS DETERMINED BY MEDICAL STAFF SHOULD BE REMOVED AT TIME OF EVACUATION. IN THE EVENT OF A MASS DISASTER SUCH AS AN EARTHQUAKE, FLOOD OR TORNADO, PUBLIC SERVICES MAY NOT BE IMMEDIATELY AVAILABLE AND ALL EQUIPMENT NECESSARY TO MAINTAIN PATIENT'S STATUS SHOULD BE REMOVED SUCH AS OXYGEN, CRASH CART, IV FLUIDS, ETC.

REPORTING THREATS OF VIOLENCE OR ACTS OF VIOLENCE

Threats of violence or acts of violence against reproductive health care providers violate federal and state criminal statutes, including the new Freedom of Access to Clinic Entrances Act (FACE) 18 U.S.C. 248. This act makes it a federal crime to threaten, injure, intimidate or interfere with persons seeking or providing reproductive health services.

If you are threatened, observe suspicious activity or require emergency assistance, please do the following:

a. for emergency assistance call your local police department at telephone number 911.

b. to report threats of violence or acts of violence call your local police at telephone number 911, then the Federal Bureau of Investigation (FBI) at telephone number 676-1922.

Exhibit #30

Lab Supervision

All procedures in the laboratory are done by an MT/MLT. The testing is done by fingerstick routing. The laboratory technician is present at all times, and patients are seen individually. The MT/MLT will provide continual observation.

On a rare occasion we need to draw a BHCG that will be sent to the hospital. The MT/MLT will do that, and they do not leave the patient alone.

The laboratory supervisor will follow-up.

Revised 7-13-11

Ex #7

Methodist

June 20, 2011

To Whom It May Concern:

National Health Care Inc. has a long standing agreement with Methodist Medical Center Laboratory that lab testing not performed on site at National Health Care is performed at MMCI lab as indicated. Invoicing is sent to National Health Care Inc. Methodist Medical Center Laboratory is a CLIA certified lab (see attached certificate).

Deb Deeb
[redacted]
Coordinator, Client Services
Methodist Medical Center Laboratory

CENTERS FOR MEDICARE & MEDICAID SERVICES

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF ACCREDITATION

LABORATORY NAME AND ADDRESS

METHODIST MEDICAL CENTER OF ILLINOIS
221 NE GLEN OAK
PEORIA, IL 61636

CLIA ID NUMBER
14D0431854

EFFECTIVE DATE
02/28/2011

LABORATORY DIRECTOR
DEVENDRA TRIVEDI MD

EXPIRATION DATE
02/27/2013

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 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, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.

Judith A. Yost

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

964 certs2_012911A

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)	07/14/1995
MYCOLOGY (120)	07/14/1995
PARASITOLOGY (130)	07/14/1995
VIROLOGY (140)	06/14/2000
SYPHILIS SEROLOGY (210)	07/14/1995
GENERAL IMMUNOLOGY (220)	07/14/1995
ROUTINE CHEMISTRY (310)	07/14/1995
URINALYSIS (320)	07/14/1995
ENDOCRINOLOGY (330)	07/14/1995
TOXICOLOGY (340)	07/14/1995
HEMATOLOGY (400)	07/14/1995
ABO & RH GROUP (510)	07/14/1995
ANTIBODY TRANSFUSION (520)	07/14/1995
ANTIBODY NON-TRANSFUSION (530)	07/14/1995
ANTIBODY IDENTIFICATION (540)	07/14/1995
COMPATIBILITY TESTING (550)	07/14/1995
HISTOPATHOLOGY (610)	07/14/1995
ORAL PATHOLOGY (620)	01/07/1999
CYTOLOGY (630)	06/13/2003

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.

PHYSICIANS LABORATORY SERVICE, INC.
P.O. BOX 1251
CLAYTON, GA 30525

JUNE 21, 2011

NATIONAL HEALTH CARE
7405 N. UNIVERSITY SUITE D
PEORIA, IL 61614

DEAR MS. VANDUYN:

I AM SENDING YOU THIS LETTER REGARDING OUR PROCEDURE FOR DISPOSAL OF TISSUES RECEIVED AT PHYSICIANS LABORATORY SERVICE, INC. ALL FETAL TISSUES RECEIVED ARE DISPOSED OF BY CREMATION AFTER DIAGNOSIS. PHYSICIANS LABORATORY SERVICE, INC. REPORTS THE MANNER OF DISPOSAL TO VITAL RECORDS AS REQUIRED BY THE DEPARTMENT OF HUMAN RESOURCES. THESE REPORTS ARE SUBMITTED ONCE A MONTH.

PHYSICIANS LABORATORY SERVICE, INC. IS LICENSED BY THE STATE #119-004, MEDICARE/MEDICAID #11-8094, AND (CLIA) CLINICAL LABORATORY IMPROVEMENT AMENDMENTS #11D0261535.

YOU MAY WANT TO PLACE THIS INFORMATION IN YOUR MANUAL FOR FUTURE INSPECTIONS. I HOPE THIS INFORMATION IS SATISFACTORY. IF I CAN BE OF FURTHER ASSISTANCE TO YOU PLEASE FEEL FREE TO CALL.

CORDIALLY,

RENEE MEYER
PHYSICIANS LABORATORY SERVICE, INC.

Ex F6

Machine Maintenance Policy

It is imperative that all of our equipment be in operating condition. Keeping the equipment in proper working order will be done in the following way:

1. Yearly maintenance checks
    a. Aspiration machine
    b. Gleamer lights
    c. Centrifrige (Lab)
    d. O_2 tank
    e. Autoclaves

At this time a chart is kept with yearly service dates. This service is provided by Kirks Medical Equipment.

Each clinic day before procedures start and patients arrive the following is done.

1. Vacuum machines are turned on and checked for proper pressure
2. Lights are checked to be sure that they are working
3. O2 valve is checked and pressure recorded
4. Autoclave will be put on vent to warm up sterilizers and check water level. They are then ready to go.

These checks will be recorded daily.

Ex # 8

KIRK RELIABLE REPAIR SERVICE

705 E. Lincoln, Ste. 114
Normal, IL 61761

Telephone: (309) 452-5248

№ 4675

Customer's Order No.

Date June 27, 11

Name National Health Care

Address 7405 N. University

City Peoria State Ill.

SOLD BY	CASH	C. O. D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT
	✓		✓			

QUAN.	DESCRIPTION	PRICE	AMOUNT
1	Tuttnauer Sterilizer Model 2340 M Ser# 980347		0
1	Door Gasket		75 00
1	Safety Valve		45 95
			120 95
	TAX		10 58
			131 53
	Service 1.5 hr	80.00	120 00
			251 53
	Travel 1.5 hr	80.00	120 00
			371 53

THANK YOU Please keep this copy for reference

TOTAL

ALL claims and returned goods MUST be accompanied by this bill.

Rec'd By _____

There are several of these tickets on file for the department.

Ex 48

O_2 Tank

LOT NUMBER

EQ 04 Y 172 C

LITERS 679

EXP DATE 06-21-2016

Ex 015
EX F4

Daily Machine Checks

Machine/Brand/Model#	Date/Int.	Date/Int.	Date/Int.	Date/Int.	Date/Int.	Date/Int.	Date/Int.	Date/Int.
Vacuum Curettage (OR 3)/Berkeley/VCII								
Vacuum Curettage (OR 2)/Berkeley/VCII								
Vacuum Curettage (OR 1)/Berkely/SVII								
Gleamer Light (OR 3)/GL13106								
Gleamer Light (OR 2)/GL13106								
Gleamer Light (OR 1)/GL13106								
Centrifuge (Lab)/Dade/569								
Oxygen Tank/E-tank								
Autoclave/Pelton-Crane/OCR								
Autoclave/Tuttanauer/2340M								
Autoclave/Tuttanauer/2340M								

Revised 8/11

Ex # 8

Machines Needing a Yearly Check
2011

Machine	Brand	Model #	Checked Date (M/D)	Initials
Vacuum Curettage (OR 3)	Berkeley	VCII	June 24-28	MV
Vacuum Curettage (OR 2)	Berkeley	VCII	" "	MV
Vacuum Curettage (OR 1)	Berkeley	SVII	" "	MV
Gleamer Light (OR 3)	Gleamer	GL13106	" "	MV
Gleamer Light (OR 2)	Gleamer	GL13106	" "	MV
Gleamer Light (OR 1)	Gleamer	GL13106	" "	MV
Centrafuge (Lab)	Dade	569	" "	MV
Oxygen Tank	E-tank	n/a	" "	MV
Autoclave	Pelton-Crane	OCR	" "	MV
Autoclave	Tuttanauer	2340M	" "	MV
Autoclave	Tuttanauer	2340M	" "	MV

Ex # 9

Sterilizer Monitoring

	Pelton Crane A4-36746		Tuttnauer 9811946		Tuttnauer 9803470	
Date	Spore	Clean	Spore	Clean	Spore	Clean
10/25/2010	PK	PK	PK	PK	PK	PK
11/04/2010	PK	PK	PK	PK	PK	PK
12/05/2010	PK	PK	PK	PK	PK	PK
01/17/2011	PK	PK	PK	PK	PK	PK
02/08/2011	PK	PK	PK	PK	PK	PK
03/22/2011	PK	PK	PK	PK	PK	PK
04/01/2011	PK	PK	PK	PK	PK	PK
05/03/2011	PK	PK	PK	PK	PK	PK
06/07/2011	PK	PK	PK	PK	PK	PK
07/01/2011	PK	PK	PK	PK	PK	PK

Exhibit #22

Laundry Washing

At this facility blood is considered potentially hazardous and infectious and it shall be handled as such.

1. In the recovery room, gowns are placed in a fluid proof container. The linen bag is yellow and labeled as infectious linens. The bags are not handled in the patient area.

2. In the laundry room, staff puts on the proper P.P.E. (gloves, apron) and removes gowns from the infectious linen bags. The gowns are placed directly into the washer with ½ cup of bleach and laundry detergent, the water temperature use is hot. They are washed at a full cycle then dried.

3. Visibly contaminated laundry will be handled differently. The laundry will be soaked in Haemo-Sal Enzyme Active Protein Dissolvent (½ cup) for 40 minutes in water in washing machine. The cycle is finished, then on full cycle with hot water and ½ cup bleach is completed. The bleach will be precisely measured at ½ cup.

4. Gowns are dried and folded and returned to the patient counseling rooms.

5. A chart will be signed off for the addition of bleach and Haemo-Sal as needed.

6. This will be checked monthly by the Administrative Assistant.

Revised July 12, 2011

#22 Cont.

HANDLING OF LAUNDRY

Contaminated laundry defined as "any laundry that may contain blood or other potentially infectious materials" shall be handled utilizing Universal Precautions to prevent occupational exposure. All used gowns and other laundry will be in yellow infectious bags. All laundry is processed on site and requires no special labeling of contaminated linen provided that Universal Precautions are adhered to when handling.

Bags or containers used to collect contaminated laundry must be able to prevent soak through or leakage of fluids to the exterior of the bag. Cloth bags should be used for the majority of laundry with the bags designed with greater ability to resist leakage for contaminated or wet linen.

Contaminated laundry shall:

1. not be sorted or rinsed in patient care areas
2. not be thrown on the floor
3. not be hugged against uniform
4. be bagged in room where linen is used
5. Be handled using appropriate personal protective equipment i.e. Gloves and other appropriate PPE when necessary

Procedure for linen processing is as follows:

1. Patient shall be instructed to remove gown and place in laundry bag.
2. At the end of each working day, contaminated linen shall be transferred from linen bag to washer using appropriate personal protective equipment.
3. Normal washing cycle shall follow.

REGULATED WASTE
THE FOLLOWING BODY SECRETIONS SHALL BE CONSIDERED AS POTENTIALLY INFECTIOUS AND SHALL BE HANDLED AND DISPOSED OF AS SUCH

BLOOD
VAGINAL SECRETIONS
SEMEN
AMNIOTIC FLUID

Laundry Washing Chart

Month__________ **Year**__________

Date: __________ #Loads__________ ½ cup bleach__________ Int.________
#Loads__________ Haemo-sal Soak ½ cup ½ bleach full cycle Int.________

Date: __________ #Loads__________ ½ cup bleach__________ Int.________
#Loads__________ Haemo-sal Soak ½ cup ½ bleach full cycle Int.________

Date: __________ #Loads__________ ½ cup bleach__________ Int.________
#Loads__________ Haemo-sal Soak ½ cup ½ bleach full cycle Int.________

Date: __________ #Loads__________ ½ cup bleach__________ Int.________
#Loads__________ Haemo-sal Soak ½ cup ½ bleach full cycle Int.________

Date: __________ #Loads__________ ½ cup bleach__________ Int.________
#Loads__________ Haemo-sal Soak ½ cup ½ bleach full cycle Int.________

Date: __________ #Loads__________ ½ cup bleach__________ Int.________
#Loads__________ Haemo-sal Soak ½ cup ½ bleach full cycle Int.________

Date: __________ #Loads__________ ½ cup bleach__________ Int.________
#Loads__________ Haemo-sal Soak ½ cup ½ bleach full cycle Int.________

Date: __________ #Loads__________ ½ cup bleach__________ Int.________
#Loads__________ Haemo-sal Soak ½ cup ½ bleach full cycle Int.________

Monthly Review____________________ Date:________________

Revised July 12, 2011

FIRE/BOMB/TORNADO EMERGENCY PROCEDURES

FIRE

Every Employee is familiar with the following locations:

Pull station locations:

1. Front waiting room
2. Under Front Desk (Silent Police Alarm)
3. Back Door
4. OR Hallway
5. Hallway to front door

Fire Extinguishers:

1. Front waiting room
2. Receptionist Area
3. By Doctor's Room
4. Back Door
5. By Counseling Room #4
6. By Pre-op
7. Front Door
8. Hallway by Recovery
9. Recovery

In the event of a fire, R.A.C.E. and P.A.S.S. procedures will be followed.

R.A.C.E

R = **RESCUE** anyone in immediate danger from the fire while avoiding endangerment of one's own life.

A = **ALARM** the director and staff physician and ensure activation of pull station alarm box. Silent police notification alarm is located under the front receptionist desk.

C = **CONFINE** the fire by closing all doors and windows

E = **EXTINGUISH** the fire by using P.A.S.S. with correct type of extinguisher for the fire or **EVACUATE** the area if the fire is too large for a fire extinguisher.

Each employee will evacuate the patients and patient's support persons under the discretion of the Director and staff physician. Employees will evacuate according to the evacuation routes posted in every hallway of the clinic, always using the closest route to safety. All staff and patients will meet at tree line of the back parking lot. Front receptionist responsible to bring daily patient roster so that all patients can be accounted for.

P.A.S.S

P = **PULL** the pin on the fire extinguisher

A = **AIM** the extinguisher nozzle at the base of the fire

S = **SQUEEZE** or press the handle

S = **SWEEP** from side to side until the fire is extinguished.

BOMB THREAT

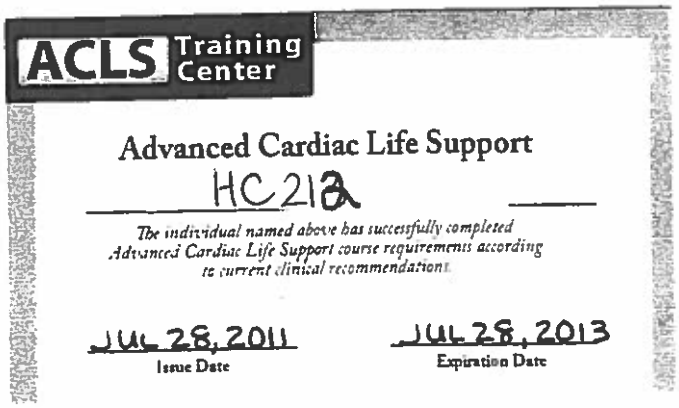
1. Activate the police call button at the front reception desk.
2. Notify the director and/or physician
3. Help route the patients through the appropriate exits
4. Follow directions from the police as deemed appropriate.

TORNADO

1. Designated tornado safe spot is the O.R. hallway. All persons in the building shall immediately go the O.R. hallway in the event of a tornado warning.
2. All patients must be accounted for by the nursing staff. Nursing supervisor will report any missing persons to director.
3. All staff must be accounted for by their immediate supervisor. Supervisors will report any missing staff to the director.
4. All persons will stay in the tornado safe spot until the ALL CLEAR is issued by the National Weather Service.

EMERGENCY PATIENT CARE WILL BE FOLLOWED BY THE PROTOCOL LISTED AS Emergency Transfer and Reporting and Emergency Evacuation Plan will be followed.

Revised July 12, 2011



ACLS Training Center

Advanced Cardiac Life Support

HC212

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

JUL 28, 2011
Issue Date

JUL 28, 2013
Expiration Date

G 7

ACLS Provider
Pacific Medical Training

Advanced Cardiac Life Support

P-2

This card certifies that the individual above has successfully completed the Advanced Cardiac Life Support course requirements in accordance with current clinical recommendations.

