The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Division of Health Care Quality
10 West Street, Boston, MA 02111-1212
617-753-8000

December 29, 2003

Carol Belding
President
Four Women, Inc.
150 Emory St.
Attleboro, MA 02703

Dear Ms. Belding:

This letter is in response to correspondence regarding waivers for Four Women, Inc., located at 150 Emory St, Attleboro, MA 02703

140.609(A): The request for a waiver of the requirement to provide routine pathology is conditionally approved. In lieu of the requirement, information submitted to the Department in support of the waiver indicated that a gross examination of all tissue specimens must be performed by the clinician who performed the procedure before the patient leaves the facility. In addition, all findings must be recorded in the chart and a policy for tissue evaluation maintained.

Waiver(s) will be evaluated at the time of on-site facility surveys, and the Department reserves the right to revoke approval(s) if deficiencies are cited which indicate waiver approval(s) adversely affect patient health and safety.

If you have any questions, please call Barbara McCready at (617) 753-8226.

Very truly yours,

Sherman R. Lohnes
Assistant Director
for
Paul I. Dreyer, Ph.D.
Director

cc: Jill Mazzola
Barbara McCready
Daniel Gent
Facility File
Waiver File
FourWomenwaiver03r

JANE SWIFT
GOVERNOR

ROBERT P. GITTENS
SECRETARY

HOWARD K. KOH,M.D.,MPH
COMMISSIONER

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Division of Health Care Quality
10 West Street, 5th Floor, Boston, MA 02111
(617) 753-8000

October 31, 2002

Carol Belding
President
Four Women, Inc.
150 Emory Street
Attleboro, MA 02703

Dear Ms. Belding:

This letter is in response to correspondence regarding physical plant waivers of the A.I.A "Guidelines" for Four Women, Inc. at 150 Emory Street, Attleboro, MA 02703.

9.5.D2: The request for a waiver of the requirement to provide a separate waiting room, handicapped toilet and bottled water dispenser from the physician's practice is approved. In lieu of the requirement, information submitted to the Department in support of the waiver indicated that the hours of operation are not the same as the physician practice. In addition, signage will be placed indicating a different provider, and arrangements have been made for bottled water supplies and the cleaning of the space after the clinic's use.

9.5.D4: The request for a waiver of the requirement to provide separate administrative offices from the reception and pre-operative room is approved. In lieu of the requirement, information submitted to the Department in support of the waiver indicated that the clinic hours of operations are not the same as the physician's practice. The functional program does not impact upon patient confidentiality and safety.

9.5.D5: The request for a waiver of the requirement to provide a multipurpose room is approved. In lieu of the requirement, information submitted to the Department in support of the waiver indicated that, per agreement, the space is available within the physician's office areas for any meetings or counseling, as the physician's office is a part time practice, and patients will not be affected.

9.5.D6: The request for a waiver of the requirement to provide a medical records room is approved. In lieu of the requirement, information submitted to the Department in support of the waiver indicated that the medical records for the day will be stored in a locked file cabinet. The medical records are stored in a locked storage cabinet located in the reception area.

9.5.F2.e: The request for a waiver of the requirement to provide an X-ray film illuminator is approved. In lieu of the requirement, information submitted to the Department in support of the waiver indicated that radiology is not part of the functional program.

Department Policy: The request for a waiver of the requirement to provide a nurses call button is approved. In lieu of the requirement, information submitted to the Department in support of the waiver indicated that a nurse or medical assistant would be in the recovery room anytime a patient is present.

9.5.F4: The request for a waiver of the requirement to provide a step-down recovery area is approved. In lieu of the requirement, information submitted to the Department in support of the waiver indicated that the clinic's functional program does not require an extended recovery period.

9.5.F5.m: The request for a waiver of the requirement to provide a housekeeping room is approved. In lieu of the requirement, information submitted to the Department in support of the waiver indicated that there is a professional cleaning service agreement and access to cleaning equipment for minor spills while the clinic is in operation.

9.5.F5.p: The request for a waiver of the requirement to provide a high-speed sterilizer is approved. In lieu of the requirement, information submitted to the Department in support of the waiver indicated that there is a sterilizer available for flash sterilization of additional instruments needed during a clinic session.

9.5.H1.a: The request for a waiver of the requirement to provide 8'-0" wide operating suite corridors and 5'-0" wide general public corridors are approved. In lieu of the requirement, information submitted to the Department in support of the waiver indicated that there is adequate stretcher, wheelchair and recovery room access through the corridors.

9.31.E5: The request for a waiver of the requirement to provide two class B oxygen and vacuum systems is approved. In lieu of the requirement, information submitted to the Department in support of the waiver indicated that the clinic's functional program does not require a prolonged oxygen and vacuum system. In addition, the clinic has a portable gastric suction machine and oxygen tank to be ready for emergency use, and checked at the beginning of each day.

9.31.E5-Table 9.2: The request for a waiver of the requirement to provide class A oxygen and vacuum for each post-anesthesia recovery room bed is approved. In lieu of the requirement, information submitted to the Department in support of the waiver indicated that the clinic's functional program does not require prolonged sedation and that portable gastric suction and oxygen is readily available, in the case of an emergency.

9.31.E5-Table 9.2: The request for a waiver of the requirement to provide class B oxygen and vacuum for each post-anesthesia recovery room bed is approved. In lieu of the requirement, information submitted to the Department in support of the waiver indicated that the clinic's functional program does not require prolonged sedation and that portable gastric suction and oxygen is readily available, in the case of an emergency.

9.31.E5-Table 9.2: The request for a waiver of the requirement to provide class A oxygen and vacuum for minor surgery is approved. In lieu of the requirement, information submitted to the Department in support of the waiver indicated that the clinic's functional program does not require prolonged sedation and that portable gastric suction and oxygen is readily available, in the case of an emergency.

Waiver(s) will be evaluated at the time of on-site facility surveys, and the Department reserves the right to revoke approval(s) if deficiencies are cited which indicate waiver approval(s) adversely affect patient health and safety.

If you have any questions, please call Emile Guy at (617) 753-8178.