MAY 5,2010
Issue Date

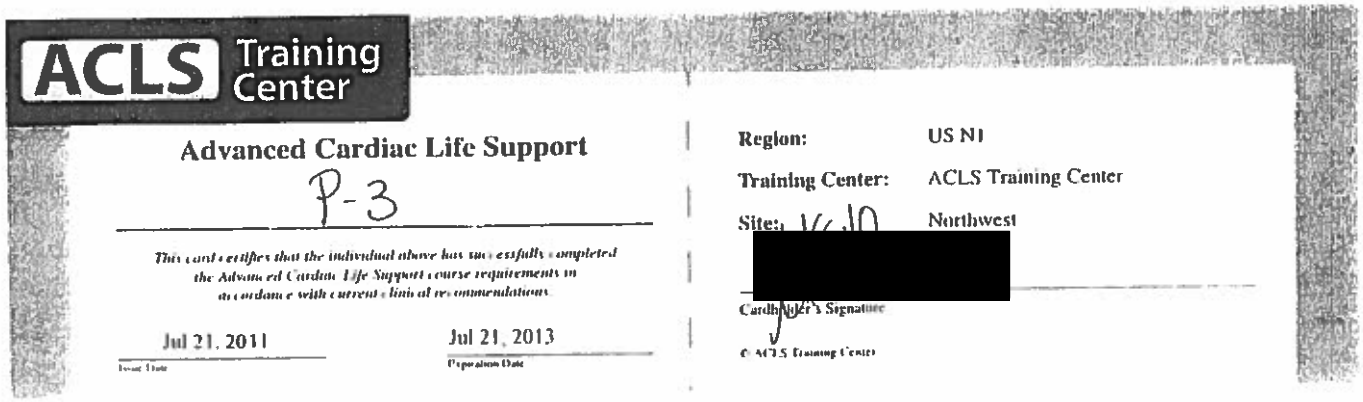
MAY 5,2012
Expiration Date

Region: Multi-Region

Training Center: Pacific Medical Training

Site: Southwest

Cardholder's Signature



ACLS Training Center

Advanced Cardiac Life Support

P-3

This card certifies that the individual above has successfully completed the Advanced Cardiac Life Support course requirements in accordance with current clinical recommendations.

Jul 21, 2011
Issue Date

Jul 21, 2013
Expiration Date

Region: US NI

Training Center: ACLS Training Center

Site: [illegible] Northwest

[redacted]

Cardholder's Signature

© ACLS Training Center

EX - T 20

National Health Care Inc. Quarter:_____ Year: _____
Quarterly Abortion Report

	Jan	Feb	Mar	Qtr1	Apr	May	Jun	Qtr2	Jul	Aug	Sep	Qtr3	Oct	Nov	Dec	Qtr4	Year Totals
Total Number of Patients																	
12 Weeks or Less (LMP)																	
13 to 16 weeks (LMP)																	
Medical AB < 9 wks																	
No. of Follow-up																	
ABORTION INCIDENTS																	
No. of Incomplete Abs																	
No. of Failed Abortions																	
No. of Perforations																	
No. of Infections																	
No. of Hemorrhages																	
No. of Ectopic Pregnancy																	
No. of Deaths*																	
Other (Specifiy_____)																	
INCIDENT MANAGEMENT																	
No. of Resuctions																	
No. of Hospitalizations																	
No. of Transfusions																	
No. of Laparotomies																	
No. of Laparoscopies																	

*Submit immediately an Abortion Incident Report

Exhibit #23

Monthly Crash Cart Check

All listed Medications and Emergency Drugs have been checked and verified as current and up to date.

O2 tank has been checked being in proper working order and the tank it filled.

The Head OR nurse will sign off monthly and the Recovery Room nurse will verify.

2011

January	_____ Checked	_____ Verified	February	_____ Checked	_____ Verified
March	_____ Checked	_____ Verified	April	_____ Checked	_____ Verified
May	_____ Checked	_____ Verified	June	_____ Checked	_____ Verified
July	_____ Checked	_____ Verified	August	_____ Checked	_____ Verified
September	_____ Checked	_____ Verified	October	_____ Checked	_____ Verified
November	_____ Checked	_____ Verified	December	_____ Checked	_____ Verified

Pertains to All QI

EX 16

Q.I. (QUALITY IMPROVEMENT TEAM)

Team Members Management

Executive Director	Margaret Van Duyn
Medical Director	Bernard Smith M.D.
Laboratory Director	Bernard Smith M.D.

Working Q.I. Team

Director	Margaret Van Duyn
Lab & Sono	[redacted]
Recovery Room	
Operating Room	
Counseling	
Surg. Prep.	
Officer Manager	

The Q.I. team will review problems by the work area involved. Every quarter we will all discuss the problem areas together.

Q.I. reports will be put in writing on a quarterly basis and kept in a binder.

The Q.I. team review includes, but not limited to, the following:

1. Policy and procedural change
2. Patient care
3. Monitoring employees and staff training
4. Ensure reviews, maintenance and inspections are performed as scheduled
5. Keeping paperwork up to date and current

National Health Care, Inc.
Director's/Consulting Committee
Annual Review

Date	Director's Initials	Comments or Actions

The annual review by the director consists of the monitoring of all procedures and polices, including any changes, additions or subtractions

Current Staff June 30, 2011

1. Executive Director
   a) Margaret Van Duyn
2. Medical Director
   a) Benard Smith, M.D.
3. ~~Medical Director/Staff~~ Physicians
   a) Benard Smith, M.D.
   b) Allen Palmer, D.O.
   c) Mandy Gittler, M.D.
4. Executive Director
   a) Margaret Van Duyn
5. Director of Nursing
   a) Tammila Johnson, RN
6. Administrative Assistant
   a) Rilla Adcock
7. OR Head Nurse
   a) Wanda Ball, RN
8. Recovery Head Nurse
   a) Tammila Johnson, RN
9. Sono
   a) Margaret Van Duyn
   b) Teresa Winkler MT
   c) Tammila Johnson, RN
10. Office Manager
    a) Pamela Krider
11. OR RN and LPN
    a) Bonnie Bottenberg, RN
    b) Jessie Mayor, LPN
12. RN, LPN, CNA
    a) Rachael Hensley LPN
13. Autoclave Technician
    a) Monica Young CNA
    b) Monica Coombs MLT
14. Receptionist
    a) Rilla Adcock
    b) Bobbi Krider CNA
15. Lab Director
    a) Bernard Smith, M.D.
16. Head Lab Technician
    a) Teresa Winkler MT
17. MT, MLT
    a) Kathy Maher MT
    b) Wendy Quinn MLT
    c) Julie Fang MLT
18. Counselors
    a) Rachael Hensley LPN
    b) Andrea Lewis RN

EXECUTION

TRANSFER AGREEMENT
between
NATIONAL HEALTHCARE - PEORIA
and
THE METHODIST MEDICAL CENTER OF ILLINOIS

THIS TRANSFER AGREEMENT ("Agreement") is made and executed on the last date written below, to be effective on June 27, 2011 ("Effective Date"), by and between NATIONAL HEALTHCARE - PEORIA, an Illinois corporation ("Facility") and THE METHODIST MEDICAL CENTER OF ILLINOIS, an Illinois not-for-profit Corporation, located and doing business in Peoria, Illinois (hereinafter referred to as "Hospital") (individually a "Party", collectively the "Parties").

RECITALS

WHEREAS, both parties desire to formalize an agreement whereby patients, regardless of payor sources, are transferred to the appropriate institution for various levels of medical or surgical care according to the dictates of the patients' medical conditions as judged by attending and consultant physicians;

WHEREAS, the Parties hereto specifically wish to facilitate: (a) the timely transfer of patients and the medical records and other information necessary or useful for the care and treatment of patients transferred to and from each Party; (b) the determination as to whether such patients can be adequately cared for other than by either of the Parties hereto; (c) the continuity of care and treatment appropriate to the needs of the transferred patient; and (d) the utilization of knowledge and other resources of both healthcare entities in a coordinated and cooperative manner to improve the professional healthcare of patients; and

NOW, THEREFORE, in consideration of the mutual covenants contained herein, and in reliance upon the recitals, set forth above and incorporated by reference herein, the Parties hereto agree as follows:

I. DUTIES AND RESPONSIBILITIES

1.1. Joint Responsibilities. In accordance with the policies and procedures of the Hospital and upon the recommendation of the patient's attending physician that such a transfer is medically appropriate, such patient shall be transferred from the Hospital to the Facility as long as the Facility has bed availability, staff availability, is able to provide the services requested by the Hospital, including on-call specialty physician availability, and pursuant to any other necessary criteria established by the Facility. In such cases, the Facility and the Hospital agree to exercise best efforts to provide for prompt admission of the patient. If applicable, the Parties shall comply with all EMTALA requirements with respect to such transfers.

1.2. Facility. The Facility shall accept patients in need of transfer from the Hospital pursuant to the criteria set forth in Section 1.1. Further, Facility shall designate a

person to coordinate with Hospital in order to establish acceptable and efficient transfer guidelines.

1.3. Hospital. Hospital shall request transfers of patients to Facility pursuant to the criteria set forth in Section 1.1. Further, Hospital shall:

a. Have responsibility for obtaining the patient's informed consent for the potential transfer to Facility, if the patient is competent. If the patient is not competent, the consent of the legal guardian, agent with power of attorney for health care, or surrogate decision maker of the patient shall be obtained.

b. Notify Facility as far in advance as possible of the impending transfer.

c. Transfer to Facility the personal effects, including money and valuables and information related thereto. A standard form shall be adopted and used by both Parties listing such personal effects and appropriate documentation and transfer procedure.

d. Affect the transfer to Facility through qualified personnel and appropriate transfer equipment and transportation, including the use of necessary and medically appropriate life support measures. Facility's responsibility for the patient's care shall begin when the patient is admitted to Facility.

e. Transfer all necessary medical records, or in the case of an emergency, as promptly as possible, transfer an abstract of the pertinent medical and other records necessary in order to continue to the patient's treatment without interruption and to provide identifying and other information, including medical, social, nursing and other care plans. Such information shall also include, without limitation and if available, current medical findings, diagnoses, advanced medical directives, rehabilitation potential, brief summary of the course of treatment at the Hospital, nursing, dietary information, ambulation status and pertinent administrative and social information.

1.4. Mutual Transfers. Patients may likewise be transferred from the Facility to the Hospital, following the same processes outlined in this Agreement. Facility and Hospital shall meet periodically to review the transfer process, of policies and procedures in order to improve the process, including efficiency, clinical care and patient safety.

1.5. Non-Discrimination. The Parties hereto acknowledge that nothing in this Agreement shall be construed to permit discrimination by either Party in the transfer process set forth herein based on race, color, national origin, handicap, religion, age, sex or any other characteristic protected by Illinois state laws, Title VI of the Civil Rights Act of 1964, as amended or any other applicable state or federal laws. Further, Section 504 of the Rehabilitation Act of 1973 and the American Disabilities

EXECUTION

Act, as amended, require that no otherwise qualified individual with a handicap shall, solely by reason of the handicap, be excluded from participation in, or denied the benefits of, or be subjected to discrimination in a facility certified under the Medical or Medicaid programs.

1.6. Name Use. Neither Party shall use the name of the other Party in any promotional or advertising material unless the other Party has reviewed and approved in writing in advance such promotional and advertising material.

1.7. Standards. Facility shall ensure that its staff provide care to patients in a manner that will ensure that all duties are performed and services provided in accordance with any standard, ruling or regulation of The Joint Commission on Accreditation of Healthcare Organizations, the Department of Health and Human Services or any other federal, state or local government agency, corporate entity or individual exercising authority with respect to or affecting Facility. Facility shall ensure that its professionals shall perform their duties hereunder in conformance with all requirements of the federal and state constitutions and all applicable federal and state statutes and regulations.

1.8. Exclusion/Debarment. Both Parties certify that they have not been debarred, suspended, or excluded form participation in any state or federal healthcare program, including, but not limited to, Medicaid, Medicare, and Tricare. In addition, each Party agrees that it will immediately notify the other Party if it subsequently becomes debarred, suspended, or excluded or proposed for debarment, suspension, or exclusion from participation in any state or federal healthcare program.

1.9. Confidentiality. Facility agrees to maintain confidentiality. Facility acknowledges that certain material, which will come into its possession or knowledge in connection with this Agreement, may include confidential information, disclosure of which to third parties pay be damaging to Hospital. Facility agrees to hold all such material in confidence, to use it only in connection with performance under this Agreement and to release it only to those persons requiring access thereto for such performance or as may otherwise be required by law and to comply with the Health Insurance Portability and Accountability Act ("HIPAA").

1.10. Access to Books and Records. Both Parties will maintain records relating to their responsibilities under this Agreement for a period of one (1) year from the date of services. During normal working hours and upon prior written and reasonable notice, each part will allow the other Party reasonable access to such records for audit purposed and also the right to make photocopies of such records (at requesting Party's expense), subject to all applicable state and federal laws and regulations governing the confidentiality of such records.

II. FINANCIAL ARRANGEMENTS.

EXECUTION

2.1 Billing and Collection. The patient is primarily responsible for payment for care provided by the Hospital or the Facility. Each Party shall bill and collect for services rendered by each Party pursuant to all state and federal guidelines and those set by third party payers. Neither the Hospital nor the Facility shall have any liability to the other for billing, collection or other financial matters relating to the transfer or transferred patient. Since this Agreement is not intended to induce referrals, there should be no compensation or anything of value, directly or indirectly, paid between the Parties.

2.2 Insurance. Each Party shall, at its expense, maintain through insurance policies, self-insurance or any combination thereof, such policies of comprehensive general liability and professional liability insurance with coverage limits of at least One Million Dollars ($1,000,000.00) per occurrence and Three Million Dollars ($3,000,000.00) annual aggregate to insure such Party and its Board, officers, employees and agents acting within the scope of their duties and employment against any claim for damages arising by reason of injuries to property or personal injuries or death occasioned directly or indirectly in connection with services provided by such Party and activities performed by such Party in connection with this Agreement. Either Party shall notify the other Party thirty (30) days prior to the termination or modification of such policies.

III. EFFECTIVE DATE, TERM AND TERMINATION.

3.1 Effective Date and Term. The promises and obligations contained herein shall commence as of June 27, 2011 and shall continue for an initial term of three (3) years, renewing automatically for one (1) year terms thereafter unless sooner terminated by either Party under Section 3.2 herein.

3.2 Termination. This Agreement may be sooner terminated on the first to occur of the following:

a. Written agreement by both Parties to terminate this Agreement.

b. In the event of breach of any of the terms or conditions of this Agreement by either Party and the failure of the breaching Party to correct such breach within ten (10) business days after written notice of such breach by either Party, such other Party may terminate this Agreement immediately with written notice of such termination to the breaching Party.

c. In the event either Party to this Agreement shall, with or without cause, at any time give to the other at least thirty (30) days advanced written notice, this Agreement shall terminate on the future date specified in such notice.

d. Debarment, suspension, or exclusion, as set forth in Section 1.7 of this Agreement.

EXECUTION

3.3. Effects of Termination. Upon termination of this Agreement, as hereinabove provided, no Party shall have any further obligations hereunder, except for obligations accruing prior to the date of termination.

IV. MISCELLANEOUS.

4.1 Entire Agreement. This Agreement constitutes the entire agreement between Parties and contains all of the terms and conditions between the Parties with respect to the subject matter hereunder. Facility and Hospital shall be entitled to no benefits or services other than those specified herein. This Agreement supersedes any and all other agreements, either written or oral, between the Parties with respect to the subject matter hereof.

4.2 Relationship of the Parties. The Parties are independent contractors under this Agreement. Nothing in this Agreement is intended nor shall be construed to create an employer/employee relationship or a joint venture relationship between the Parties, or to allow any Party to exercise control or direction over the manner or method by which any of the Parties perform services herein.

4.3 Amending. It may only be amended, modified or terminated by an instrument signed by the Parties.

4.4 Assignment. Neither party will assign this Agreement without the prior written consent of the other party. Notwithstanding any provision of this Agreement to the contrary, either party will have the right to assign or otherwise transfer its interest under this Agreement to a related entity. A "related entity" will include a parent, wholly-owned subsidiary, an entity resulting from a sale of all or substantially all of that party's assets or from a merger, affiliation, or consolidation of that party with or into another entity. Such an assignment will not require the consent or approval of the other party.

4.5 Survival. The invalidity or unenforceability of any particular provision of this Agreement shall not affect the other provisions hereof, and this Agreement shall be construed in all respects as if such invalid or unenforceable provision were omitted.

4.6 Waiver. The waiver by either Party of a breach or violation of any provision of this Agreement shall not operate as, or be construed to be, a waiver of any subsequent breach of the same or other provisions hereof.

4.7 Notices. Notices required herein shall be considered effective when delivered in person, or when sent by United States certified mail, postage prepaid, return receipt requested and addressed to:

Facility	Hospital
National Healthcare - Peoria	The Methodist Medical Center of Illinois
7405 N. University	221 NE Glen Oak Avenue

Peoria, IL 61614
Ottawa IL 61350
Attention: Margaret Van Duyn
Fax: _____
Telephone: 309.691.9073

Peoria, IL 61636
Attention: Deborah R. Simon
Fax: 309.680.2543
Telephone: 309.672.5928

Or to other such address, and to the attention of such other person(s) or officer(s) as a Party may designate by written notice.