Very truly yours,

Jean Pontikas

Jean Pontikas
Assistant Director
for
Paul I. Dreyer, Ph.D.
Director

cc: Nina Edwards
Richard Cardarelli
Donna Allen
Barbara McCready
Emile Guy
Facility File
Waiver File
4women waiver let02

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Division of Health Care Quality
10 West Street, 5th Floor, Boston, MA 02111
(617) 753-8000

JANE SWIFT
GOVERNOR

ROBERT P. GITTENS
SECRETARY

HOWARD K. KOH,M.D.,MPH
COMMISSIONER

September 11, 2002

Carol Belding
President
Four Women, Inc.
150 Emory Street
Attleboro, MA 02703

RE: DoN Project #5-4885
and DoN .308 Exemption

Dear Ms. Belding:

I am pleased to inform you that the support documentation which you and your architect, *Richard Cardarelli, AIA*, submitted for **Four Women, Inc. a proposed new single-specialty freestanding ambulatory gynecological surgery center with two operating rooms, to be located at 150 Emory Street, Attleboro, MA 02703**, has been reviewed and meets the Department's criteria for plan approval under our "self-certification" process.

Based on the affidavit[1], the requested waivers and the architect's checklist[1], the plans submitted to this office on July 15, 2002 with revisions received on August 29, 2002 and September 6, 2002 are approved. This approval is not based on an actual plan review by this Department.

The requested waivers of the shared functional areas with a physician's practice; the combined reception/administrative office space; the multipurpose room; the medical records room; the x-ray film illuminator; the nurse call signals at each recovery bed; the step down recovery area; the housekeeping room size; the high speed sterilizer; the corridor width; and medical gas outlets will be addressed separately. Plan approval is contingent upon receiving waiver approval and meeting the waiver approval conditions.

You are reminded that it is your responsibility and that of your design representatives to design and construct the facility in accordance with the Department's applicable physical plant requirements. If at a later date this Department either reviews the plans or inspects the completed project and physical plant deficiencies are

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[1] The submitted forms were for compliance with the 2001 Edition of the AIA *Guidelines for Design and Construction of Hospital and Health Care Facilities*.

cited, it will be your responsibility to correct the areas of concern and to comply with the referenced regulations.

This plan approval format is for the Department of Public Health's Regulations only. It is still your responsibility to have the plans reviewed by the Department of Public Safety and the Attleboro Building Inspector.

This approval is limited to project development and does not provide for occupancy or utilization of the completed project.

I. PLAN APPROVAL CONDITIONS: PHYSICAL PLANT

This approval is contingent upon providing the required locked cabinets and medication refrigerator at the drug distribution stations.

You should also be aware that additional revisions to the plans may be needed to ensure compliance with the **Accessibility Guidelines of the Americans with Disabilities Act (ADA)**. This office, however, is not responsible for enforcing these guidelines.

Please note that, for Medicare/Medicaid Certification, it is the responsibility of the facility's owners and of their design representatives to design and construct the facility in strict compliance with the **National Fire Protection Association Life Safety Code (1985 Edition)** and the applicable related standards contained in the appendices of the Code.

II. PLAN APPROVAL CONDITIONS: DETERMINATION OF NEED

The following are conditions to plan approval, for compliance with Determination of Need approval conditions:

A. Pursuant to **DON Regulation 105 CMR 100.551(I)**, firm figures specifying the actual capital cost for this project must be submitted to the Determination of Need Program Director no later than 180 days after the receipt of this letter. This submission of final figures shall consist of: (1) A completed **Form 4 (Capital Cost Estimate)** and (2) Documentation (i.e., executed construction contract, equipment purchase agreement, etc.) of the major costs listed on **Form 4**.

Note: Division of Health Care Finance and Policy approval of the project's costs and charges cannot be obtained without submission of these final figures to the DON Program Director. Should you fail to submit these final figures within the specified time period, final approved project costs shall be deemed to be those set forth in the Notice of Determination of Need and any of its subsequent amendments, with the addition of inflation to the date of final plan approval.

B. Any amendment request for a cost increase must be submitted to the DON Program Director within 180 days of receipt of this plan approval letter.

C. Construction of this project must commence no later than the expiration date for the Determination of Need authorization period.

D. Contract change orders which alter or modify the scope of work as contained in the Notice of Determination of Need must be submitted to this office for prior approval.

E. A **Construction Status Report** form (copy enclosed) must be submitted to this office as follows:

1. The initial report is due no later than 30 days after receipt of this letter.

2. A quarterly report is due on a calendar basis, e.g. every January 1st, April 1st, July 1st, and October 1st.

3. The final report is due upon completion of the project.

For your convenience, you should reproduce a sufficient number of copies of the **Construction Status Report** form to cover the full period of construction.

III. SURVEY AND LICENSURE PROCESS

In order to initiate the survey and licensure process, it is your best interest to notify this Division in writing at least four (4) months before the anticipated dates of completion of construction and of occupancy of the new facility. This notification should be addressed to David Brown, Program Coordinator, Division of Health Care Quality, Department of Public Health, 10 West Street, 5th Floor, Boston, MA 02111.

If you have any questions, please call at (617) 753-8178.

Very truly yours,

Emile J. Guy
Project Engineer

Enc.

cc: Nina Edwards
Richard Cardarelli
Barbara McCready
David Brown
Clinic file

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned.**

Plans on 8½" x 11" sheets must be provided for clarification, as needed.

Four Women, INc, 150 Emory Street, Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : 9.5.D4

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities"[01]

Specific physical plant condition to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):

Administrative Offices share space with reception and pre-op rm

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

During most of the work week this space is empty. Staff can use this space to answer phones, book appointments, take messages.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

There will be no patients in the building when this space is being used for administrative purposes. If a supervisor needs privacy in speaking to a staff member, they can close a door in the pre-op counseling rooms.
Again, this cannot impact on patients as they will not be there.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

Medical record cabinets are to be placed behind the reception desk. These will be locked when not under the direct supervision of a staff person. A sign is planned to indicate this is a staff only area.

Signature of the facility's clinical representative _____

Representative's Name CArol Belding *Title* President *Tel.#* 508-222-

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: Emile Abry 9/19/02 ☒ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

*Attachments must include the facility's name and the referenced regulation number.

Four Women, Inc.
150 Emory Street
Attleboro, MA 02703

Waiver #2

Project Engineer's Waiver Comments/Conditions:

I recommend waiver approval to allow the administrative and business offices to be combined with the reception and pre-op areas in lieu of having separate functional areas away from public and patient areas.

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned**.

Plans on 8½" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc., 150 Emory Street, Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : 9.5.D5

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" 01

Specific physical plant condition to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):

Multipurpose room

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

The surgery center operates with limited hours, Wed and Fri evening and Saturday a.m. To rent additional space when there is adequate room not being used is unnecessary.

unnecessary

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

Staff meetings take place when the entire office is empty. Patients are not affected in any way. The physican office located next door is a part time practice. We will schedule a staff meeting when there are no patients scheduled. Four Women does not provide group counseling or group grief sessions at this time.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

Meetings will not be held anywhere inside the surgical suite. Pre-clinic announcements may be made individually or a memo posted in the staff changing room. If at a later date patient educational sessions were needed, alternative space would be located for the purpose.

Signature of the facility's clinical representative Carol Belding

Representative's Name Carol Belding *Title* President *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: Emil Ay 8/4/02 ☒ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

*Attachments must include the facility's name and the referenced regulation number.

Four Women, Inc.
150 Emory Street
Attleboro, MA 02703

Waiver #3

Project Engineer's Waiver Comments/Conditions:

I recommend waiver approval of not providing a multipurpose room.

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned.**

Plans on 8½" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc., 150 Emory Street, Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : 9.5.D6

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" 01

Specific physical plant condition to be waived *(e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):*

Medical records room

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

It is too costly to have another room for a limited number of medical records.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

Lack of separate room will not jeopardize patient health or safety or confidentiality. Offsite medical records can be accessed in time for an abortion appointment, which are made a day to a week ahead of time. All records on site will be secure with locked cabinets. Charts are numbered and have no names, they are out of reach of patients behind a desk in staff area.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

Two locking 36 inch wide medical record storage cabines will be placed in the reception area. They hold 3,300 typical abortion patient charts. This is approximately a year's worth of charts fo Four Women. Because the majority of women may only visit us one time, and charts must be held for many years, charts will then be stored according to Massachusetts regulations.

Signature of the facility's clinical representative Carol Belding

Representative's Name Carol Belding *Title* President *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: Emil Ruz 9/4/02 ☒ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Four Women, Inc.
150 Emory Street
Attleboro, MA 02703

Waiver #4

Project Engineer's Waiver Comments/Conditions:

I recommend waiver approval to allow the medical records to be stored within locked cabinets in the reception area in lieu of having a separate medical records storage area.

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned.**

Plans on 8½" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc., 150 Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : 9.5.F2.e

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" 01

Specific physical plant condition to be waived *(e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):*

X-ray film illuminator

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

This adds unnecessary and unused equipment to an OR.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

~~Patients will not be affected. X-Rays are not used~~ in abortion care.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

None, there is no need for X-ray film illuminator. There is a light table in the dirty room that could be cleaned and used in some odd emergency, but that should not be the case.

*Signature of the facility's **clinical** representative* Carol Belding

Representative's Name Carol Belding *Title* President *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: Emil Gery 8/4/02 ☒ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Four Women, Inc.
150 Emory Street
Attleboro, MA 02703

Waiver #5

Project Engineer's Waiver Comments/Conditions:

I recommend waiver approval of not having x-ray film illuminators in the ORs as x-rays are not used in the abortion process.

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned**.

Plans on 8½" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc., 150 Emory Street, Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : ~~9.5.F3~~ Policy

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" 01

Specific physical plant condition to be waived *(e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):*

Nurses call button at each bed

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

This kind of service is not usually found in abortion facilities
It adds to expense and complicates an already uncomplicated procedure and recovery.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

The recovery room is not very large. There is designated space for five recumbent chairs. There is a nurse and usually a medical assistant with patients at all times. (The nurse cannot leave the room without the float nurse covering her.) No patient is out of hearing or sight. If curtains are closed, they are closed to the sides of women next to a patient, not the nurses.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

Women in our recovery room are under constant supervision. They are usually alert and sitting up. They can tell us if they are in distress. We can provide a bell or something that can alert staff if the patient needs help. buzzer
See attached policy for the recovery room.

*Signature of the facility's **clinical** representative* Carol Belding

Representative's Name Carol Belding *Title* President *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: Emil Ptey 9/8/02 ☒ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Four Women, Inc.
150 Emory Street
Attleboro, MA 02703

Waiver #6

Project Engineer's Waiver Comments/Conditions:

I recommend waiver approval of the policy requiring a nurse call sending station at each recovery bed.

FOUR WOMEN, INC.

TITLE: RECOVERY ROOM STAFFING/ SAFETY

PURPOSE: To maintain patient safety during recovery period.

POLICY: **I. Location**

It is the policy of Four Women, Inc. to maintain the safety of all patients. The recovery room has designated space for five recumbent chairs. The recovery room layout at Four Women, Inc. provides an unobstructed view of all patients, therefore women in the recovery room are under constant supervision.

When privacy becomes necessary for a patient, the curtain between the recumbent chairs can be drawn. Although the closing of curtains between patients maintains the privacy of the women in the recovery room, it does not obstruct the staff's view of the other patients.

II. Staff

The recovery room staff consists of at least one R.N. and a medical assistant for up to 5 patients. The R.N. must remain in the recovery room at all times, unless relieved by another R.N. or other licensed staff.

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned.**

Plans on 8½" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc., 150 Emory Street, Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : 9.5.F4

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" [01]

Specific physical plant condition to be waived *(e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):*

Step-down recovery area

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

It is not customary for a step down recovery area to be used in abortion care. Space is expensive and it would get little or no use.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

Again, it is not customary for a step down recovery lounge to be used in abortion care. A woman spends approximately 45 minutes in the recovery room chair and leaves on her own, not in a wheel chair.
~~A step down lounge is not needed in abortion care as recovery~~ time is relatively brief.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

All women receive refreshment in their recovery room chair. They spend all the time they need in that chair. This gives a person a feeling of well-being as they have one nurse. When a woman is discharged she is able to dress herself and walk out the door.

*Signature of the facility's **clinical** representative* Carol Belding

Representative's Name Carol Belding *Title* President *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: [signature] 9/4/02 ☒ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Four Women, Inc.
150 Emory Street
Attleboro, MA 02703

Waiver #7

Project Engineer's Waiver Comments/Conditions:

I recommend waiver approval of not providing a step down recovery area as it is nor required by the service as described by the facility.

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned.**

Plans on 8½" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc. 150 Emory Street, Attleboro, MA 02703
Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : 9.5.F5.m
105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" 01

Specific physical plant condition to be waived *(e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):*

Housekeeping room

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

Space for the center is at a premium and an entire room could not be dedicated for housekeeping. It was too costly.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

Patients will not be affected by the lack of a housekeeping room
Other housekeeping facilities will be provided, see below.
The housekeeping equipment is used for touch ups and small cleaning jobs: Professional cleaners come in with heavy equipment and supplies to clean floors and walls. Service Master has cleaned the floors and Naps from Attleboro.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

Two smaller housekeeping closets are provided. Sinks are in each closet, racks will be provided to hang mops, brooms, and other housekeeping supplies. A rolling bucket will be purchased to fit under the sink.