4.8 Governing Law. This Agreement shall be construed and interpreted in accordance with the laws in Illinois.

4.9 Nonexclusive. Nothing in this Agreement will be construed as limiting the right of either party to affiliate or contract with any other party.

4.10 It is understood and agreed that neither Party to this Agreement shall be legally liable for any negligent nor wrongful act, either by commission or omission, chargeable to the other, unless such liability is imposed by law and that this Agreement shall not be construed as seeking to either enlarge or diminish any obligations or duty owed by one Party against the other or against a third party.

IN WITNESS WHEREOF, the Parties have hereto executed this Agreement as of the last date written below.

Facility:
NATIONAL HEALTHCARE - PEORIA

By: [redacted]
Margaret Van Duyn, Clinical Director
for National Health Care
Date: June 20th 2011

Hospital:
THE METHODIST MEDICAL CENTER OF ILLINOIS

By: [redacted]
Deborah R. Simon, Sr VP & COO
Date: 6/21/11

REVIEWED FOR
LEGAL SUFFICIENCY
6/20/2011
MHSC CORPORATE COMPLIANCE

Methodist

June 20, 2011

To Whom It May Concern:

National Health Care Inc. has a long standing agreement with Methodist Medical Center Laboratory that lab testing not performed on site at National Health Care is performed at MMCI lab as indicated. Invoicing is sent to National Health Care Inc. Methodist Medical Center Laboratory is a CLIA certified lab (see attached certificate).

Deb Deeb
[redacted]
Coordinator, Client Services
Methodist Medical Center Laboratory

CENTERS FOR MEDICARE & MEDICAID SERVICES
CLINICAL LABORATORY IMPROVEMENT AMENDMENTS
CERTIFICATE OF ACCREDITATION

LABORATORY NAME AND ADDRESS

METHODIST MEDICAL CENTER OF ILLINOIS
221 NE GLEN OAK
PEORIA, IL 61636

CLIA ID NUMBER
14D0431854

EFFECTIVE DATE
02/28/2011

LABORATORY DIRECTOR
DEVENDRA TRIVEDI MD

EXPIRATION DATE
02/27/2013

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown herein (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, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

684 certs2_012911A

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)	07/14/1995
MYCOLOGY (120)	07/14/1995
PARASITOLOGY (130)	07/14/1995
VIROLOGY (140)	06/14/2000
SYPHILIS SEROLOGY (210)	07/14/1995
GENERAL IMMUNOLOGY (220)	07/14/1995
ROUTINE CHEMISTRY (310)	07/14/1995
URINALYSIS (320)	07/14/1995
ENDOCRINOLOGY (330)	07/14/1995
TOXICOLOGY (340)	07/14/1995
HEMATOLOGY (400)	07/14/1995
ABO & RH GROUP (510)	07/14/1995
ANTIBODY TRANSFUSION (520)	07/14/1995

LAB CERTIFICATION (CODE)	EFFECTIVE DATE
ANTIBODY NON-TRANSFUSION (530)	07/14/1995
ANTIBODY IDENTIFICATION (540)	07/14/1995
COMPATIBILITY TESTING (550)	07/14/1995
HISTOPATHOLOGY (610)	07/14/1995
ORAL PATHOLOGY (620)	01/07/1999
CYTOLOGY (630)	06/13/2003

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.

Copied 8/16/11 EKCO 24

Q.I. Quarterly Review
August 31, 2011

Attending:

Bernard Smith, MD

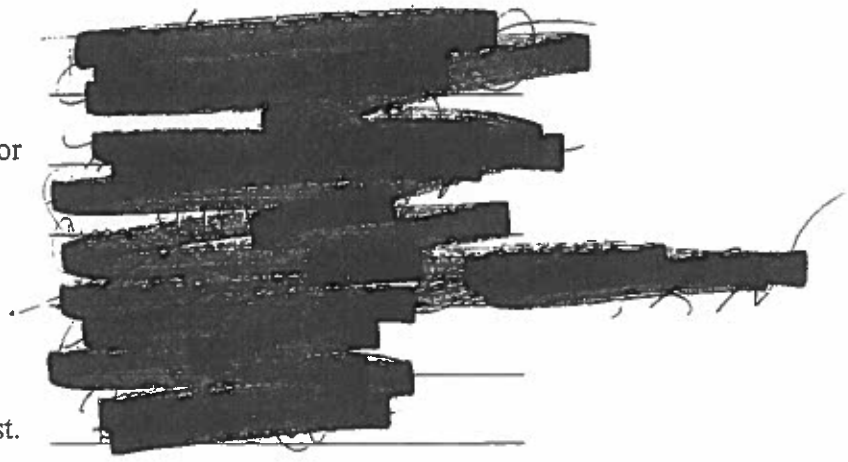
Margaret Van Duyn, Administrator

Tammy Johnson, RN

Wanda Ball, RN

Pam Krider, Secretary

Rilla Adcock, Administrative Asst.



Meeting commended at 2:30pm. Teresa Winkler, MT was unavailable at this time.

We have implemented many new ways to track and document the procedures we do and how we validate them. Today, we are reviewing how that is proceeding and if corrections need to be implemented.

1. Sterilizer Monitor Book – up to date, last cleaning and spore testing 8-8-2011. Signed off properly

2. Laundry – Procedure being followed and each load is documented and bleach and hot water have been used. Last documentation 8-26-2011.

3. Lidocaine Log – Documentation is done correctly, the use and discards are initialed and checked by the nurse responsible for the mix of medication. Last documentation on August 31, 2011.

4. Crash Cart Log – checked and verified and is up to date. Last documentation August 31, 2011.

5. Call Back Log – discussion was had about the increase of call backs. Dr. Smith reviewed and we will detail more description about call backs to try and determine some possible solutions. Last documentation August 31, 2011.

6. Tissue and Chart Review – All charts have been reviewed and signed off on by Wanda Ball, RN and the physician for that surgery day. They were found to be properly documented and reviewed by the administrator. All scants and tissues in question are faxed and reviewed immediately. Documentation is made in the chart at that time. Patient contact is indicated, the path report is reviewed by the physician in person or by phone.

Q.I. (QUALITY IMPROVEMENT TEAM)

Team Members Management

Executive Director	Margaret Van Duyn
Medical Director	Bernard Smith M.D.
Laboratory Director	Bernard Smith M.D.

Working Q.I. Team

Director	Margaret Van Duyn
Lab & Sono	Teresa Winkler M.T.
Recovery Room	Tammy Johnson R.N.
Operating Room	Wanda Ball, R.N.
Counseling	Tammy Johnson R.N.
Surg. Prep.	Pam Krider
Officer Manager	Rilla Adcock

The Q.I. team will review problems by the work area involved. Every quarter we will all discuss the problem areas together.

Q.I. reports will be put in writing on a quarterly basis and kept in a binder.

The Q.I. team review includes, but not limited to, the following:

1. Policy and procedural change
2. Patient care
3. Monitoring employees and staff training
4. Ensure reviews, maintenance and inspections are performed as scheduled
5. Keeping paperwork up to date and current

Illinois Department of
PUBLIC HEALTH

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

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.idph.state.il.us

September 19, 2011

License # 7001670

Margaret Van Duyn, Administrator
National Health Care Services of Peoria Inc.
7405 N University
Peoria, IL 61641

Dear Ms Van Duyn:

To maintain a license under the Ambulatory Surgical Treatment Act, ("Act") 210 ILCS 5 and the Title 77 Ill. Admin. Code 205, the Ambulatory Surgical Treatment Center Licensing Requirements, a pregnancy termination center ("PTC") must meet all of the provisions of the Act and its regulations. Specifically, Section 10(f) of the Act and Section 205.840 of the Code allows for the Department to issue suspensions of a service or a license, as prescribed by law.

The Department conducted a revisit survey of National Health Care Services of Peoria Inc. on 9/6/11 to the first survey of 6/16/11. During the survey, the following violations were assessed:

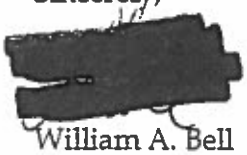
1) The failure to demonstrate that the physician reviewed the medical history, lab work, tests and physical examination or complete a pre-anesthetic evaluation prior to abortion procedure constitutes a serious detriment to the health, safety or welfare of patients. Preoperative care is mandated under Section 205.520b).

2) The failure to ensure all physicians with surgical privileges have surgical practice privileges at an Illinois Hospital with skilled equivalent practice privileges further poses detriment to the health, safety or welfare of the patients. Upon survey, the notarized letters confirmed with Department surveyors that physician privileges had expired. This is in clear violation of Section 205.230a)4).

Therefore, the Department requires <u>that IMMEDIATE ACTION be taken to correct the cited deficiencies cited within 48 hours of the receipt of this letter.</u> Failure on your part to meet these requirements will result in adverse licensure action including summary suspension, revocation and imposition of a fine of up to $500 per violation per day. Please note that you must correct any other licensure violations as cited in the enclosed statement of deficiencies.

Should you have any questions regarding this notification, please address your concerns immediately to Karen Senger, Nurse Supervisor, at the Illinois Department of Public Health, Division of Health Care Facilities and Programs, 525 West Jefferson Street, 4th Floor, Springfield, IL 62761, or 217-782-7412. The Illinois Department of Public Health's TTY number, for hearing impaired use only, is 800-547-0466. The Springfield Division's office fax number is 217-782-0382.

Sincerely,



William A. Bell
Assistant Deputy Director
Bureau of Hospitals and Ambulatory Services

National Health Care, Inc.

7405 N. University Street, Suite D
Peoria, Illinois 61614
309-691-9073
(Illinois) 800-322-1622
(Iowa) 800-322-5442
www.abortionaccessnhc.com

September 21, 2011

Ms. Karen Senger
Nurse Supervisor
Illinois Department of Public Health
Division of Health Care Facilities and Programs
525 West Jefferson Street, 4th Floor
Springfield, IL 62761-0001

Dear Mr. Bell and Ms. Senger:

I received your letter of September 19, 2011, on September 21, 2011. National Health Care has taken action to correct the cited deficiencies noted in your letter and the attached Statement of Deficiencies. In addition to this letter detailing the steps we have taken to correct the deficiencies noted verbally during the September 6, 2011, revisit survey, and your recent Statement of Deficiencies. I have also enclosed the Plan of Correction with corrective steps noted on that document, and several Exhibits documenting the corrective steps we have taken.

Corrective steps taken relating to Section 205.520(b):

- The Administrator has revised the form for pre-operative and operating room notes included in patient charts to include a certification that the physician and the registered nurse has "reviewed the patient's medical history, performed a physical exam and found them to be within the clinic's guidelines" (See Exhibit 6).
- On Thursday, September 15, 2011, the Consulting Committee met in an emergency meeting during which they reviewed the revised form for pre-operative and operating room notes. The Consulting Committee approved the revised form (See Exhibit 4).
- The revised form of notes is currently being used with all NHC patients undergoing abortion procedures, and has been used with all patients since the Consulting Committee approved the revised form on September 15, 2011.
- On Friday, September 16, 2011, the Administrator mailed to the attention of Jodee Havens at IDPH a copy of the Emergency Consulting Committee meeting minutes noting that the Consulting Committee had approved the revised form for pre-operative and operating room notes to be included in patient charts. On Monday, September 19, 2011, the Administrator telephoned Jodee Havens and Karen Senger, Nurse Supervisor for IDPH, and informed both of them that she had mailed a copy of the Emergency Consulting Committee meeting minutes.

Corrective steps taken relating to Section 205.230(a)(4):

- After IDPH Medical Staff verified that the skill-equivalent practice privileges granted P-2 at Illinois Masonic Hospital had expired, the Administrator informed P-2 on September 6, 2011 that P-2's practice privileges at Illinois Masonic Hospital were no longer valid, and immediately suspended her privileges at NHC. The Medical Director of NHC confirmed in writing that P-2 would not perform patient procedures at NHC until P-2 had reestablished skill-equivalent practice privileges at a licensed Illinois hospital (See Exhibit 3).
- Since the discovery that P-2's skill-equivalent practice privileges at Illinois Masonic Hospital had expired, P-2 has not performed any surgical procedures for patients at NHC.
- On September 7, 2011, Jodee Havens, telephoned the Administrator to confirm that P-2 was not scheduled to perform patient procedures on that day. The Administrator verbally confirmed to Ms. Havens that P-2 was not at the clinic and would not perform patient procedures that day.
- On Thursday, September 6, 2011, the Consulting Committee met in an emergency meeting and suspended P-2 from the medical staff at NHC (See Exhibit 3). The Committee also resolved that going forward "all privileges will be documented as well as what scope of their practice is and what procedures they can do with the hospital" (See Exhibit 3).
- On Friday, September 16, 2011, the Administrator mailed to the attention of Jodee Havens at IDPH a copy of the Emergency Consulting Committee meeting minutes noting P-2 had been suspended from the medical staff at NHC and noting the change in policy concerning the documentation of skill-equivalent practice privileges. On Monday September 19, 2011, the Administrator telephoned Jodee Havens and Karen Senger, and informed both of them that she had mailed a copy of the Emergency Consulting Committee meeting minutes confirming P-2's suspension from practice at NHC.
- Today, Wednesday, September 21, 2011, the Administrator received notice that P-2 had been granted skill-equivalent practice privileges at Illinois Masonic Hospital. A copy of the documentation provided by Illinois Masonic Hospital of the privileges granted P-2 is attached as Exhibit 3.
- The Consulting Committee did review the documentation provided by Illinois Masonic Hospital to consider the reinstatement of P-2 to the medical staff of NHC on September 21, 2011. P-1 has re-credentialed P-2 and her hospital privileges confirmed.

I hope that the enclosed letter and documents fulfill the necessary requirements of the department. Please contact me if there is any further assistance that you require of me.

Respectfully Submitted,

Margaret Van Duyn
Executive Director

September 16, 2011

Ms. Jodie Havens R.N.
Illinois Department of Public Health
Division of Health Care Facilities and Programs
525 West Jefferson Street, 4th Floor
Springfield, IL 62761-0001

Dear Ms. Havens:

Please find enclosed the corrections and a copy of the Emergency Consulting Committee Meeting.

I hope this completes our correction plan.

Respectfully,

Margaret Van Duyn
Director

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

☐ ASTC Ξ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL Pregnancy Termination Center

NAME AND ADDRESS OF FACILITY National Health Care Inc
7405 N. University, Peoria, IL 61614

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

DATE OF SURVEY 09/06/11 BY 11384 & 30375
(Surveyor)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY 06/16/11

(Provider's Representative)

Section 205.230 Standards of Professional Work	(a)(2)The consulting committee shall review development and content of the written policies and procedures of the center, the procedures for granting privileges, and the quality of the surgical procedures performed. Evidence of such review shall be recorded in the minutes. This requirement was not met as evidenced by: A. Based on a review of PTC policy manual and staff interview, it was determined the PTC failed to ensure a procedure for granting PTC privileges was approved by the consulting committee, implemented, and followed. Findings include: 1. The PTC policy manual was reviewed. It included a procedure for granting privileges, although the manual had not been reviewed and approved by the consulting committee as of 09/06/11. 2. During a staff interview, conducted with the Administrator on 09/06/11 at 11:30 AM, the above finding was confirmed.	RECEIVED OHCR HCF&P 2011 SEP 23 A 11: 18 1. The Policy and Procedure was reviewed in its entirety on September 15, 2011 and was approved by the Consulting Committee. Ex. 1
Section 205.230 Standards of Professional Work (a) (3) (4)	(a)(3) Credentials shall be provided by those physicians seeking practice privileges. These credentials shall be reviewed by the credentials committee and specific practice privileges identified and recorded. Record of such accepted practice privileges shall be available for facility staff use and public information within the facility. (4) Each member of the medical staff granted specific surgical practice privileges shall provide a notarized statement or documentation indicating the name of the IL licensed hospital (s) where they have skilled equivalent practice privileges. Such statements or documentation shall be available for inspection by the Department. A list of privileges granted each medical staff member of	

E#1

Policy and Procedure Review

Review of Policy and Procedure will be done on an annual basis. Anytime a procedure is changed it will be noted in the comment section and dated.

Director	Dr. Palmer	Dr. Gittler	
[redacted]	_____	_____	January 2011
[redacted]	[redacted]	Not eligible	September 2011
_____	_____	_____	January 2012
_____	_____	_____	January 2013
_____	_____	_____	January 2014

Comments: Sept. 15, 2011 Emergency review of P&P manual / MOD New OR Sheets, New Recovery Sheets and new QA team & policy - / [redacted]

Section 205.230 Standards of Professional Work	the ambulatory surgical treatment center shall be available at all times for use by the staff of the center and for inspection by the Department staff. As used in this subsection, "skilled equivalent" means the ability to perform similar procedures requiring the same level of training and experience. This requirement was not met as evidenced by: A. Based on a review of Medical Staff credential files, consulting committee recommendations and staff interview, it was determined in 1 of 2 Medical staff credential files reviewed, the PTC failed to ensure specific practice privileges granted to P-1 had equivalent practice privileges at an Illinois Hospital. Findings include: 1. Documentation indicated the PTC consulting committee met 07/07/2011 to review medical staff credentials and privileges were granted. The consulting committee notes indicated: "privileges granted and reviewed for elective abortions and IV sedation." 2. A review of Medical Staff credential files included a notarized statement from an Illinois Hospital indicating privileges were granted. The Hospitals were contacted on survey date 09/06/11. It was verified by the Medical Staff secretary at the IL Masonic Hospital in Chicago, that P-1 did not have admitting privileges there and had not had admitting privileges since 2007, contrary to what the credential file of P-1 indicated. 3. During a staff interview, conducted with the Administrator on 9/06/11 at 11:30 AM, the above findings were confirmed. The Administrator indicated "we have letters (notarized statements) from the physicians indicating they have privileges at those Hospitals." It was verified by the PTC Administrator on 09/06/11, that the notarized statements provided by the	1. Correct date to August 31, 2011. Ex. 2 2. On September 9, 2011, the Department verified P-1 was current. The nurses found one staff physician (P-2) privileges had expired. That issue with P-2 (staff physician) has been resolved. Please find enclosed P-2 Temporary Privileges. Ex. 3

Ex #2

Q.I. Quarterly Review
August 31, 2011

Attending:

Bernard Smith, MD

Margaret Van Duyn, Administrator

Tammy Johnson, RN

Wanda Ball, RN

Pam Krider, Secretary

Rilla Adcock, Administrative Asst.

Meeting commended at 2:30pm. Teresa Winkler, MT was unavailable at this time.

We have implemented many new ways to track and document the procedures we do and how we validate them. Today, we are reviewing how that is proceeding and if corrections need to be implemented.

1. Sterilizer Monitor Book – up to date, last cleaning and spore testing 8-8-2011. Signed off properly

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E#3

National Health Care, Inc.

September 6, 2011

At 2:40pm, Dr. Palmer and I had a private discussion about the situation with the staff physicians.

Dr. Gittler no longer will be practicing here until her privileges are reinstated. I was previously under the assumption that Dr. Gittler's paperwork was complete.

Dr. Smith has not been here since the first visit from the department on June 16, 2011.

On September 7, 2011, Jodee Havens from the Department called to make sure of Dr. Gittler's status and she was informed by me that Dr. Palmer was here and Dr. Gittler was re-applying for privileges.

Meeting adjourned 3:15pm.

Respectfully Submitted,

[redacted]

Margaret Van Duyn
Administrative Director

[redacted]

Dr. Allen Palmer, D.O.
Staff Physician

Ex #3

Re-Credentialing Review
September 21, 2011

Allen Palmer, D.O., our current Medical Director today, will review Mandy Gittler, M.D. our staff physician for compliance in regards to staff privileges.

Dr. Palmer reviewed Dr. Gittler credentials today:

1. Resume
2. Current Illinois License
3. Illinois Hospital Affiliation, Illinois Masonic current and on active staff
4. Notarized letter stating privileges
5. No outstanding malpractice issues
6. ACLS certification will be completed August 5, 2011. Will follow-up for completion.
7. Dr. Gittler had her operating skills reviewed previously and again today.
8. Privileges granted for pregnancy termination and intravenous sedation.

I found the above requirements satisfied and current.

Sept. 21 2011
Date

[redacted]
Allen Palmer, D.O.

Mandy Gittler, M.D.

[redacted]
Margaret Van Duyn, Administrator

Dr. Gittler will be back next month.

EX # 3

Advocate Illinois Masonic Medical Center

836 West Wellington Avenue || Chicago, IL 60657 || T 773.975.1600 || advocatehealth.com

September 20, 2011

Mandy Gittler, MD
All Women's Health
2000 West Armitage Avenue
Chicago, Illinois 60647

Dear Dr Gittler:

I am pleased to grant temporary admitting privileges to you effective September 21, 2011 while your request is being processed.

The enclosed privilege sheet signed by Dr. Jose Elizondo, Chair of the Department of Family Medicine, represents your allowable practice privileges while working at the Advocate Illinois Masonic Medical Center. Should you desire a change in privileges in the future, Dr. Elizondo will be happy to assist you with your request.

Thank you for your interest, and please do not hesitate to call me if I can be of any assistance.

Sincerely,

[redacted]

Susan Nordstrom Lopez
President
Advocate Illinois Masonic Medical Center

/kr
Enclosure: privilege sheet

cc: Jose F. Elizondo, MD

Family Medicine - Adults Inpatient Care (surgical)

Description: As stated below.

Request ☐	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request*	Section Chief Recommend ☐	Dept Chair Recommend ☐
	Family Medicine- Adults Inpatient Care (Surgical)		
☐	Privileges include being able to assist in surgery, suture uncomplicated laceration, I & D of abscess, simple skin biopsy or excision, removal of non-penetrating corneal foreign body, uncomplicated minor closed fractures (not involving traction or major manipulation), uncomplicated dislocations.	☐	☐
☐	Admit to inpatient or appropriate level of care	☐	☐
☐	Perform History and Physical Examination	☐	☐

Qualifications

Clinical Experience (Reappointment) Management of 20 hospitalized patient during the previous 24 months

FPPE/OTHER

☐ Three retrospective chart reviews chosen to represent a diversity of medical conditions and management challenges.

Family Medicine – Inpatient Care (Pediatric Patients)

Description: As stated below.

Request ☐	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request*	Section Chief Recommend ☐	Dept Chair Recommend ☐
	Family Medicine- Inpatient Care (Pediatric Patients)		
☐	Privileges include being able to admit and treat the general pediatric patient under the age of 18 years without major complications or serious life threatening disease. This includes the care of the normal newborn as well as the uncomplicated premature infant equal to or greater than 36 weeks gestation.	☐	☐
☐	Admit to inpatient or other level of care	☐	☐
☐	Perform History and Physical Examination	☐	☐
☐	Circumcision	☐	☐
☐	Neonatal Resuscitation (requires NALS certification)	☐	☐
☐	Lumbar Puncture (documentation may be required)	☐	☐

Qualifications

Clinical Experience (Initial) Management of 10 pediatric patients during the previous 24 months, waived for applicants who completed residency training in family medicine during the previous 12 months.

Clinical Experience (Reappointment) Management of 10 pediatric patients during the previous 24 months.

FPPE/OTHER

☐ Three retrospective chart reviews chosen to represent a diversity of medical conditions and management challenges.

Published: [pubdate]

Family Medicine - Obstetrics Privileges (uncomplicated)

Description: As stated below.

Request ☐	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request*	Section Chief Recommend ☐	Dept Chair Recommend ☐
	Family Medicine- Obstetrics Privileges (uncomplicated)		
☐	Provide care to women throughout the course of pregnancy, labor, and delivery periods in both the ambulatory and inpatient setting. Manage medical diseases that are complicating factors in pregnancy. Privileges include being able to perform normal spontaneous vaginal delivery, including ante-partum and post-partum care, repair of minor vaginal and cervical lacerations, use of outlet devices and the care of uncomplicated gynecological patients.	☐	☐
☐	Admit to inpatient or other level of care	☐	☐
☒	Perform History and Physical Examination	☐	☒
☐	Management of normal labor of a pregnancy no less than 36 weeks gestation age and not more than 42 weeks completed gestation. Includes management of women with a previous cesarean section with a documented low-transverse uterine scar with obstetrics consultation.	☐	☐
☐	Intepretation of fetal monitor tracing (requires periodic competency testing)	☐	☐
☐	Amniotomy	☐	☐
☐	Assist at C-sections	☐	☐
☐	Episiotomy and repair	☐	☐
☐	Placement of external and internal fetal monitors	☐	☐
☐	Induction of labor (with obstetric consultation)	☐	☐
☐	Bedside Ultrasound for AFI, NST, and biophysical profile	☐	☐
☐	Manual removal of placenta, post-delivery	☐	☐
☐	Pudendal anesthesia	☐	☐
☐	Repair of first, second and third-degree perineal lacerations and other associated lacerations	☐	☐
☐	Vacuum assisted vaginal delivery (with obstetric notification and documentation)	☐	☐
☒	Dilation and curettage	☐	☒
☐	Low or outlet forceps delivery (with obstetric notification and documentation)	☐	☐
☐	Repair of fourth-degree perineal lacerations and other associated lacerations (with obstetrics consultation)	☐	☐
	Management of:		
☐	Abnormal labor progress	☐	☐
☐	Antepartum hemorrhage	☐	☐
☐	Chorioamnionitis	☐	☐
☐	Fetal demise	☐	☐
☐	Fetal distress	☐	☐
☐	Hypertensive disorders (with obstetrics consultation)	☐	☐
☐	IUGR (intrauterine growth restriction-with obstetrics consultation)	☐	☐
☐	Gestational diabetes (with obstetrics consultation)	☐	☐
☐	Malpresentation (with obstetrics consultation)	☐	☐
☐	Post-maturity (>42 weeks EGA-with obstetrics consultation)	☐	☐
☐	Premature labor (with obstetrics consultation)	☐	☐

	Advanced Privileges (Requires additional training and evidence of such training)		
☐	C-section delivery (must have obstetric back-up physician on call)	☐	☐

Qualifications

Education/Training	Confirmation from program director that residency training included a minimum of 12 weeks rotation in obstetrics
Clinical Experience (Initial)	Management of 10 deliveries during the previous 12 months **OR** Completion of residency training in family medicine during the previous 12 months and confirmation from program director that the family physician managed 30 deliveries during residency program
Clinical Experience (Reappointment)	Management of 20 deliveries during the previous 24 months
Other Requirements	Identification of obstetrician or obstetric team that will serve as backup in case of emergencies

FPPE/OTHER

☐ Five retrospective chart reviews chosen to represent a diversity of obstetrical conditions and management challenges.

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform and for which I wish to exercise at Advocate Illinois Masonic Medical Center. Furthermore, I understand that in exercising any clinical privileges granted, I am constrained by any Hospital and Medical Staff policies and rules to any applicable or particular situation. Any restriction in clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents. I also attest that my professional liability covers the privileges that I have requested.

[redacted]
Practitioner's Signature

9/8/11
Date

Department Chair Recommendation - Privileges

I have reviewed the requested clinical privileges and supporting documentation and make the following recommendation(s):

☒	Recommend all requested privileges
☐	Do not recommend any of the requested privileges
☐	Recommend privileges with the following conditions/modifications/deletions (listed below)

Privilege	Condition/Modification/Deletion/Explanation
Moderate sedation	approved pending compliance with Hospital Policy test passed 9/21/11 KR

Department Chair Recommendation - FPPE Requirements

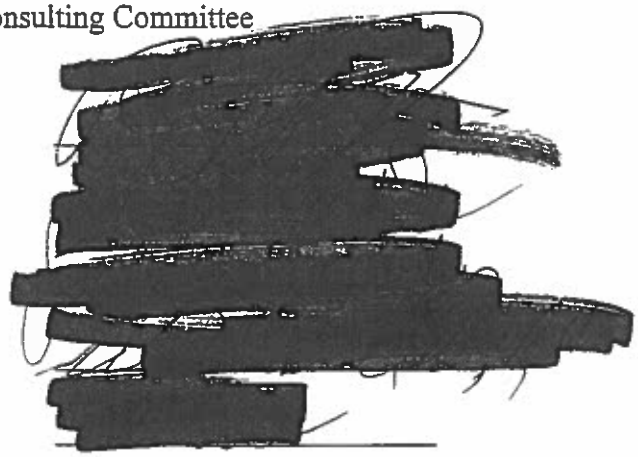
Signature of Section Chief _____ Date _____

Signature of Department Chair _____ Date 9-09-11

	physicians, indicating where their skilled practice privileges were, had not been verified as valid with the Hospitals.	
Section 205.230 (b) (1) Standards of Professional Work	(b)(1) The Medical Director shall secure compliance with the policies and procedures pertaining to medical and surgical procedures, approved by the consulting committee. This requirement was not met as evidenced by: A. Based on a review of PTC policy manual and staff interview, it was determined the PTC Medical Director failed to ensure policies and procedures pertaining to medical and surgical procedures were approved by the consulting committee. Findings include: 1. The PTC policy manual was reviewed on survey date 09/06/11. Policy and Procedure Review documentation indicated "Review of Policy and Procedure will be done on a semi-annual basis..." There was no documentation to indicate the policies and procedures had been reviewed or approved by the consulting committee. 2. During a staff interview, conducted with the Administrator on 09/06/11 at 12:30 PM, the above finding was confirmed.	1. The complete policy and procedure was reviewed by the physician and supervisory staff on September 15, 2011. Ex. 4
Section 205.240 Policies and Procedures Manual	The management/ owner of the ambulatory surgical treatment center shall formulate a written policies and procedures manual. This shall be done in cooperation with the medical and professional staff and shall be approved by the consulting committee. These procedures shall provide for the acceptance,... This requirement was not met as evidenced by: A. Based on a review of PTC policy manual and staff interview, it was determined the PTC failed to ensure its policies and procedures were approved by the	

Ex 4

September 15, 2011
Emergency Consulting Committee



Attending: Dr. Allen Palmer

Margaret Van Duyn, Director

Tammy Johnson, RN Recovery

Wanda Ball, RN OR

Rilla Adcock, Admin. Asst.

The meeting commenced at 2:20pm. The first item on the agenda is the situation with our staff physicians.

1. Dr. Bernard Smith is no longer working at the facility because he can't meet the hospital requirement. He will complete the year as our Medical Director.
2. Dr. Mandy Gittler is not working at this time as she gets her privileges renewed at the hospital.
3. Dr. Stewart Kernes is no longer working here as he is unable to secure hospital privileges.

It was discussed that all privileges will be documented as well as what scope of their practice is and what procedures they can do with the hospital.

Nurses and Staff

1. All operating room nurses have been certified in Advanced Cardiac Life Support (ACLS).

Written Policy:

1. Policy and Procedure was reviewed and is complete.
2. Policy Review signed by Dr. Palmer
3. The two (2) new pages that will be placed in the patients' charts, one in recovery and one in the operating room, have been approved by the committee.

Dr. Smith is still our acting Medical Director and will review the policy at a later date.

Meeting Adjourned at 3:20pm.
No charts Reviewed.

Respectfully Submitted,

Margaret Van Duyn
Director

	consulting committee.	
Section 205.240 Policies and Procedures Manual	Findings include: 1. The revised PTC policy manual, since survey date 06/16/11, was reviewed on 09/06/11. There was no documentation to indicate the consulting committee had approved the manual. 2. During a staff interview, conducted with the Administrator on 09/06/11 at 12:30 PM, the above finding was confirmed.	1. The complete policy and procedure was reviewed by the physician and supervisory staff on September 15, 2011. Ex. 4
Section 205.320 Presence of Qualified Physician	A qualified physician shall be present at the facility until all patients are medically discharged. The discharge criteria shall be defined by the qualified consulting committee. This requirement was not met as evidenced by: A. Based on a review of PTC policy manual and staff interview, it was determined the PTC failed to ensure discharge criteria was established and approved by the consulting committee. Findings include: 1. The PTC policy manual was reviewed on 09/06/11. There was no documentation regarding a newly implemented discharge criteria policy had been incorporated into the manual and the policy manual had not been approved by the consulting committee as of survey date 09/06/11. 2. During a staff interview, conducted with the Administrator on 9/06/11 at 12:30 PM, the above finding was confirmed.	1. Discharge criteria was noted and approved on September 15, 2011. Ex. 5
Section 205.520 b) Pre-operative care	b) A complete medical history shall be obtained and the physical examination shall be complete. A pre-anesthetic evaluation shall be completed specifically identifying any patient sensitivity or contraindications to anesthesia. This requirement was not met as evidenced by:	

Ex 5

Recovery Room
Discharge Criteria and Patient Care

1. Once OR nurse has placed patient in recliner, situate patient.

    a. Have blue pad already placed on chair
    b. Elevate feet by placing chair in reclined position
    c. Place white blanket over patient
    d. Give patient an ice pack to put over abdomen
    e. Give patient cup of Sierra Mist and cookies
    f. Ask if ride is already waiting for them (call if necessary)
    g. Ask how patient is doing and inform that cramping will calm down in about 15 minutes.

2. Patient's blood pressure is immediately taken and assessed.

3. Patient's initial post-op charting

    a. Write chair number in tab by name
    b. Write time patient arrived to post-op
    c. Write down blood pressure and pulse
    d. Indicate patient's pain level.

4. Visual assessment of patient is completed. Review patient IV site for redness. Apply ice on injecting site if needed. Document in chart if abnormal.

5. Recovery Time:

    a. No anesthesia and ride = at least 30 minutes
    b. Anesthesia and ride = at least 40 minutes
    c. No anesthesia and no ride = at least 45 minutes
    d. Patient is not allowed to have anesthesia if driving themselves
    e. Patient time may increase if patient has an abnormal assessment

6. Blood pressure is reassessed 5 minutes before discharge.

7. Medications are administered by nurse in post-op per Physicians orders.

8. Review patients chart for known allergies and daily medications before dispensing medications.

9. All patients receive and antibiotic. Standard is Doxycycline, 100mg, dispense #6 take twice a day with water and food and informed to avoid sunlight and antacids. If allergy to

Doxycycline or other antibiotic then substitute Amoxocillin 500mg #15 for 5 days or another as instructed by the Physician.