*Signature of the facility's **clinical** representative* Carol Belding

Representative's Name Carol Belding *Title* President *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: [signature] 2/12/02 ☑ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Four Women, Inc.
150 Emory Street
Attleboro, MA 02703

Waiver #8

Project Engineer's Waiver Comments/Conditions:

I recommend waiver approval of allowing housekeeping closets in lieu of having a housekeeping room contingent upon all cleaning equipment being stored in the closets and not inappropriately stored elsewhere in the building.

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned.**

Plans on 8½" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc., 150 Emory Street, Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : 9.5.F5.P

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" 01

Specific physical plant condition to be waived *(e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):*

High Speed Sterilizer

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

This is an added expense and it is not usually found in an abortion center.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

Women would not be affected by the lack of a high speed sterilizer. There are ample sterile instruments to be used in any given clinic.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

More sets are kept in storage than are needed in any day. If more patients show up than there are sterile wrapped sets, we can run several sets through the sterilizer and "flash" them. Each set consists of the same instruments they are all interchangeable. Specialty items are packed individually. We also have extra items packed

Signature of the facility's ***clinical*** *representative* Carol Belding

Representative's Name Carol Belding *Title* President *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: Emil Kay 5/14/02 ☒ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Four Women, Inc.
150 Emory Street
Attleboro, MA 02703

Waiver #9

Project Engineer's Waiver Comments/Conditions:

I recommend waiver approval of not having a high speed sterilizer as noted in the facility's request.

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned.**

Plans on 8½" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc., 150 Emory Street, Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request: Corridor width 9.5.H1.a

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" 01

Specific physical plant condition to be waived *(e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):*

8 foot corridor width in OR suite, 5 feet in other areas
Recption area has wide corridors of 5'7" and 7'9" planned.

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

Space is expensive and at a premium. We feel patients can be safely transported or escorted (as they are walking) to the recovery room with hallway widths as drawn. The new reception/administrative area is spacious and has ample room for patients. Abortion care can be noisy as there are suction machines that create a vibration sound. It would be better for patients to have a door closed for quiet.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

Most patients go to the recovery room walking with a medical staff person. Those who have had light sedation are groggy, but awake and are in a wheel chair, again escorted to the recovery room.

There is plenty of room to get someone safely out of the building in an emergency.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

The majority of the OR corridor is 8 feet. There is a short six foot corridor to the recovery room with a 36 inch door for sound privacy. We can remove the door from the plans if you so desire.

All space will be tested with wheel chair/stretcher/recovery room chair to be sure it is easily accesible.

*Signature of the facility's **clinical** representative* Carol Belding

Representative's Name Carol Belding *Title* President *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: [illegible] 9/8/92 ☒ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Four Women, Inc.
150 Emory Street
Attleboro, MA 02703

Waiver #10

Project Engineer's Waiver Comments/Conditions:

I recommend having a 7'9" corridor width in lieu of the required 8'0" leading from the ORs to the recovery room along side of the reception desk.

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned.**

Plans on 8½" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc., 150 Emory Street, Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request: 9.31.E5 and table 9.2

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" 01

Specific physical plant condition to be waived *(e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):*

2 OX & 2 VAC Class B: intermediate surgery (sedation)

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

The cost of installing a full piped in oxygen and vacuum system was estimated to be approximately $500,000 by Coast to Coast Medical in Fall River, MA. This is not an affordable option.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

A typical surgical abortion takes five minutes for the surgeon to perform. Due to the nature of abortion surgery, and fasting before hand, emergency gastric suctioning is incredibly rare. Oxygen dosing is more often but is of short duration.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

We have at least one oxygen tank to be placed next to the procedure table in the OR. This will be ready for immediate emergency use and checked at the beginning of each surgical day.

A portable gastric suction machine will be placed next to the OR table and immediatly available in case of emergency.

*Signature of the facility's **clinical** representative* Carol Belding

Representative's Name Carol Belding *Title* President *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: _____ 5/18/92 ☒ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: _____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: _____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

Four Women, Inc.
150 Emory Street
Attleboro, MA 02703

Waiver #11

Project Engineer's Waiver Comments/Conditions:

I recommend waiver approval of the piped in medical gases in the operating rooms and in the recovery room contingent upon providing the portable tanks and suction equipment as outlined in the waiver request.

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned.**

Plans on 8½" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc., 150 Emory Street, Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : 9.31.E5 table 9.2

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" 01

Specific physical plant condition to be waived *(e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):*

1 OX & 1 VAC for each bed, Class A: Post-anesthesia recovery rm.

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

The cost of installing a full piped in oxygen and suction system was $500,000 from Coast to Coast Medical. (approximate) This is not an affordable option.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

After a local abortion procedure women walk with an attendant into the recovery room. They recover in a sitting position and are awake and alert the entire time. An oxygen tank (portable) and a gastric suction machine (portable) will be placed next to each chair and readily available in the case of an emergency.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

As stated above, an oxygen tank and suction machine, both portable will be placed next to each recovery room chair. These are perfect and safe for a simple procedure such as an abortion. emergency back up

*Signature of the facility's **clinical** representative* Carol Belding

Representative's Name Carol Belding *Title* President *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: Erik Jay 9/18/02 ☒ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Four Women, Inc.
150 Emory Street
Attleboro, MA 02703

Waiver #12

Project Engineer's Waiver Comments/Conditions:

I recommend waiver approval of the piped in medical gases in the operating rooms and in the recovery room contingent upon providing the portable tanks and suction equipment as outlined in the waiver request.

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned.**

Plans on 8½" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc., 150 Emory Street, Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : 9.31.E5 and Table 9.2

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" [01]

Specific physical plant condition to be waived *(e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):*

1 OX & 1 VAC for each bed, Class B: Post-anesthesia recovery room

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

The cost of installing a fully piped in oxygen and vacuum system was estimated to be $500,000 by Coast to Coast Medical in Fall River, MA.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

Abortion patients recover very quickly. The women are in the recovery room for usually 45 minutes or less. They are sitting upright or gently reclined. There are no beds in abortion recovery rooms. Due to the short nature of the procedure and fast acting anesthesia/sedation drugs, women are awake and alert much more quickly than most surgeries.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

At least one portable oxygen tank will be placed next to each recumbent recovery room chair. A portable gastric suction machine will also be placed next to each chair. Both will be ready to be used in the case of a rare emergency.

*Signature of the facility's **clinical** representative* Carol Belding

Representative's Name Carol Belding *Title* President *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: _____ 9/6/02 ☒ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: _____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: _____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

Four Women, Inc.
150 Emory Street
Attleboro, MA 02703

Waiver #13

Project Engineer's Waiver Comments/Conditions:

I recommend waiver approval of the piped in medical gases in the operating rooms and in the recovery room contingent upon providing the portable tanks and suction equipment as outlined in the waiver request.