10. All patients that are 12 weeks gestation or further received Methergine 0.2mg #6 one at dinner and bedtime today then three times a day until gone per standing order.

11. RH card is given to patients with negative blood types that received the RhoGam shot during the procedure.

12. Doctor's notes to excuse from work or school are given as indicated on post-op orders. Doctor notes state patient is able to resume normal activities after three days.

13. Birth control information is given as directed per Physician.

14. Any other information is given as directed by the Physician.

15. Abnormalities in Post-Op:

    a. Nausea/vomiting/restlessness/diaphoreses. Retake patient's blood pressure for possible drop from pre-procedure blood pressure. If low blood pressure is discovered and symptomatic, patient may receive 0.4 Atropine IM x 1 dose to elevate blood pressure symptoms. Patient is educated about need of medication due to blood pressure dropping and informed they will feel better in 5-10 minutes. Caffeine beverages are given as needed to assist in raising blood pressure.
    b. If patient has extreme nausea/vomiting that does not ease after vomiting, give patient Tigan 200mg IM per direct order of the Physician.
    c. Increased abdominal pain that does not ease after 10 minutes fundal massage to check for fundal bogginess. Possible return to Sono and possible return to procedure room for recheck and/or re-suction by Physician.
    d. Patients that did not receive any anesthesia but are having severe cramping/also those who have had anesthesia may have Toradol 30mg Po/IM as directed by the physician. Patients are informed the use of non-narcotic anti-inflammatory that helps with cramping.
    e. Patients who received anesthesia and are very drowsy and hard to arouse Spo_2 is assessed if low then 90% patient encouraged to deep breath if very drowsy and decreased reaction to sternal rub, standing orders to reverse anesthesia with Romazicon, after physician evaluation.
    f. All abnormal situations in post-op are relayed to physicians for orders.

16. Patients are released from Post-op, and then RN does not leave until the last patient has left the premises.

A. Based on a review of fourteen clinical records and staff interview, it was

determined the Facility failed to ensure medical histories and complete physical examinations were reviewed by the physician prior to the procedure.

Findings include:

1. Fourteen clinical records were reviewed on survey date 09/06/11. None of the records contained documentation to indicate the histories (completed by the patient), nor the physical examinations (laboratory work, pelvic, and sonogram completed by the nurse, laboratory, and/or sonographer) were reviewed by the physician prior to the procedure. There was no documentation to indicate a pre-anesthetic evaluation was conducted, prior to the administration of IV moderate sedation, on any clinical records reviewed.
2. An interview was conducted with the Administrator on 09/06/11. It was verbalized that the patients fill out their own histories. There was no documentation to indicate the physician or nurses administering IV sedation reviewed the medical histories. The Administrator indicated they were in the process of getting the forms into place.
3. During a staff interview, conducted with the Administrator on 9/06/11 at 12:30 PM, the above findings were confirmed.

The new medical and surgical page is included and was approved by the Consulting Committee on September 15, 2011.

Ex. 6

Pt. # _____ Pt. Name _____ Ex #6 _____ Date ____/____/____

RECOVERY ROOM

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

MEDICATIONS

I.V. medication given: _____ SONO _____

____ Ergonovine 0.2mg 1 P.O. upon admit
____ Doxycycline 100 mg 1 B.I.D. #6
____ Ergonovine 0.2 mg T.I.D. #6
____ Ergonovine 0.2 mg #2 Take 1 @dinner 1 @ bedtime
____ Tri-Cyclen Lo 28-Day Disp 1 Rx Ref x 2
____ Ibuprofen 800 mg #10

Scant Tissue - check up explained _____Staff/Intitial
____ Rh Immune Card: given with explanation
____ Postcare emerg. # B.C. and medications
____ Work / School Excuse
____ Femcon Fe Disp 1 Ref x 2
____ Loestrin 24 Fe 28 Disp 1 Ref x 2
____ Nuva Ring Disp 1 Ref x 2

NURSES NOTES/POST-OP INSTRUCTIONS

Other: _____

_____

_____

_____

Drew Reviewed

Discharged to Driver: _____ _____ RN/LPN

Patient discharged on the written order of the physcian. Condition at discharge is satisfactory and pt. ambulating with out assistance.

Time _____ _____RN/LPN _____ M.D.

PATH REPORT

Date _____ Fax ☐ Reg ☐ GMS: _____ Diag: _____

Follow up: _____

_____

_____

CHECK UP

Date _____ Preg. Test _____ Hgb _____ Sono _____

Follow Up _____

_____

Medication _____

_____ M.D.

Revised 08/11

Pt # _____ Pt. Name Ex 6 _____ Date: ____ / ____ / _____

SONO

1 LMP _____ Calc WK _____ Gravida ____ Para ____ SONO WEEKS _____

Sac Seen ☐ CA ☐ Yolk Sac ☐ Fetal Pole ☐ CRL _____ B.P.D. _____

Other: _____ _____ Int.

LAB

2 Preg Test Sens: _____ Hgb _____ Rh _____

Rho-Gam _____ Tech _____

PRE-OP

3 Time _____ B.P. _____ Pulse _____

Misoprostol info: ☐ _____ Pt. Int. Misoprostol 200 mcg#2 ☐ _____ Int.

OR NOTES

Admit Time _____ B.P. _____ Pulse _____ O2 Sat _____

Gest _____ Ant _____ Mid _____ Post _____ Adnexa _____

* Revised Abnormalities were noted in the following areas: Heart _____ Lungs _____ Abd _____ Pelvis _____

A. Paracervical block: Lidocaine HCL 1% 15 ml 20 ml Additives in Block: 5cc 8.4% Sodium Bicarbonate 0.2 ml Vaspressin per 45cc Lidocaine

☐ Fentanyl 50mcg given I.V. Midazolam HCL 2.5 mg ☐ 2.0 mg ☐ Time _____ _____ M.D./RN

B. Cervix dilated to _____ Uterine Depth _____ Cannula _____mm Blood Loss _____ mL Tissue to P.L.S.

Rho-Gam: Cervical ☐ IM ☐ Mini 50ug ☐ Full 300ug ☐ Methergine 0.2mg/cervical ☐ Pitocin 10 units/cervical ☐

C.L.O.C: Alert and Resposive ☐ Easily Arousable ☐ Other: _____

_____

_____

_____

Revised * * New

I have reviewed the patient's medical history, performed a physical exam and found them to be within the clinic's guidelines.

_____ RN

_____ M.D.

Discharge: Satisfactory ☐ Walked to RR c assist ☐

National Health Care, Inc.
/405 N. University Street, Suite D
Peoria, Illinois 61614
309-691-9073
(Illinois) 800-322-1622
(Iowa) 800-322-5442
www.abortionaccessnhc.com

September 24, 2011

Karen Senger R.N.
Illinois Department of Public Health
525-535 West Jefferson St.
Springfield, IL 62761-0001

Dear Ms. Senger:

I have reviewed all the paper work that was provided from the Advocate Illinois Masonic Medical Center.

I also obtained a printout of her skill equivalent practice privileges, you have them in you office. Dr. Gittler is currently enrolled in a class to secure her ability to provide intravenous sedation.

I have verified these credentials by phone with the office of Dr. Jose Elizondo. I also verified the privilege sheet sent to us, that information was provided by Susan Nordstrom Lopez, President of the hospital.

Respectfully,

Bernard Smith M.D.
Medical Director
National Health Care Inc.

Procedure Policy Review
Yearly Review

January 2011

Date: Jan. 4, 2011

[redacted]
Medical Director

Comments: _____

January 2012

Date: Jan. 18 2011

[redacted]
Medical Director

Comments: _____

Sept. 2011(24) I reviewed the revised Procedure Policy Review and review the Emergency Consulting Committee Epaste.

[redacted]

January 2013

Date: _____

[redacted]
Medical Director

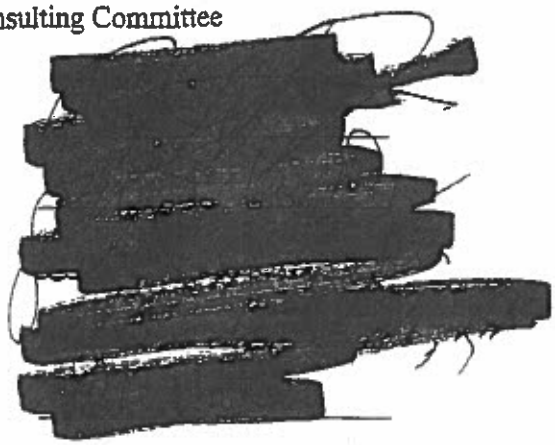
Comments: _____

RECEIVED OHCR HCF & P
2011 JUL 26 A 7:01

Revised July 12, 2011

Ex 4

September 15, 2011
Emergency Consulting Committee



Attending: Dr. Allen Palmer

Margaret Van Duyn, Director

Tammy Johnson, RN Recovery

Wanda Ball, RN OR

Rilla Adcock, Admin. Asst.

The meeting commenced at 2:20pm. The first item on the agenda is the situation with our staff physicians.

1. Dr. Bernard Smith is no longer working at the facility because he can't meet the hospital requirement. He will complete the year as our Medical Director.
2. Dr. Mandy Gittler is not working at this time as she gets her privileges renewed at the hospital.
3. Dr. Stewart Kernes is no longer working here as he is unable to secure hospital privileges.

It was discussed that all privileges will be documented as well as what scope of their practice is and what procedures they can do with the hospital.

Nurses and Staff

1. All operating room nurses have been certified in Advanced Cardiac Life Support (ACLS).

Written Policy:

1. Policy and Procedure was reviewed and is complete.
2. Policy Review signed by Dr. Palmer
3. The two (2) new pages that will be placed in the patients' charts, one in recovery and one in the operating room, have been approved by the committee.

Dr. Smith is still our acting Medical Director and will review the policy at a later date.

Meeting Adjourned at 3:20pm.
No charts Reviewed.

Bernard Smith M.D.
Medical Director

Respectfully Submitted,

Margaret Van Duyn
Director

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

Ξ ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

Pregnancy Termination Center

NAME AND ADDRESS OF FACILITY: National Health Care, Inc
7405 N. University Street, Suite D, Peoria, IL 61614

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)(2) Corrected	Standards of Professional Work		
205.230(a)(3)(4) Corrected	Standards of Professional Work		
205.230(b)(1) Corrected	Standards of Professional Work		
205.240 Corrected	Policies and Procedures Manual		
205.320 Corrected	Presence of Qualified Physician		
205.520 (b) Corrected	Pre-operative care An onsite follow up visit, to 09/06/11, was conducted on 10/07/11. Since the last visit, National Health Care, Inc. provided services on 09/15/11, 09/17/11, 09/29/11, and 10/06/11. P-1 was the physician who performed the procedures for the above listed dates. Policy and Procedure manual was reviewed and approved on 09/15/11 by the Consulting Committee. Medical History, Physical Exam and discharge criteria were present in 15 of 15 records reviewed.		

DATE OF SURVEY 10/07/11 BY 30375 (Surveyor) _____ (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY 09/06/11

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: National Health Care, Inc 7405 N. University Street, Suite D Peoria, Illinois 61614

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 205.410 Equipment	**Equipment shall be in good working order…** This requirement was not met as evidenced by: A. Based on observation, document review, and staff interview, it was determined the PTC failed to ensure it established, implemented, and maintained an ongoing preventative maintenance program for equipment utilized in the provision of patient care. This has the potential to affect 100% of the patients. Findings include: 1. During a tour of the PTC, conducted with the Administrator on 10/2/13 at 12:00 PM, it was observed that no equipment was tagged with information to indicate when preventative maintenance had been performed. 2. A form titled "Machines Needing a Yearly Check" was reviewed. It indicated 3 Vacuum Curettage and 3 Gleamer Light – one of each in each procedure room, Centrafuge, Oxygen	205.410 Equipment 1. A new log book has been instituted. This change was done immediately. The title was misleading. We routinely clean the autoclaves with Omni Cleaner for the Pelton Crane and Chamber bright for the Tuttanauer. We had a policy in place during the inspection. It appeared to be missed.	Ex. #1 & 2 Everything is done, we are waiting on a part. Head Surg tech and head nurse responsible. They will sign off.

DATE OF SURVEY 10-2-13 BY 26336, 32822, 31195, 32189 (Surveyor) (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

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

Ξ ASTC HHA HMO HOSPICE HOSPITAL

NAME AND ADDRESS OF FACILITY: National Health Care, Inc 7405 N. University Street, Suite D Peoria, Illinois 61614

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
	Tank, 1 Pelton- Crane Autoclave, and 2 Tuttanauer Autoclaves. It further indicated these were checked in June and July of 2011 with receipts for servicing at that time. There was no documentation to indicate preventative maintenance for 2012 or 2013. 3. The PTC policy manual was reviewed. There was no policy to address the preventative maintenance of patient care equipment. The only form present was the "Machines Needing a Yearly Check". 4. During a staff interview, conducted with the Administrator on 10/2/13 during the tour and at 3:00 PM, it was verbalized that "A man from… comes when we call. We don't do it every year. We just call … if something isn't working right and … comes and fixes it." It was confirmed that there was no policy in place and "I haven't done it yearly".	Autoclave Daily Log and Maintenance 1. Spore and cleaning is performed and dated. 2. Should a problem arise, we have a serviced back up Tuttanauer. 3. Safety valve is checked and steam release every two months. 4. Five year check and calibration was done in 2011. 5. Re-check calibration is being done and will be completed by February 27, 2014.	Feb. 27, 2014

DATE OF SURVEY 10-2-13 BY 26336, 32822, 31195, 32189 (Surveyor)

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

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

ASTC HHA HMO HOSPICE HOSPITAL

NAME AND ADDRESS OF FACILITY: National Health Care, Inc 7405 N University Street, Suite D Peoria, Illinois 61614

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 205.410 Equipment	**d) The facility shall... written procedures to assure the safety in storage and use of all narcotics and medications in accordance with state and federal law.** This requirement was not met as evidenced by: A. Based on observation, document review, and staff interview, it was determined the PTC failed to ensure a process was established, implemented, and maintained to ensure medications were stored in a secure manner. This has the potential to affect 100% of the patients. Findings include: 1. During a tour of the PTC, conducted on 10/2/13 at 12:00 PM with the Administrator, a 3 shelf metal cart was observed in the hallway with medications laying freely on a lid and some in an unlocked plastic container as well as biologicals on the top shelf, biological on the middle shelf, and	205.410 Safety in Storage Crash Cart: 1. All medications have been secured and under lock and key. 2. All biologicals have been secured on every shelf.	10-6-2013

DATE OF SURVEY 10-2-13 BY 26336, 32822, 31195, 32189 (Surveyor) (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

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

Ξ ASTC HHA HMO HOSPICE HOSPITAL

NAME AND ADDRESS OF FACILITY: National Health Care, Inc. 7405 N. University Street, Suite D Peoria, Illinois 61614

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
	respiratory items on the bottom shelf. When asked what this cart was, the Administrator said "It's our Crash Cart" 2. A form titled "Crash Cart" was presented by the Administrator. It indicated the following: "Drug Box: 1. Epinephrine... 2. Atropine...3. Albuterol inhaler...5. Flumazenil... Shelf One: 1. Vasopressin 2. Rho-Gam Full & Mini Dose 3. Methergine... 9. Butterfly infusion sets 10. Chromic gut sutures... Shelf Two: 1. 1- 5% Dextrose..." These were the items observed on the crash cart. 3. The PTC policy titled "Medication Handling Protocol" was reviewed. It indicated "All medications are to be stored in a locked cabinet..."		
Section 205.410 Equipment	**B.** Based on observation, document review, and staff interview, it was determined the PTC failed to ensure outdated drugs		

DATE OF SURVEY 10-2-13 BY 26336, 32822, 31195, 32189 (Surveyor) (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY

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

Ξ ASTC HHA HMO HOSPICE HOSPITAL

NAME AND ADDRESS OF FACILITY: National Health Care, Inc. 7405 N. University Street, Suite D Peoria, Illinois 61614

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	were not available for use in the patient care areas. This has the potential to affect 100% of the patients. Findings include: 1. During a tour of the PTC, conducted on 10-2-13 at 12:00 PM with the Administrator, the following outdated medications were observed in the Recovery Room narcotic drawer: 2 vials of 10 ml Sterile Water expired April 1, 2013; 2 vials Flumazenil 0.5 mg/5 ml expired 10/12; and 2 vials Flumazenil 1 mg/10 ml expired 4/13. 2. The policy manual was reviewed on 10/2/13. There was no policy to address monitoring of medications for outdates. 3. During a staff interview, conducted with the Administrator and the Recovery Room nurse, it was verbalized, by both, that there is no policy for outdated medications and no documentation as to	205.410 Outdated Drugs 1. Sterile water and Flumazenil have been removed and discarded the end of the inspection. 2. A check sheet with expiration dates of all medications has been implemented.	10-16-13/ MW