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned.**

Plans on 8½" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc., 150 Emory Street, Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : 9.31.E5 and Table 9.2

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" 01

Specific physical plant condition to be waived *(e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):*

1 OX & 1 VAC Class A: minor surgery (local anesthesia)

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

The cost of installing a full piped in oxygen and vacuum system was estimated to be approximately $500,000 by Coast to Coast Medical in Fall River, MA. This is not an affordable option.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

A typical surgical abortion takes five minutes for the surgeon to perform. Due to the nature of abortion surgery, and fasting before hand, emergency gastric suctioning is incredibly rare. Oxygen dosing is more often but is of short duration.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

~~There~~ There will be at least one portable oxygen tank next to the procedure table in the OR. This will be ready for immediate emergency use and checked at the beginning of each surgical day.

A portable gastric suction machine will be set up next to the OR table.

*Signature of the facility's **clinical** representative* Carol Belding

Representative's Name Carol Belding *Title* President *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: Eric Gay 9/18/03 ☒ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Four Women, Inc.
150 Emory Street
Attleboro, MA 02703

Waiver #14

Project Engineer's Waiver Comments/Conditions:

I recommend waiver approval of the piped in medical gases in the operating rooms and in the recovery room contingent upon providing the portable tanks and suction equipment as outlined in the waiver request.

ORIG ret 8/6/02

ARCHITECT AND LICENSEE'S AFFIDAVIT

(Check Appropriate Facility Type)

☐ LONG TERM CARE FACILITY[1] ☒ CLINIC[2] ☐ CLINIC SATELLITE[2]

☐ HOSPITAL[3] ☐ HOSPITAL SATELLITE[3] ☐ DIALYSIS FACILITY[4]

The undersigned **Architect** hereby certifies:

1. It has created the architectural plans and specifications attached hereto as Attachment 1 (the "plans") regarding physical plant improvements (please note a brief project description) ambulatory surgical center at (Note the facility's licensed or proposed licensed name.)

Four Women, Inc., 150 Emory St., Attleboro, MA 02703
facility's licensed name or proposed name — address — city/town — zip code

if hospital or clinic satellite, name — address — city/town — zip code

2. The plans have been reviewed against regulations outlined in applicable Massachusetts Department of Public Health licensure regulations [1]105 CMR 150.000 et seq., or [2]105 CMR 140.000 et seq., or [3]105 CMR 130.000 et seq., or [4]105 CMR 145.000 et seq, and the applicable sections of the [2, 3, & 4] 2001 Edition of the Guidelines for Design and Construction of Hospital and Health Care Facilities as appropriate to the facility type.

3. To the undersigned's knowledge, information and belief, the plans meet the requirements of the above referenced codes and regulations in all material aspects, except for the non-conforming items (list regulation numbers) for which waivers will be required, separate waiver forms are attached for each item:

9.5.F5.P	9.5.F5.m	
corridor width	9.5.F2.e	9.5.F3
9.5.D5	4-9 31.E5,table9.2	9.5.D6
9.5.F4		9.5.D2

Architectural Firm Name: Richard J. Cardarelli, A.I.A.

Signature: [signature]

Name: Richard J. Cardarelli, A.I.A.

Title: Sole Prop.

Date: 06/28/02 Revision Dates: 4/20/02

Architect's Stamp

4. The undersigned **Licensee/proposed licensee** understands and agrees that notwithstanding the plan approval self-certification or abbreviated review process undertaken pursuant to this and the accompanying documents, the Division of Health Care Quality of the Department of Public Health (the "Division") shall have continuing authority to (a) review the plans submitted herewith and/or inspect the work with regard thereto, and (b) withdraw its approval thereto.

5. The facility, Four Women, shall have a continuing obligation to make any changes required by the Division to comply with the above mentioned codes and regulations whether or not physical plant construction or alterations have been completed. (Note the facility's licensed or proposed licensed name and if it is a hospital or clinic satellite note both the parent and satellite's name.)

Facility Name: Four Women, INc.

Address: 150 Emory St.
Attleboro, MA 02703

Date: 2/6/02

Authorized Signature: Carol Belding 7/12/0 resubmit date

Name: Carol Belding

Title: President

Witness: [signature] 7/12/02 vm

July, 2001 DPH-DHCQ

PLEASE SUBMIT THE ORIGINAL AFFIDAVIT, NOT A COPY.

RICHARD J. CARDARELLI REGISTERED ARCHITECT No. 06880 BOSTON, MA

ARCHITECT AND LICENSEE'S AFFIDAVIT

(Check Appropriate Facility Type)

☐ LONG TERM CARE FACILITY[1] ☒ CLINIC[2] ☐ CLINIC SATELLITE[2]

☐ HOSPITAL[3] ☐ HOSPITAL SATELLITE[3] ☐ DIALYSIS FACILITY[4]

The undersigned **Architect** hereby certifies:

1. It has created the architectural plans and specifications attached hereto as Attachment 1 (the "plans") regarding physical plant improvements (please note a brief project description) ambulatory surgical center at (Note the facility's licensed or proposed licensed name.)

Four Women, Inc., 150 Emory St., Attleboro, MA 02703
facility's licensed name or proposed name — address — city/town — zip code

if hospital or clinic satellite, name — address — city/town — zip code

2. The plans have been reviewed against regulations outlined in applicable Massachusetts Department of Public Health licensure regulations [1]105 CMR 150.000 et seq., or [2]105 CMR 140.000 et seq., or [3]105 CMR 130.000 et seq., or [4]105 CMR 145.000 et seq. and the applicable sections of the [2, 3, & 4] 2001 Edition of the Guidelines for Design and Construction of Hospital and Health Care Facilities as appropriate to the facility type.

3. To the undersigned's knowledge, information and belief, the plans meet the requirements of the above referenced codes and regulations in all material aspects, except for the non-conforming items (list regulation numbers) for which waivers will be required, separate waiver forms are attached for each item:

	9.5.F5.P	9.5.F5.m	9.5.F3
	corridor width	9.5.F2.e	9.5.D6
	9.5.D5	4-9 31.E5,table9.2	9.5.D2
	9.5.F4		

Architectural Firm Name: Richard J. Cardarelli, A.I.A.

Architect's Stamp

Signature: _____

Name: Richard J. Cardarelli, A.I.A.

Title: Sole Prop.

Date: _____ Revision Dates: _____

4. The undersigned **Licensee/proposed licensee** understands and agrees that notwithstanding the plan approval self-certification or abbreviated review process undertaken pursuant to this and the accompanying documents, the Division of Health Care Quality of the Department of Public Health (the "Division") shall have continuing authority to (a) review the plans submitted herewith and/or inspect the work with regard thereto, and (b) withdraw its approval thereto.