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Section 205.410 Equipment	when they were last checked for outdates. C. Based on observation, document review, and staff interview, it was determined the PTC failed to ensure single dose vials were not available for use on multiple patients. This has the potential to affect 100% of the patients. Findings include: 1. During a tour of the PTC, conducted on 10/2/13 at 12:00 PM with the Administrator, the following single dose vials were observed in the narcotic drawer available for use on multiple patients: 21 vials of 10 ml Fentanyl Citrate 500 mcg/ 10 ml. 2. During a staff interview, conducted with the Recovery Room Nurse it was verbalized that the RN draws up the medication ordered and administers it to the patient. When asked how many	205.410 Single Dose Vials 1. We have since changed our Fentanyl.	11-4-2013

DATE OF SURVEY 10-2-13 BY 26336, 32822, 31195, 32189 (Surveyor) (Provider's Representative)

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Section 205.410 Equipment	patients one vial is used for, it was verbalized "It depends on how much the doctor wants them to have." When showed that the vial was a single dose vial, the nurse verbalized "I didn't realize that it was a single dose vial." D. Based on observation, document review, and staff interview, it was determined the PTC failed to ensure medication syringes were labeled and stored in a safe, clean area. This has the potential to affect 100% of patients. Findings include: 1. During a tour of the PTC, conducted on 10/2/13 at 12:00 PM, in the Sterilizing Room, two unlabeled 12 cc syringes with 10 ml of clear fluid were observed laying in a drawer on the "Clean" side of the Sterilizing Room. The Sterilizing Room technician verbalized "Those are	205.410 Label Medication 1. All lidocaine syringes are labeled and dated. That was our protocol and the nurse made a mistake and she has been showed the proper way to label medications.	10/12/13

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	syringes of Lidocaine that the nurse drew up and wanted ready if they need them." This was confirmed by the Administrator at that time. The Sterilizing Room technician was observed removing sterilized items from the sterilizer and dripping condensation onto the syringes. 2. During a staff interview, conducted with the Administrator on 10/2/13 at 3:00 PM, when asked what the PTC policy was for labeling and storing of medications that are drawn up for use, the Administrator verbalized "We don't have a policy that tells what they are suppose to do. They know they are suppose to label them and since it was put in the drawer on the "Clean" side, it should be ok."	2. A Protocol for labeling medication has been put into the Policy and Procedure. This policy was discussed and signed off on by appropriate staff. 3. All Lidocaine syringes have been moved to a out of eyesight area on the clean side. They are kept in the area where they are drawn up.	10/12/13

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Section 205.420 Sanitary Facility	**(c)(2) The sterilization of materials shall be done by autoclaving the materials in accordance with the recommendations 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 evidenced by: Based on observation, document review, and staff interview, it was determined the PTC failed to ensure weekly biological spore assay was conducted on each autoclave utilized. This has the potential to affect 100% of the patients. Findings include: 1. During a tour of the PTC, conducted on 10/2/13 at 12:00 PM with the Administrator, there were no biological spore assays observed in the sterilizing room.	205.420 1. We have always done spore assays. I removed the box	E#1 Ex #2

DATE OF SURVEY 10-2-13 BY 26336, 32189, 32822, 31195 (Surveyor) (Provider's

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	2. During a staff interview, conducted with the Administrator on 10/2/13 at 3:00 PM, it was verbalized "We only have to do them monthly because we only do procedures weekly and the manufacturer told us that since we only do surgical abortions once a week that monthly would be fine. We mail it to them and they send back with pass or fail." When asked for documentation, from the manufacturer, related to this. It was verbalized "I don't have anything to say that. That's just what they told us." When asked for the manufacturer's guidelines. It was verbalized "We don't have any of the manufacturer guidelines."	"Maxi Test" and gave it to the male inspector. He found the test adequate. We were only doing them monthly. We now do them weekly.	Ex#1 Ex#2

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Section 205.230(4) Standard of Professional Work	**(4) Each member of the medical staff granted specific surgical practice privileges shall provide a notarized statement of documentation indicating the name of the Illinois' licensed hospital(s) where they have skilled-equivalent practice privileges...** This requirement is not met as evidenced by: Based on document review and interview, it was determined in 1 of 2 physicians (E #2) with surgical practice privileges, the Pregnancy Termination Center (PTC) failed to ensure the physician was granted skilled-equivalent practice privileges at an Illinois licensed hospital. Findings include: 1. On 10/02/13, a review of E #2's personnel files was conducted. E #2 was employed as a licensed physician, Illinois license # 036.043089, with a specialty of Obstetrics/Gynecology. There is no	The privileges are current and enclosed.	Ex#3

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Section 205.230(4) Standard of Professional Work (cont)	documentation to indicate E #2 was granted skilled-equivalent practice privileges at an Illinois licensed hospital. 2. On 10/02/13, at 3:00 pm, an interview with the Administrator (E #1) was conducted. E #1 indicated E #2 was granted skilled-equivalent practice privileges at an Illinois licensed hospital and those privileges expired October 2013. During the survey, E #1 indicated the Illinois licensed hospital was contacted by phone and E #2's privileges letter would be faxed to E #1. As of the time of the exit conference, E #1 was unable to provide the privilege letter.	205.230 (4) 1. I had the conformation of Dr's appointment but not a descriptive "letter". I called and verified the doctors had still equivalent privileges.	Ex #3

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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 205.610 Clinical Record	**Section 205.610 Clinical Record** **Accurate and complete clinical records shall.....** **(j) medication and medical treatments** This requirement was not met as evidenced by: Based on record review and interview it was determined in 4 of 8 (Pt #1, #2, #3, #8) clinical records reviewed in which the patient received surgical abortions, the PTC failed to ensure the administration of all medications were properly documented. Findings include: 1. The clinical record of Pt #1 was reviewed. Pt #1 presented to the PTC for a surgical abortion on 10/2/13. On the Intra-operative Report the following discrepancies were noted: a) "Paracervical block: Lidocaine HCL 1% 12ml 20 ml Additives in block 0.2 ml Vasopressin per 50 cc Lidocaine." There is no		

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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 205.610 Clinical Record (cont)	documentation to indicate what dosage of Lidocaine HCL was given or if Vasopressin was given. b) Rho-Gam injectable was given. There is no documentation to indicate what dosage of Rho-Gam was given and what part of the body the injection was given. 2. The clinical record of Pt #2 was reviewed. Pt #2 presented to the PTC for a surgical abortion on 9/18/13. On the Intra-operative Report the following discrepancies were noted: a) "Paracervical block: Lidocaine HCL 1% 12ml 20 ml Additives in block 0.2 ml Vasopressin per 50 cc Lidocaine." There is no documentation to indicate what dosage of Lidocaine HCL was given or if Vasopressin was given. b) Rho-Gam injectable was given. There is no documentation to indicate what dosage of Rho-Gam was given and what part of the body the injection was given.		

DATE OF SURVEY 10-2-13 BY 26336, 32822, 31195, 32189
(Surveyor)

(Provider's Representative)

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Section 205.610 Clinical Record (cont)	3. The clinical record of Pt #3 was reviewed. Pt #3 presented to the PTC for a surgical abortion on 9/11/13. On the Intra-operative Report the following discrepancies were noted: a) "Paracervical block: Lidocaine HCL 1% 12ml 20 ml Additives in block 0.2 ml Vasopressin per 50 cc Lidocaine." There is no documentation to indicate what dosage of Lidocaine HCL was given or if Vasopressin was given. b) Rho-Gam injectable was given. There is no documentation to indicate what dosage of Rho-Gam was given and what part of the body the injection was given 4. The clinical record of Pt #8 was reviewed. Pt #8 presented to the PTC for a surgical abortion on 9/7/13. On the Intra-operative Report the following discrepancies were noted:	205.610 1. We had an inservice the following week charting completely. It appears that the record keeping in the operating room was not complete. I did not see the charts discussed. I have since reviewed charts and they are complete.	Completed 10/12/13 Ex #4

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Section 205.610 Clinical Record (cont)	a) "Paracervical block: Lidocaine HCL 1% 12ml 20 ml Additives in block 0.2 ml Vasopressin per 50 cc Lidocaine." There is no documentation to indicate what dosage of Lidocaine HCL was given or if Vasopressin was given. b) Rho-Gam injectable was given. There is no documentation to indicate what dosage of Rho-Gam was given and what part of the body the injection was given On 10-2-13, at 2:00PM, an interview with E#1 was conducted. E#1 confirmed there was no policy for documentation and confirmed the medical record should have included documentation as to the amount of medication given and the location of injection.		

DATE OF SURVEY 10-2-13 BY 26336, 32822, 31195, 32189 (Surveyor)

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Section 205.610 Clinical Record (cont)	a) "Paracervical block: Lidocaine HCL 1% 12ml 20 ml Additives in block 0.2 ml Vasopressin per 50 cc Lidocaine." There is no documentation to indicate what dosage of Lidocaine HCL was given or if Vasopressin was given. b) Rho-Gam injectable was given. There is no documentation to indicate what dosage of Rho-Gam was given and what part of the body the injection was given On 10-2-13, at 2:00PM, an interview with E#1 was conducted. E#1 confirmed there was no policy for documentation and confirmed the medical record should have included documentation as to the amount of medication given and the location of injection.		

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[redacted] (Provider's Representative)

Heath Care.

Ex #1
Ex #2

Machine Maintenance Policy

It is imperative that all of our equipment be in operating condition. Keeping the equipment in proper working order will be done in the following way:

1. Yearly maintenance checks
    a. Aspiration machine
    b. Gleamer lights
    c. Centrifrige (Lab)
    d. O_2 tank
    e. Autoclaves

At this time a chart is kept with yearly service dates. This service is provided by Kirks Medical Equipment, Normal, IL 452-5248.

Each clinic day before procedures start and patients arrive the following is done.

1. Vacuum machines are turned on and checked for proper pressure
2. Lights are checked to be sure that they are working
3. O2 valve is checked and pressure recorded
4. Autoclave will be put on vent to warm up sterilizers and check water level. They are then ready to go.

These checks will be recorded daily.

Maintenance Check List

1. Aspiration Machines

    a. Yearly visual check and all gauges checked for proper pressure.
    b. These machines are checked daily for proper pressure before clinic.
    c. We have a reserve unit.

2. Gleamer Lights

    a. Yearly Visual Check
    b. Light Bulbs are available at all times

3. Centrifuge (Lab)

    a. Complete overhaul 2011
    b. RPM checked yearly
    c. Quality Control with samples done on daily basis

4. O2 Tank

    a. Checked monthly
    b. Refilled P.R.N.

5. Autoclaves

    a. Spore check done weekly
    b. Sterile strip and tape with every pack

11-6-18/...

Sterilizer Monitoring

	Pelton Crane A4-36746			Tuttnauer 9811946			Tuttnauer 9803470		
Date	Spore Test	Clean	Safety Valve	Spore Test	Clean	Safety Valve	Spore Test	Clean	Safety Valve
1/7/14	PK	PK		NOT IN USE			PK	PK	PK
1/21/13	PK	PK					PK	PK	
1/30/14	PK	N/A					PK	N/A	PK
2/11/14	PK	PK					PK	PK	

Sterilizer Monitoring

	Pelton Crane A4-36746			Tuttnauer 9811946			Tuttnauer 9803470		
Date	Spore Test	Clean	Safety Valve	Spore Test	Clean	Safety Valve	Spore Test	Clean	Safety Valve
1/3/13	PK	PK		OUT	In Load		PK	PK	PK
2/11/13	PK	PK					PK	PK	
3/15/13	PK	PK					PK	PK	PK
4/8/13	PK	PK					PK	PK	
5/13/13	PK	PK					PK	PK	PK
6/4/13	PK	PK					PK	PK	
7/10/13	PK	N/A					PK	N/R	PK
8/12/13	PK	N/A					PK	N/A	
9/4/13	PK	PK					PK	PK	PK
10/8/13	PK	PK					PK	PK	
11/13/13	PK	PK					PK	PK	PK
11/19/13	PK	N/A					PK	N/A	
11/25/13	PK	N/A					PK	N/A	PK
12/4/13	PK	PK					PK	PK	
12/17/13	PK	PK					PK	PK	PK
12/26/13	PK	PK					PK	PK	

CROSSTEX® A CANTEL MEDICAL COMPANY | Biological Monitoring Service Provider

In Partnership With

HENRY SCHEIN®

STERILIZER TEST REPORT

NATIONAL HEALTH CARE
7405 N UNIVERSITY
SUITE D
PEORIA, IL 61614

Customer ID #: AV313

DATE RANGE

01/01/13 - 12/31/13

Test #	Test Date	Serial #	Manufacturer	Result
VK7981	01/03/2013	A4-36746	Pelton Crane	Passed
VZ4638	02/11/2013	A4-36746	Pelton Crane	Passed
WM1683	03/15/2013	A4-36746	Pelton Crane	Passed
WO4671	03/15/2013	9803470	Tuttnauer	Passed
WV1099	04/08/2013	A4-36746	Pelton Crane	Passed
WV1100	04/08/2013	9803470	Tuttnauer	Passed
XJ9749	05/13/2013	A4-36746	Pelton Crane	Passed
XJ9750	05/13/2013	9803470	Tuttnauer	Passed
XU0219	06/04/2013	9803470	Tuttnauer	Passed
XU0220	06/04/2013	A4-36746	Pelton Crane	Passed
YI1203	07/10/2013	A4-36746	Pelton Crane	Passed
YI1204	07/10/2013	9803470	Tuttnauer	Passed
YU5696	08/12/2013	A4-36746	Pelton Crane	Passed
YU5737	08/12/2013	9803470	Tuttnauer	Passed
ZE9147	09/04/2013	A4-36746	Pelton Crane	Passed
ZE9150	09/04/2013	9803470	Tuttnauer	Passed
ZU6607	10/08/2013	A4-36746	Pelton Crane	Passed
ZU6632	10/08/2013	9803470	Tuttnauer	Passed
AB40340	11/13/2013	9803470	Tuttnauer	Passed
AB51534	11/13/2013	A4-36746	Pelton Crane	Passed
AB72406	11/19/2013	A4-36746	Pelton Crane	Passed
AB72407	11/19/2013	9803470	Tuttnauer	Passed
AC04188	11/25/2013	9803470	Tuttnauer	Passed
AC04086	11/25/2013	A4-36746	Pelton Crane	Passed
AC24763	12/04/2013	9803470	Tuttnauer	Passed
AC32677	12/04/2013	A4-36746	Pelton Crane	Passed
AC83295	12/17/2013	A4-36746	Pelton Crane	Passed
AC83296	12/17/2013	9803470	Tuttnauer	Passed

Biological Monitoring Service
P.O. Box 4758
Englewood, CO 80155
(800) 819-3336

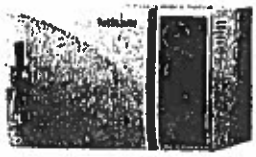
[redacted]

Leann Keefer, RDH, MSM
General Manager

Support

- Office Based Practices
  - Register Your Autoclave
  - MSDS
  - Installation
  - Cleaning and Maintenance
  - Instrument Preparation
  - FAQ
  - Service and Repair
  - Operators Manual
- Scientific Division

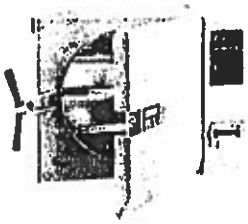
Cleaning and Maintenance



CAUTION: Before starting, be sure that the electric cord is disconnected and that there is no pressure in the autoclave (unless otherwise instructed).

Daily

Clean door gasket with a mild detergent, water and a cloth or sponge.



Weekly

1. ONCE PER WEEK clean the Air Trap Jet by moving the clean out wire in and out ten times. (The Air Jet is located in the water reservoir.It is best cleaned while the unit is running (20-30 psi), although this is not mandatory).
2. For Electronic models clean the water sensor in the rear of the chamber with a damp cloth or sponge. (cleaning the dirt off the sides of the sensor is more important than the tip)
3. Once per week clean the chamber with Chamber Brite. Sprinkle the Chamber Brite powder along the bottom of a cold autoclave chamber (if the unit is HOT fill with water first). Run a normal sterilization cycle without drying.

Drain and flush the solution from reservoir and discard.Wipe the inside of chamber with water and a damp cloth or sponge. Fill the reservoir with distilled water. (Check the Chamber Brite package for further details).

For "M" & "MK"models - Turn knob to fill to flush the fill tube at the back of the chamber.

For "Automatic"models -Operate manual water fill button to flush the fill tube.

4. Clean tray holder and trays with detergent, or a non-abrasive stainless steel cleaner and water, using a cloth or sponge. DO NOT use steel wool, a steel brush or bleach.
5. Put a few drops of oil on the door hinge pin and door tightening bolt.
6. Clean outside of the unit with a soft cloth.

Every Two Months

Clean and check the safety valve.

Safety Valve Cleaning Procedure

In order to prevent the safety valve from becoming blocked, it is necessary every 2 months, under ordinary usage, to allow the steam pressure to escape through the valve.

1. Begin a normal sterilization cycle according to manual instructions.
2. Allow a pressure of approximately 30 psi to build up in the chamber.
3. Turn the unit off.
4. Remove water reservoir cover.

   CAUTION

   This next step will expose you to HOT STEAM

   CAUTION

   To avoid being burned by hot steam, do not place your face over the safety valve.
5. Pull the ring of the safety valve using a screwdriver,hook,or other tool and open the safety valve for only 2 seconds, then release.
6. For manual units turn the multivalve into the exhaust position and allow all the pressure to vent before opening the door.
7. For electronic units turn the power on and press the Stop Button to abort and vent the cycle

Surgery Daily Checks

	Berkeley SV11		
	Gleamer Light GL13106		
OR1	Biological Exp:		
		Date:	Int:
	Berkeley VC11		
	Gleamer Light GL13106		
OR2	Biological Exp:		
		Date:	Int:
	Berkeley VC11		
	Gleamer Light GL13106		
OR3	Biological Exp:		
		Date:	Int:
	Berkeley SV11		
	Gleamer Light GL13106		
OR1	Biological Exp:		
		Date:	Int:
	Berkeley VC11		
	Gleamer Light GL13106		
OR2	Biological Exp:		
		Date:	Int:
	Berkeley VC11		
	Gleamer Light GL13106		
OR3	Biological Exp:		
		Date:	Int:
	Berkeley SV11		
	Gleamer Light GL13106		
OR1	Biological Exp:		
		Date:	Int:
	Berkeley VC11		
	Gleamer Light GL13106		
OR2	Biological Exp:		
		Date:	Int:
	Berkeley VC11		
	Gleamer Light GL13106		
OR3	Biological Exp:		
		Date:	Int:

BMonitoring

Test Results

Test Results

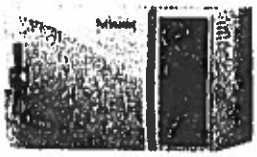
Click on a test number for detailed information. NOTE: The list is sorted by 'TEST DATE'.

AE38156	2/1/2014	2/5/2014 10:58:53 AM	A4-36746	Passed. No growth observed after incubation period.
AE38252	1/30/2014	2/5/2014 11:32:46 AM	9803470	Passed. No growth observed after incubation period.
AE29739	1/30/2014	2/3/2014 2:29:00 PM	9803470	Passed. No growth observed after incubation period.
AE29501	1/21/2014	2/3/2014 11:30:12 AM	A4-36746	Passed. No growth observed after incubation period.
AD38571	1/7/2014	1/13/2014 10:28:08 AM	A4-36746	Passed. No growth observed after incubation period.
AD42314	1/7/2014	1/14/2014 11:29:54 AM	9803470	Passed. No growth observed after incubation period.
AD02768	12/26/2013	1/2/2014 11:40:15 AM	9803470	Passed. No growth observed after incubation period.
AD11508	12/26/2013	1/6/2014 11:45:46 AM	A4-36746	Passed. No growth observed after incubation period.
AC83295	12/17/2013	12/28/2013 9:52:38 AM	A4-36746	Passed. No growth observed after incubation period.
AC83296	12/17/2013	12/28/2013 9:52:53 AM	9803470	Passed. No growth observed after incubation period.
AC24763	12/4/2013	12/13/2013 2:29:00 PM	9803470	Passed. No growth observed after incubation period.
AC32677	12/4/2013	12/16/2013 2:29:00 PM	A4-36746	Passed. No growth observed after incubation period.
AC04086	11/25/2013	12/10/2013 10:53:08 AM	A4-36746	Passed. No growth observed after incubation period.
AC04188	11/25/2013	12/10/2013 10:21:40 AM	9803470	Passed. No growth observed after incubation period.
AB72406	11/19/2013	12/3/2013 10:42:17 AM	A4-36746	Passed. No growth observed after incubation period.

Support

- Office Based Practices
  - Register Your Autoclave
  - MSDS
  - Installation
  - Cleaning and Maintenance
  - Instrument Preparation
  - FAQ
  - Service and Repair
  - Operators Manual
- Scientific Division

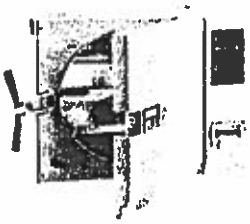
Cleaning and Maintenance



CAUTION: Before starting, be sure that the electric cord is disconnected and that there is no pressure in the autoclave (unless otherwise instructed).

Daily

Clean door gasket with a mild detergent, water and a cloth or sponge.



Weekly

1. ONCE PER WEEK clean the Air Trap Jet by moving the clean out wire in and out ten times. (The Air Jet is located in the water reservoir.It is best cleaned while the unit is running (20-30 psi), although this is not mandatory).
2. For Electronic models clean the water sensor in the rear of the chamber with a damp cloth or sponge. (cleaning the dirt off the sides of the sensor is more important than the tip)
3. Once per week clean the chamber with Chamber Brite. Sprinkle the Chamber Brite powder along the bottom of a cold autoclave chamber (If the unit is HOT fill with water first). Run a normal sterilization cycle without drying.

Drain and flush the solution from reservoir and discard.Wipe the inside of chamber with water and a damp cloth or sponge. Fill the reservoir with distilled water. (Check the Chamber Brite package for further details).

For "M" & "MK"models - Turn knob to fill to flush the fill tube at the back of the chamber.

For "Automatic"models -Operate manual water fill button to flush the fill tube.

4. Clean tray holder and trays with detergent, or a non-abrasive stainless steel cleaner and water, using a cloth or sponge. DO NOT use steel wool, a steel brush or bleach.
5. Put a few drops of oil on the door hinge pin and door tightening bolt.
6. Clean outside of the unit with a soft cloth.

Every Two Months

Clean and check the safety valve.

Safety Valve Cleaning Procedure

In order to prevent the safety valve from becoming blocked, it is necessary every 2 months, under ordinary usage, to allow the steam pressure to escape through the valve.

1. Begin a normal sterilization cycle according to manual instructions.
2. Allow a pressure of approximately 30 psi to build up in the chamber.
3. Turn the unit off.
4. Remove water reservoir cover.

   CAUTION

   This next step will expose you to HOT STEAM

   CAUTION

   To avoid being burned by hot steam, do not place your face over the safety valve.
5. Pull the ring of the safety valve using a screwdriver,hook,or other tool and open the safety valve for only 2 seconds, then release.
6. For manual units turn the multivalve into the exhaust position and allow all the pressure to vent before opening the door.
7. For electronic units turn the power on and press the Stop Button to abort and vent the cycle

Machine Maintenance

All equipment will be checked daily before procedures begin. The following apply:

OR1 A. Berkely SVII
B. Gleamlight GL13106
C. Biological Exp.

OR2 A. Berkely VCII
B. Gleamlight GL13106
C. Biological Exp.

OR3 A. Berkely VCII
B. Gleamlight GL13106
C. Biological Exp.

Autoclaves: A. Pelton Crane A4-36746
B. Tuttnauer 9811946
C. Tuttnauer 9803470

Additional Maintenance:

1. Autoclaves will be cleaned daily with Omni Clave or Chamber Brite according to manufactures' directions.
2. Safety valves checked for proper steam release daily.
3. Rubber Door Gasket

Extended Maintenance

1. Tuttenaur machines calibrated every two years.
2. Any problems noted will be addressed by Phil Romaners equipment repair.
3. Extended maintenance will be noted as completed on Maintenance Log.
4. Any repairs will be verified by the head of Quality Control and signed off.

Quality Control Maintenance

1. Pelton Crane A4-36746

   Date: Complete Check Feb. 2014 Excellent working order, new door gasket

   _____ Int.

2. Tuttnauer 9811946

   Date: Complete overhaul 2011 and 2014(Feb)

   be Calibrated

   _____ Int.

3. Tuttanauer 9803470

   Date: Currently being checked

   _____ Int.

Surgery Daily Checks JAN. 2014

OR1	Berkeley SV11 O/K	
	Gleamer Light GL13106 O/K	
	Biological Exp: O/K	
		Date: 1-8-14 Int: PK
OR2	Berkeley VC11 O/K	
	Gleamer Light GL13106 O/K	
	Biological Exp: O/K	
		Date: 1-8-14 Int: PK
OR3	Berkeley VC11 O/K	
	Gleamer Light GL13106 O/K	
	Biological Exp: O/K	
		Date: 1-8-14 Int: PK
OR1	Berkeley SV11 O K	
	Gleamer Light GL13106 O/K	
	Biological Exp: O/K	
		Date: 1-15-14 Int: PK
OR2	Berkeley VC11 O/K	
	Gleamer Light GL13106 O K	
	Biological Exp: O/K	
		Date: 1-15-14 Int: PK
OR3	Berkeley VC11 O K	
	Gleamer Light GL13106 O/K	
	Biological Exp: O K	
		Date: 1-15-14 Int: PK
OR1	Berkeley SV11 O K	
	Gleamer Light GL13106 O/K	
	Biological Exp: O/K	
		Date: 1-18-14 Int: PK
OR2	Berkeley VC11 O K	
	Gleamer Light GL13106 O/K	
	Biological Exp: O/K	
		Date: 1-18-14 Int: PK
OR3	Berkeley VC11 O K	
	Gleamer Light GL13106 O K	
	Biological Exp: O/K	
		Date: 1-18-14 Int: PK

Surgery Daily Checks

OR1	Berkeley SV11	OK
	Gleamer Light GL13106	OK
	Biological Exp:	OK
	Date: 1-22-14	Int: PK
OR2	Berkeley VC11	OK
	Gleamer Light GL13106	OK
	Biological Exp:	OK
	Date: 1-22-14	Int: PK
OR3	Berkeley VC11	OK
	Gleamer Light GL13106	OK
	Biological Exp:	OK
	Date: 1-22-14	Int: PK
OR1	Berkeley SV11	
	Gleamer Light GL13106	
	Biological Exp:	
	Date: 1-29-14	Int: PK
OR2	Berkeley VC11	OK
	Gleamer Light GL13106	OK
	Biological Exp:	OK
	Date: 1-29-14	Int: PK
OR3	Berkeley VC11	OK
	Gleamer Light GL13106	OK
	Biological Exp:	OK
	Date: 1-29-14	Int: PK
OR1	Berkeley SV11	
	Gleamer Light GL13106	
	Biological Exp:	
	Date:	Int:
OR2	Berkeley VC11	
	Gleamer Light GL13106	
	Biological Exp:	
	Date:	Int:
OR3	Berkeley VC11	
	Gleamer Light GL13106	
	Biological Exp:	
	Date:	Int:

Surgery Daily Checks Feb. 2014

OR1	Berkeley SV11	OK
	Gleamer Light GL13106	ok
	Biological Exp:	ok
	Date: 2-12-14 Int:	PK
OR2	Berkeley VC11	O/K
	Gleamer Light GL13106	O/K
	Biological Exp:	OK
	Date: 2-13-14 Int:	P/K
OR3	Berkeley VC11	O/K
	Gleamer Light GL13106	O/K
	Biological Exp:	O/K
	Date: 2-13-14 Int:	P/K
OR1	Berkeley SV11	O/K
	Gleamer Light GL13106	O/K
	Biological Exp:	O/K
	Date: 2-19-14 Int:	P/K
OR2	Berkeley VC11	O/K
	Gleamer Light GL13106	O/K
	Biological Exp:	O/K
	Date: 2-19-14 Int:	P/K
OR3	Berkeley VC11	O/K
	Gleamer Light GL13106	O/K
	Biological Exp:	O/K
	Date: 2-19-14 Int:	P/K
OR1	Berkeley SV11	
	Gleamer Light GL13106	
	Biological Exp:	
	Date:	Int:
OR2	Berkeley VC11	
	Gleamer Light GL13106	
	Biological Exp:	
	Date:	Int:
OR3	Berkeley VC11	
	Gleamer Light GL13106	
	Biological Exp:	
	Date:	Int:

Expired Medication

Month ____________ Date: ____________

When a medication injectable, capsule, or tablet is expired it will be disposed of in the medical waste.

The medication will be listed below and when is it disposed of it will be signed off as expired and verified.

Name of Drug: ____________________________ Exp: ____________________

Disposal Method: ____________________________ Verify __________Int.

__________Int.

Month ____________ Date: ____________

When a medication injectable, capsule, or tablet is expired it will be disposed of in the medical waste.

The medication will be listed below and when is it disposed of it will be signed off as expired and verified.

Name of Drug: ____________________________ Exp: ____________________

Disposal Method: ____________________________ Verify __________Int.

__________Int.

Month ____________ Date: ____________

When a medication injectable, capsule, or tablet is expired it will be disposed of in the medical waste.

The medication will be listed below and when is it disposed of it will be signed off as expired and verified.

Name of Drug: ____________________________ Exp: ____________________

Disposal Method: ____________________________ Verify __________Int.

__________Int.

Controlled Substance Log / Non-Injectables

Date	Time	Physician	RN/LPN	RN/LPN/Verified
1-10-14	0830	[redacted]	[redacted]	[redacted]
Start #:	9	16	196	
Medication:	Tylenol #3 10 Tab/btl	Mifeprex 200mg Tab 3 Tab/Box	Xanax 0.5mg Tab	
End #	10	13	196	[redacted]

Date	Time	Physician	RN/LPN	RN/LPN/Verified
1/22/14	0830	[redacted]	[redacted]	[redacted]
Start #:	10	13	198	
Medication:	Tylenol #3 10 Tab/btl	Mifeprex 200mg Tab 3 Tab/Box	Xanax 0.5mg Tab	
End # (10) 13		11	196	[redacted]

Date	Time	Physician	RN/LPN	RN/LPN/Verified
1/29/14	0845	[redacted]	[redacted]	[redacted]
Start #:	13	11	196	
Medication:	Tylenol #3 10 Tab/btl	Mifeprex 200mg Tab 3 Tab/Box	Xanax 0.5mg Tab	
End #	10	9	196	[redacted]

Date	Time	Physician	RN/LPN	RN/LPN/Verified
2/8/14	0830	[redacted]	[redacted]	[redacted]
Start #:	10	9	196	
Medication:	Tylenol #3 10 Tab/btl	Mifeprex 200mg Tab 3 Tab/Box	Xanax 0.5mg Tab	
End #	8	5	196	[redacted]

Date	Time	Physician	RN/LPN	RN/LPN/Verified
2/12/14	0830	[redacted]	[redacted]	[redacted]
Start #:	8	5	196	
Medication:	Tylenol #3 10 Tab/btl	Mifeprex 200mg Tab 3 Tab/Box	Xanax 0.5mg Tab	
End #	6	3	196	[redacted]

Date	Time	Physician	RN/LPN	RN/LPN/Verified
2/19/14	0830	[redacted]	[redacted]	[redacted]
Start #:	5	3	196	
Medication:	Tylenol #3 10 Tab/btl	Mifeprex (12) 200mg Tab 3 Tab/Box	Xanax 0.5mg Tab	
End #	4		191	[redacted]

Controlled Substance Log/Injectables

Date	Time	Physician	RN/LPN	RN/LPN/Verified
2/19/14	0830	[redacted]		

Medication:

Fentanyl Cit 50mcg/mL 10mL/btl	Other Fentanyl Cit	Midazolam HCL 5mg/mL 10mL/btl
	27	13+3

Prep Nurse: [redacted]

Dose Drawn: Fentanyl 50mcg/Midazolam HCL 2.5mg

Time	# Drawn	Additional	RN/LPN
0830	[illegible]		[redacted]

Fentanyl	Midazolam	O.R. 1	O.R. 2	O.R. 3	Discarded
Lot #: 34-411-DK Exp: 1 Apr 2015	Lot #: 033374 Exp: 03/2015	5	6	5	Re 2

End:
Fentanyl: 19
Midazolam: 1 [illegible] Board

RN/LPN [redacted] RN/LPN Verified [redacted]

Date	Time	Physician	RN/LPN	RN/LPN/Verified

Medication:

Fentanyl Cit 50mcg/mL 10mL/btl	Other Fentanyl Cit	Midazolam HCL 5mg/mL 10mL/btl

Prep Nurse: _____

Dose Drawn: Fentanyl 50mcg/Midazolam HCL 2.5mg

Time	# Drawn	Additional	RN/LPN

Fentanyl	Midazolam	O.R. 1	O.R. 2	O.R. 3	Discarded
Lot #: Exp:	Lot #: Exp:				

End:
Fentanyl: _____
Midazolam: _____

RN/LPN _____ RN/LPN Verified _____

Recovery Room
Patient Log
All Drugs Given

Date/Dr.	Patient #/Int.	Drug	Dispensing Nurse
1/22/14 DR.P	[redacted]	J13C41C Exp 1/15 Tylenol #3 #10	[redacted]
1/29/14 Dr.S	[redacted]	Lot J13C41C Exp:01/15 Tylenol #3 #10	[redacted]
1/29/14 Dr.S	[redacted]	Lot J1005 Exp 04-16 ID# J1005006911 Toradol 30mg	[redacted]
1/29/14 Dr.S	[redacted]	Lot J13C41C Exp 01/15 Tylenol #3 #10	[redacted]
1/29/14	[redacted]	Lot 01006 Exp 04-16 ID# 1100600547S Toradol 30mg	[redacted]
1/29/14 Dr.S	[redacted]	J13C41C 1/15 Tylenol #3 10	[redacted]
2/8/14 DR.P	[redacted]	Lot J13C41C Exp 01/15 Tylenol #3 #10	[redacted]
2/8/14 DR.P	[redacted]	Lot #11005 Exp 04-16 ID# 11005006911 Toradol 30mg	[redacted]
2/8/14 DR.P	[redacted]	Lot J13C41C Exp 01/15 Tylenol #3 #10	[redacted]
2/8/14 DR.P	[redacted]	Lot A0006 Exp 04-16 ID 1100600547S Toradol 30mg	[redacted]
2/8/14 DR.P	[redacted]	Lot 11006 Exp 04-16 ID# 1100600547S Toradol 30mg	[redacted]
2/8/14 1142 DR.P	[redacted]	ID 11006 003475 4/14 Toradol 30mg	[redacted] pt received percocet.
2/12/14 DR.S	[redacted]	lot 11006 Exp 04-16 0 Mirapex 200mg	[redacted]
2/12/14 DR.S	[redacted]	lot# J13C41C Exp 01/14 Tylenol #3	[redacted]
2/12/14 DRS	[redacted]	lot# J13C41C Exp 1/15 tylenol #3	[redacted]
2/12/14 DR.S	[redacted]	Lot 01006 4/16 ID# 1100600547S Toradol 30mg	[redacted]
2/12/14 DR.S	[redacted]	Lot J13C41C Exp 01/15 Tylenol #3	[redacted]
2/19/14	[redacted]	lot 11006 4/16 ID# 11006 006475 4/14 Mirapex 200mg	[redacted]
2/19/14	[redacted]	lot# J13C41C Exp 01/15 tylenol #3	[redacted]

Ex #3

GATEWAY REGIONAL MEDICAL CENTER

September 16, 2013

Allen S. Palmer, DO
3394 McKelvey, Suite 111
Bridgeton, MO 63044

Dear Dr. Palmer:

On behalf of the Board of Trustees, it is my pleasure to inform you that your reappointment to the Medical Staff has been approved. You have been granted membership on the Courtesy staff with clinical privileges in Gynecology for up to two (2) years beginning 09/09/2013.