5. The facility, Four Women, shall have a continuing obligation to make any changes required by the Division to comply with the above mentioned codes and regulations whether or not physical plant construction or alterations have been completed. (Note the facility's licensed or proposed licensed name and if it is a hospital or clinic satellite note both the parent and satellite's name.)

Facility Name: Four Women, INc.

Address: 150 Emory St.
Attleboro, MA 02703

Date: 2/6/02

Authorized Signature: Carol Belding

Name: Carol Belding

Title: President

Witness: _____

PLEASE SUBMIT THE ORIGINAL AFFIDAVIT, NOT A COPY.

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned**.

Plans on 8½" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc., 150 Emory Street, Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : Corridor width

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" 01

Specific physical plant condition to be waived *(e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):*

8 foot corridor width in OR suite, 5 feet in other areas

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

Space is expensive and at a premium. We feel patients can be safely transported or escorted (as they are walking) to the recovery room with hallway widths as drawn.

Abortion care can be noisy as there are suction machines that create a vibration sound. It would be better for patients to have a door closer for quiet.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

Most patients go to the recovery room walking with a medical staff person. Those who have had light sedation are groggy, but awake and are in a wheel chair, again escorted to the recovery room.

There is plenty of room to get someone safely out of the building in an emergency.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

The majority of the OR corridor is 8 feet. There is a short six foot corridor to the recovery room with a 36 inch door for sound privacy. We can remove the door from the plans if you so desire.

Signature of the facility's clinical representative Carol Belding

Representative's Name Carol Belding *Title* President *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

***Attachments must include the facility's name and the referenced regulation number.**

COMPLIANCE CHECKLIST

Outpatient Surgical Facilities

The following Checklist is for plan review of hospital outpatient surgical facilities and ambulatory surgery centers, and is derived from the AIA/HHS Guidelines for Design and Construction of Hospital and Health Care Facilities, 2001 Edition (Section 9.5), appropriately modified to respond to DPH requirements for projects in Massachusetts which include Hospital Licensure Regulations 105 CMR 130.000 and Clinic Licensure Regulations 105 CMR 140.000. Applicants must verify project compliance with all the requirements of the Guidelines, Licensure Regulations & Policies when filling out this Checklist, and must include the DPH Affidavit when submitting project documents for self-certification or abbreviated review.

Other jurisdictions, regulations and codes may have additional requirements which are not included in this checklist, such as:

- NFPA 101 Life Safety Code and applicable related standards contained in the appendices of the Code.
- 708 CMR, the State Building Code.
- Joint Commission on the Accreditation of Health Care Organizations.
- CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Facilities.
- Accessibility Guidelines of the Americans with Disabilities Act (ADA).
- Architectural Access Board.
- Local Authorities having jurisdiction.

Instructions:

1. The Checklist must be filled out completely with each application.
2. Each requirement line (___) of this Checklist must be filled in with one of the following codes, unless otherwise directed. If an entire Checklist section is affected by a renovation project, "E" for existing conditions may be indicated on the requirement line (___) next to the section title. If more than one space serves a given required function (e.g. patient room or exam room), two codes separated by a slash may be used (e.g. "E/X"). Clarification should be provided in that regard in the Project Narrative.

X = Requirement is met.

☒ = Check this box under selected checklist section titles or individual requirements for services that are not included in the project.

E = Functional space or area is existing and not affected by the construction project; this category does not apply if the existing space or area will serve a new or relocated service or if the facility is currently not licensed & applying for licensure.

W = Waiver requested for Guidelines, Regulation or Policy requirement that is not met (for each waiver request, complete separate waiver form & list the requirement ref. # on the affidavit).

3. Mechanical, plumbing and electrical requirements are only partially mentioned in this checklist.
4. Oxygen, vacuum & medical air outlets are identified respectively by the abbreviations "OX", "VAC" & "MA".
5. Items in italic, if included, refer to selected recommendations of the Appendix of the Guidelines, adopted by policy.
6. Requirements referred to as "Policies" are DPH interpretations of the AIA Guidelines or of the Regulations.

Facility Name: Four Women, Inc.

Dates: 2/5/02

Initial: CB

Revisions: 3/5/02

Carol Belding 7/12/02 Resubmit

Facility Address: 150 Emory Street
Attleboro, MA 02703

Satellite Name: (if applicable)

DON Identification: (if applicable) 5-4885

Satellite Address: (if applicable)

Project Reference:

Building/Floor Location: ground/first floor

OPTIONAL ASSOCIATED SERVICES IN PROJECT (CHECKLISTS ATTACHED)

☐ Medical Clinics / Hosp. Outpatient Depts ☐ Outpatient Diagnostic Facilities ☐ Endoscopy Suites

ARCHITECTURAL REQUIREMENTS

9.5.A/ Policy — GENERAL

- x Facilities designed for max. 23 hrs patient stay
- x Surgical suite divided into 3 contiguous areas:
  - x unrestricted (control point monitoring general access)
  - x semi-restricted (peripheral support spaces)
  - x restricted (operating rooms & immediate support spaces)

9.5.C — PARKING

- x 4 spaces per procedure room
- x 1 space for each staff member
- x Spaces near the entrance for pickup
- 140.209 x Handicapped parking

9.5.D — x ADMINISTRATION & PUBLIC AREAS

- 9.5.D1 x Covered entrance for patient pickup
- 9.5.D2 x Lobby area:
  - W waiting area
  - x convenient wheelchair storage
  - x reception/information desk
  - W handicapped public toilets
  - ___ public telephone **or** x convenient office telephone
  - ___ drinking fountain **or** W bottled water dispenser
- 9.5.D3 x Interview space
  - x sight/sound privacy
- 9.5.D4 x Administrative offices:
  - x separate from public and patient areas
  - x provide for confidentiality of records
  - x enclose offices for consultation
- 9.5.D5 W Multipurpose room(s)
- 9.5.D6 W Medical records room
- 9.5.D7 x Lockable staff storage
- 9.5.D8 x General storage

9.5.E — x STERILIZING FACILITIES

- ☐ check if service provided off-site
- 9.5.E1 x Soiled workroom:
  - x work surface
  - x washer/sterilizer decontaminators
- 9.5.E2 x Clean assembly/workroom
  - x terminal sterilization equipment
  - x space for carts
- 9.5.E3 x Clean/sterile supplies

MECHANICAL/PLUMBING/ ELECTRICAL REQUIREMENTS

- x Lighting of parking lot & approaches to building
- W Handwashing station
- ___ Vent. min. 10 air ch./hr (exhaust)
- x Handwashing station
- x Clinical flushing-rim sink
- x Vent. min. 10 air ch./hr (exhaust)
  - x negative pressure
- x Handwashing station
- x Vent. min. 4 air/ch./hr
  - x positive pressure
- x Temperature/humidity control

	ARCHITECTURAL REQUIREMENTS	MECHANICAL/PLUMBING/ ELECTRICAL REQUIREMENTS
9.5F	x CLINICAL FACILITIES	
	x Pre-operative area	
	___ separate pediatric pre-operative space	
	[x] check if no pediatric surgery is performed	
9.5.F1	x Exam/testing room	
	x min. 80 sf	x Handwashing station
	x charting counter/shelf	x Vent. min. 6 air ch./hr
	x sight/sound privacy	x Portable or fixed exam light
		x Min. 2 el. duplex receptacles
	x Operating rooms/ Post-anesthesia recovery rooms	
	Class **A**: minor surgery (local anesthesia)	
	[ ] check if service not included in project	
9.5.F2.b	x Operating rooms	
	x min. 120 sf	W 1 OX & 1 VAC
	x 10'-0" minimum dimension	x Vent. min. 6 air ch./hr
	x min. 3'-0"clearance on all sides of operating table	x positive pressure
	W X-ray film illuminator	x Portable or fixed exam light
9.5.F3	x Post-anesthesia recovery room	
	x min. 1 recovery station per OR	
	x min. 2'-6" clearance on sides and end of beds	x Handwashing station
7.7B2 Policy	x cubicle curtains	x Access to bedpan cleaning equipment
	x beds located for direct observation from nurses station	W 1 OX & 1 VAC for each bed
	___ separate pediatric recovery space	W Nurses call button at each bed
	[x] check if no pediatric surgery is performed	x Vent. min. 6 air ch./hr
	___ space for parents	
	Class **B**: intermediate surgery (sedation)	
	[ ] check if service not included in project	
9.5.F2.c	x Operating rooms	
	x sole access through restricted corridor	W 2 OX & 2 VAC
	x min. 250 sf	x Vent. min. 15 air ch./hr
	x 15'-0" minimum dimension	x positive pressure
	x min. 3'-6"clearance on all sides of operating table	x 2 remote return registers near floor level
	W X-ray film illuminator	x Portable or fixed exam light
		x 8 elec. duplex receptacles (36" AFF)
		x Lighting, all receptacles & fixed equipment on emergency power
		x Emergency communication
9.5.F3 7.7B2 Policy	x Post-anesthesia recovery room	
	x min. 2 recovery stations per OR	x Handwashing station
	x min. 3'-0" clearance on sides and end of beds	x Access to bedpan cleaning equipment
	x sight/sound privacy	W 1 OX & 1 VAC for each bed
	x beds located for direct observation from nurses station	W Nurses call button at each bed
	___ separate pediatric recovery space	x Vent. min. 6 air ch./hr
	[x] check if no pediatric surgery is performed	
	___ space for parents	

	ARCHITECTURAL REQUIREMENTS	MECHANICAL/PLUMBING/ ELECTRICAL REQUIREMENTS
	Class C: major surgery (regional or general anesthesia) X ☐ check if service not included in project	
9.5.F2.d	___ Operating rooms ___ sole access through restricted corridor ___ min. 400 sf ___ 18'-0" minimum dimension ___ min. 4'-0" clearance on all sides of operating table ___ X-ray film illuminator	___ 2 OX & 3 VAC ___ Vent. min. 15 air ch./hr ___ positive pressure ___ 2 remote return registers near floor level ___ Portable or fixed exam light ___ 8 elec. duplex receptacles (36" AFF) ___ Lighting, all receptacles & fixed equipment on emergency power ___ Emergency communication
9.5.F3 7.7B2 Policy	___ Post-anesthesia recovery room ___ min. 3 recovery stations per OR ___ min. 4'-0" clearance on sides and end of beds ___ sight/sound privacy ___ beds located for direct observation from nurses station ___ separate pediatric recovery space ☐ check if no pediatric surgery is performed ___ space for parents	___ Handwashing station ___ Access to bedpan cleaning equipment ___ 1 OX & 1 VAC for each bed ___ Nurses call button at each bed ___ Vent. min. 6 air ch./hr
9.5.F4	W Step-down recovery area ___ number of stations is at least half the number of stations required for post-anesthesia recovery ___ control station ___ space for family members ___ provisions for privacy ___ convenient toilet room ___ sized for patient & assistant ___ nourishment facilities	___ Handwashing station ___ Vent. min. 10 air ch./hr (exhaust) ___ Handwashing station

	ARCHITECTURAL REQUIREMENTS	MECHANICAL/PLUMBING/ ELECTRICAL REQUIREMENTS
9.5.F5	X SUPPORT SERVICES	
9.5.F5.a	X Control station at entrance of operating suite	
9.5.F5.b	X Drug distribution station	
	X refrigerator	X Handwashing station
	X double locked storage	
9.5.F5.c	X Scrub stations	
	X near each OR entrance	X Knee/foot controls
	X each serves not more than 2 OR's	or
		___ Electronic sensor controls on emergency power (Policy)
9.5.F5.d	X Soiled workroom(s)	
	X work counter	X Handwashing station
	X waste receptacle	X Clinical flushing-rim sink
9.5.F5.e	X soiled workroom(s) convenient to OR's	X Vent. min. 10 air ch./hr (exhaust)
		X negative pressure
9.5E3	X Clean/sterile supplies	
		X Vent. min. 6 air ch./hr
		X Temperature/humidity control
9.5.F5.f	___ Anesthesia workroom for Class C surgery	
	☒ check if function & Class C surgery not included in project	___ 1OX & 1 MA
		___ Sink(s)
	___ work counter(s) & racks for cylinders	___ Vent. min. 8 air ch./hr
	___ separate storage for clean & soiled items	___ all air exhausted to outdoors
	___ case cart & equipt storage	
9.5.F5.g	X Medical gas supply & reserve storage	
9.5.F5.h	X Equipment and stretcher storage	X Vent. min. 8 air ch./hr
		X all air exhausted to outdoors
9.5.F5.i	X Staff change areas	
	X lockers	
	X showers	
	X toilets	
	X space for donning scrub suits and booties	X Handwashing stations
	X one-way traffic directly into surgical suite	X Vent. min. 10 air ch./hr (exhaust)
9.5.F5.j	X Outpatient surgery change areas	
	X waiting room	
	X lockers	
	X toilets	X Handwashing stations
	X clothing change areas	X Vent. min. 10 air ch./hr (exhaust)
	X space for administering medications	
9.5.F5.k	X Stretcher storage	
9.5.F5.l	X Staff lounge	
	X Staff toilets	
	X off surgical suite	X Handwashing station
	X near recovery area	X Vent. min. 10 air ch./hr (exhaust)
9.5.F5.m	W Housekeeping room	
		X Service sink
9.5.F5.n	X Wheelchair storage	X Vent. min. 10 air ch./hr (exhaust)
9.5.F5.o	X Access to crash carts for surgery & recovery	
9.5.F5.p	W High-speed sterilizer	