Clinical privileges have been granted as specified on the enclosed Delineation of Privileges form. Please review these carefully, as you have only been granted privileges to perform those procedures outlined on the Delineation of Privileges form.

As a member of the Medical Staff, you are required to abide by all hospital policies and the Code of Ethical Conduct. Your appointment is subject to the terms and conditions of the Medical Staff Bylaws, Rules and Regulations and all other Medical Staff Policies and Procedures that are in force during the term of your appointment.

Should you have any questions regarding your appointment or your current privileges, please do not hesitate to contact the Medical Staff Office at 618-798-3260 for assistance.

We appreciate your continued support and value your contribution as a member of the Medical Staff.

Sincerely,

M. Edward Cunningham, CEO

Received Oct 2013

GATEWAY REGIONAL MEDICAL CENTER

September 16, 2013

Allen S. Palmer, DO
3394 McKelvey, Suite 111
Bridgeton, MO 63044

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Should you have any questions regarding your appointment or your current privileges, please do not hesitate to contact the Medical Staff Office at 618-798-3260 for assistance.

We appreciate your continued support and value your contribution as a member of the Medical Staff.

Sincerely,

M. Edward Cunningham, CEO

Medical staff office

Approved Clinical Privileges

Hospital: Gateway Regional Medical Center
Specialty: Obstetrics/Gynecology
Physician: Palmer, Allen S.

Code	Privilege Description	Approved w/ Restrictions
1764	Abdominal pregnancy	
1765	Ablation, endometrial, electrosurgical, hysteroscopic	
1766	Ablation, endometrial, electrosurgical; non-hysteroscopic	
1767	Ablation, endometrial; thermal; non-hysteroscopic	
1769	Abortion, inevitable or incomplete, suction and evacuation	
1778	Bartholin gland cystectomy, Bartholin gland excision; Bartholin gland cyst marsupialization; Bartholin gland abscess; I&D	
1779	Biopsy - cervix, perineum, vulva	
1780	Biopsy - vagina	
1782	Biopsy, endometrial	
1798	Colporrhaphy, anterior/posterior	
1799	Colposcopy	
1800	Conization of cervix (LEEP, cold or hot knife)	
1805	Cystocele, repair	
1810	D&C: diagnostic, therapeutic, including retained placenta	
1816	Ectopic pregnancy - salpingectomy or salpingotomy, laparoscopy or laparotomy	
1817	Ectopic pregnancy, non-surgical management	
1821	Evacuation of hematoma, vaginal	
1822	Evacuation of hematoma, vulvar	
1823	Evacuation of pelvic abscess	
1830	Excision, ovarian cyst	
1831	Excision, vaginal lesion	
1832	Excision, vulvar, perineal lesion	
1836	Exploratory laparotomy	
1846	Hymenectomy	
1847	Hymenotomy	
1850	Hysterectomy, abdominal (with or without adnexae), total, subtotal, including cancer staging procedures	
1853	Hysterectomy, vaginal, with or without adnexal	
1855	Hysteroscopy, diagnostic or operative	
1860	Laser, external, cervical, vaginal, perineal	
1861	Laser, intra-abdominal (laparotomy, laparoscopic)	
1892	Oophorectomy	
1900	Perineoplasty	
1905	Polypectomy - cervical, endometrial	
1913	Removal of foreign body from vagina and uterus	
1917	Repair of enterocele	
1918	Repair of rectocele	
1924	Salpingectomy - total or partial	
1925	Salpingo-oophorectomy	
1928	Salpingostomy	
1949	Uterine suspension	

Approved Clinical Privileges

Hospital: Gateway Regional Medical Center
Specialty: Obstetrics/Gynecology
Physician: Palmer, Allen S.

Clinical Privilege	Description	Approved w/ Restrictions
1965	Wedge resection of ovaries	
5453	Make referrals and request consultations	
5455	Perform History and Physical examination	
5607	Hysterectomy, abdominal (with or without adnexae), total, subtotal	

Ex #3

GATEWAY REGIONAL MEDICAL CENTER

June 13, 2013

Yogendra Shah, MD
Hope Clinic for Women
1602 21st St
Granite City, IL 62040

RE: Notarized Copy of Privileges

Yogendra Shah, MD is a current member of the Gateway Regional Medical Staff and is approved to practice the attached privileges for the appointment: October 5, 2011 – October 5, 2013.

Signed before me on 6-13-2013
Date

by [redacted]
Name of Person

[redacted]
Position of Person Signing

Notary Public

[redacted]
Signature

Ky L. Scott
Print Name

6/13/13
Date

OFFICIAL SEAL
KY L SCOTT
Notary Public - State of Illinois
My Commission Expires Aug 10, 2014

NOTARY SEAL

checked MD

Gateway Regional Medical Center

Delineation Of Privileges

Provider Name: Shah, Yogendra A., MD - Active
Appointment: 10/05/2011 - 10/05/2013

Privilege Status	
Obstetrics, Gynecology	
Approved	Ablation, endometrial, electrosurgical, hysteroscopic
Approved	Abortion, inevitable or incomplete; suction and evacuation
Approved	Anesthesia - pudendal block; spinal, paracervical, saddle, epidural, local block
Approved	Aspiration, breast cyst
Approved	Bartholin gland cystectomy, Bartholin gland excision; Bartholin gland cyst marsupialization; Bartholin gland abscess; I&D
Approved	Biopsy - cervix, perineum, vulva
Approved	Biopsy - vagina
Approved	Biopsy, endometrial
Approved	Colposcopy
Approved	Conization of cervix (LEEP, cold or hot knife)
Approved	Culdocentesis
Approved	Cystocele, repair
Approved	Cystostomy repair
Approved	D&C: diagnostic, therapeutic, including retained placenta
Approved	Ectopic pregnancy - salpingectomy or salpingotomy; laparoscopy or laparotomy
Approved	Evacuation of hematoma, vaginal
Approved	Evacuation of hematoma, vulvar
Approved	Evacuation of pelvic abscess
Approved	Excision of Skene's Duct cyst
Approved	Excision of vaginal cysts
Approved	Excision of vulvar lesion, not at delivery
Approved	Excision, ovarian cyst
Approved	Excision, vaginal lesion
Approved	Excision, vulvar, perineal lesion
Approved	Exploratory laparotomy
Approved	Hysterectomy, abdominal (with or without adnexae), total, subtotal, including cancer staging procedures
Approved	Hysterectomy, vaginal, with or without adnexal
Approved	Hysterosalpingography

Applicant's Initials: _____ Approving Physician Initials: _____

Printed on Thursday, June 13, 2013

Gateway Regional Medical Center

Delineation Of Privileges

Provider Name: Shah, Yogendra A., MD - Active
Appointment: 10/05/2011 - 10/05/2013

Privilege Status	
Approved	Hysteroscopy, diagnostic or operative
Approved	Insertion/removal of IUD
Approved	Laceration repair, bladder and urethral
Approved	Laceration repair, perineal, obstetrical, gynecological
Approved	Laceration repair, rectal, obstetrical, gynecological
Approved	Laceration repair, vaginal, obstetrical, gynecological
Approved	Laparoscopic approach, surgical interventions
Approved	Laser, endometrial ablation, hysteroscopic
Approved	Laser, external, cervical, vaginal, perineal
Approved	Laser, intra-abdominal (laparotomy, laparoscopic)
Approved	Myomectomy - laparotomy, laparoscopy
Approved	Omentectomy
Approved	Oophorectomy
Approvec	Paravaginal defect repair
Approvec	Pelvic exam under anesthesia
Approvec	Perineoplasty
Approvec	Polypectomy - cervical, endometrial
Approvec	Removal of foreign body from vagina and uterus
Approvec	Repair of enterocele
Approvec	Repair of rectocele
Approvec	Repair recto-vaginal fistula
Approvec	Repair surgical rent of bowel
Approvec	Salpingectomy - total or partial
Approvec	Salpingo-oophorectomy
Approvec	Treatment of complicated pelvic inflammatory disease
Approvec	Treatment of uncomplicated pelvic inflammatory disease
Approvec	Tubal insufflation
Approvec	Tubal ligation, laparoscopy or laparotomy (bilateral)
Approvec	Uterine/vaginal packing

Applicant's Initials: _____ Approving Physician Initials: _____

Printed on Thursday, June 13, 2013

Gateway Regional Medical Center

Delineation Of Privileges

Provider Name: Shah, Yogendra A., MD - Active
Appointment: 10/05/2011 - 10/05/2013

Privilege Status	
Approved	Wide lip excision of vulvar lesion
Approved	Admit Patient
Approved	Order Diagnostic Services
Approved	Order Therapeutic Services
Approved	Make referrals and request consultations
Approved	Render care within the scope of training in a medical emergency
Approved	Perform History and Physical examination
Approved	Hysterectomy, abdominal (with or without adnexae), total, subtotal

205.610

Inservice

October 9, 2013

Today we have reviewed the corrections needed to be done after the Illinois Department of Health was here for inspection.

1. Better charting, fill all areas that are required.

    a. These will be checked when the path reports are reviewed and will be signed off by the staff member doing the checking.
    b. Policy reviewed about expired drugs and disposal.
    c. General equipment and biologicals in OR reviewed.

Attending:

Pam Krider Surg Tech.

Rilla Adcock, Surg Tech.

Tammy Johnson, R.N.

Heather Hoagland, R.N.

Bonnie Bottenberg, R.N.

Samantha Blevins, R.N.

Jessie Mayor, L.P.N.

Lisa Parish, L.P.N.

[redacted]

Margaret Van Duyn

[redacted]

Director

Pt # _____ Pt. Name _____ Date: ____/____/____ (Ex 4)

SONO

1 LMP _____ Calc WK _____ SONO WEEKS _____

Sac Seen ☐ CA ☐ Yolk Sac ☐ Fetal Pole ☐ CRL _____ B.P.D. _____

Other: _____ _____ Int.

LAB

2 Preg Test Sens_____ Non-Sens_____ Hgb_____ Rh_____ Repeat Neg_____ _____Tech

Rho-Gam _____

PRE-OP

3 Time _____ Temp _____ B.P. _____ Pulse _____ Gravida _____ Para _____

Allergy to: Lidocaine Yes ☐ No ☐ Latex Yes ☐ No ☐ _____

Miso info: ☐ _____ Pt. Int. Misoprostol 200 mcg#2/Buccal ☐ _____ RN/LPN Int.

PRE SURG EXAM

Admit Time _____ B.P. _____ Pulse _____ O2 Sat _____ Height _____ Weight _____lbs

Gest _____ Ant ☐ Mid ☐ Post ☐ Adnexa ☐

Reviewed Medical History ☐ Allergy ☐ _____

Abnormalities were noted in the following areas: Heart _____ Lungs _____ Abd _____ Pelvis _____

Wants I.V. Sedation: Yes ☐ No ☐ Pt. states she is not driving: Yes ☐ _____ RN Int.

OR NOTES

A. Paracervical block: Lidocaine HCL 1% 12 ml 20 ml Additives in Block: 0.2 ml Vaspressin per 50 cc Lidocaine

Circle one

☐ Fentanyl 50mcg given I.V. Midazolam HCL 2.5 mg ☐ 2.0 mg ☐ Time _____ _____ M.D./RN

B. Cervix dilated to _____ Uterine Depth _____ Cannula _____mm Blood Loss _____ mL Tissue to P.L.S.

Rho-Gam: Cervical ☐ IM ☐ Mini 50ug ☐ Full 300ug ☐ Methergine 0.2mg/cervical ☐ Misoprosotol 400 mcg vag ☐

C.L.O.C: Alert and Resposive ☐ Easily Arousable ☐ Intraoperative Sono: _____

_____

Other: _____

_____

_____

I have reviewed the patient's medical history, performed a physical exam and found them to be within the clinic's guidelines.

_____ RN

_____ M.D.

Discharge Time: _____ Satisfactory ☐ Walked to RR ☐ assist ☐

Revised 10/13

Pt # _____ Pt. Name _____ Date ____ / ____ / ____

E+A

Lab.

1. Preg Test Sensitive _____ Preg test Non-sensitive _____ Hgb. _____

Rh _____ Repeat Neg _____ Rho-Gam _____ _____ Int.

Sono

2. LMP _____ Calc Weeks _____ Gravida _____ Para _____

Abd Ultrasound ☐ VAG Probe ☐ Gest Sac. Seen ☐ Fetal Pole ☐ Y ☐ N Cardiac Act ☐

Other: _____

_____

Measurement _____ Wks _____ _____ Int.

P.E.

3. Time _____ B.P. _____ Pulse _____

Abnormalities were noted in the following areas: Heart ____ Lungs ____ Abd ____ Pelvis ____

I have reviewed the patient's medical history, performed a physical exam and found them to be within the clinic's guidelines.

_____ M.D.

Procedure Notes

4. Mifeprex (Mifepristone) 200mg tablet 1 taken orally.

Lot # _____ Exp: _____ _____ M.D.

~~X~~ Rho-Gam by I.M. injection: ☐ Mini 50ug ☐ Lot # _____ Injection Site _____

_____ RN/LPN

Recovery Room

5. _____ Misoprostol (Cytotec) 200 mcg #4 for vaginal insertion. _____ Ibuprofen 800 mg #10

_____ Tylenol #3 1 q 6 hrs/Rx #10 _____ Rho-Gam Card _____ After care and questions

_____ Type of B.C.P. _____ ☐ Sunday Start

☐ Check up Appt. 2 weeks post : _____

Other: _____

_____

_____ RN/LPN

Follow-up

6. Date: _____

Preg Test: Sens _____ Non-Sensitive _____ Hgb _____ Int. _____

Sono: ☐ Ab Ultrasound: ☐ Vag Probe Gest Sac ☐ Y ☐ N

Comments: _____ _____ Int.

Post Check P.E.: BP _____ Other: _____

_____

_____

Birth Control: _____ _____ M.D.

We have addressed the issue of chart review, after a review with the physician, we will start a record keeping system.

All charts and pathology reports will be reviewed and signed off on after being checked for completeness. This will be recorded on a weekly basis and kept in the patient log.

If any changed or chart corrections are made, they will be noted by the patient identification numbers.

Please find the log in sheet enclosed.

Chart Review

Month _____

Date: _____ Charts Reviewed: _____ _____Int.

Corrections Made: _____

_____

_____

Date: _____ Charts Reviewed: _____ _____Int.

Corrections Made: _____

_____

_____

Date: _____ Charts Reviewed: _____ _____Int.

Corrections Made: _____

_____

_____

Date: _____ Charts Reviewed: _____ _____Int.

Corrections Made: _____

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Date: _____ Charts Reviewed: _____ _____Int.

Corrections Made: _____

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Date: _____ Charts Reviewed: _____ _____Int.

Corrections Made: _____

_____

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