GENERAL STANDARDS

Details and Finishes

Corridor width:

__W min. 8'-0" corridor width in surgical suite

__x min. 5'-0" corridor width in other patient areas

Staff corridors

__x min. corridor width 44"

__x Two remote exits from each outp. facility suite & floor

__x Fixed & portable equipment recessed does not reduce required corridor width (9.2.H1.c)

__x Work alcoves include standing space that does not interfere with corridor width

☐ check if service not included in project

Doors:

__x doors min. 3'-0" wide (9.2.H1.d)

__x all doors are swing-type (Policy)

__x doors do not swing into corridor (Policy)

Patient toilet room doors

__x outswinging or on pivots

__x can be opened by staff in an emergency

__x Glazing (9.2.H1.e):

__x safety glazing or no glazing under 60" AFF & within 12" of door jamb

__x Thresholds & expansion joints flush with floor surface

__x Handwashing stations located for proper use & operation (9.2.H1.g)

__x min. 15" from centerline to side wall (Policy)

Vertical clearances (9.2.H1.j):

__x ceiling height min. 7'-10", except:

__x 7'-8" in corridors, toilet rooms, storage rooms

__x sufficient for ceiling mounted equipment

__x min. clearance 6'-8"under suspended pipes/tracks

Floors (9.2.H2.c):

__x floors easily cleanable & wear-resistant

__x washable flooring in rooms equipped with handwashing stations (Policy)

__x non-slip floors in wet areas

__x wet cleaned flooring resists detergents

__x monolithic floors & integral bases in operating rms

Walls (9.2.H2.d):

__x wall finishes are washable

__x smooth/water-resist. finishes at plumbing fixtures

Ceilings:

Restricted areas (operating rooms)

__x monolithic ceilings (7.28.B8)

Semi-restricted areas

___ monolithic ceilings (7.28.B8) **or** __x washable ceiling tiles with gasketed & clipped down joints

ELEVATORS

___ Provide at least one elevator in multistory facility **or** __x Each floor has an entrance located at outside grade level or HC accessible by ramp from outside grade level

___ wheelchair accessible

___ each elevator meets 9.30.B requirements

Mechanical (9.31.D)

__x Mech. ventilation provided per Table 7.2

__x Exhaust fans located at discharge end

__x Fresh air intakes located at least 25 ft from exhaust outlet or other source of noxious fumes

__x Contaminated exhaust outlets located above roof

__x Ventilation openings at least 3" above floor

__x Central HVAC system filters provided per Table 9.1

Plumbing (9.31.E)

Handwashing station equipment

__x handwashing sink

__x hot & cold water

__x single lever or wrist blades faucet

__x soap dispenser

__x hand drying facilities

Sink controls (9.31.E1):

__x hands-free controls at all handwashing sinks

__x blade handles max. 4½" long

__x blade handles at scrub, clinical sinks min 6" long

__W Medical gas outlets provided per 9.31.E5 & Table 9.2

__x No flammable anesthetics

Electrical (9.32)

__x All occupied building areas shall have artificial lighting (9.32.D3)

__x Emergency power complies with NFPA 99, NFPA 101 & NFPA 110 (9.32.H)

DPH Copy for Comment

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned.**

Plans on 8½" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc., 150 Emory Street, Attleboro, MA 02703
Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request: 9.5.D5 Not on Attachment
105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" 01

Specific physical plant condition to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):

Multipurpose room

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

The surgery center operates with limited hours, Wed and Fri evening and Saturday a.m. To rent additional space when there is adequate room not being used is unnecessary.
unnecessary

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

Staff meetings take place when the entire office is empty. Patients are not affected in any way. The physician office located next door is a part time practice. We will schedule a staff meeting when there are no patients scheduled.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

Meetings will not be held anywhere inside the surgical suite. Pre-clinic announcements may be made individually or a memo posted in the staff changing room.

Signature of the facility's clinical representative Carol Belding

Representative's Name Carol Belding *Title* President *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

*Attachments must include the facility's name and the referenced regulation number.

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Plans on 8½" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc., 150 Emory Street, Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : 9.5.D2

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" 01

Specific physical plant condition to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):

Shared waiting room; handicapped toilet; bottled water with physician practice

? who provides water

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

The surgery center only operates limited hours, (Wed. & Fri. evening, Saturday morning.) To rent additional space for waiting rooms would be very expensive for such limited use.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

Because the space is not used at the same time as the physician's practice there will be no adverse impact on patients. The room will be thoroughly cleaned between each use.

who cleans

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

Each provider will have a separate reception area. Signage will clearly indicate the different providers. And a guard will be on duty during surgical abortion clinics. Neither provider will be open at the same time.

Signature of the facility's clinical representative Carol Belding

Representative's Name Carol Belding *Title* President *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng:_____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm:_____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir:_____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

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Four Women, Inc., 150 Emory Street, Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : 9.5.D6

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" 01

Specific physical plant condition to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):

Medical records room

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

It is too costly to have another room for a limited number of medical records.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

Lack of separate room will not jeopardize patient health or safety or confidentiality. Offsite medical records can be accessed in time for an abortion appointment, which are made a day to a week ahead of time. All records on site will be secure with locked cabinets.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

? PATIENT PRIVACY IN RECEPTION AREA

Two locking 36 inch wide medical record storage cabines will be placed in the recpetion area. They hold 3,300 typical abortion patient charts. This is approximately a year's worth of charts fo Four Women. Because the majority of women may only visit us one time, and charts must be held for many years, charts will then be stored according to Massachusetts regulations.

Signature of the facility's clinical representative Carol Belding

Representative's Name Carol Belding *Title* President *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

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Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request: 9.5.F2.b, 9.5.F2.c

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" 01

Specific physical plant condition to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):

X-ray film illuminator

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

This adds unnecessary and unused equipment to an OR.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

~~Patients will not be affected. X-Rays are not used~~ in abortion care.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

None, there is no need for X-ray film illuminator. There is a light table in the dirty room that could be cleaned and used in some odd emergency, but that should not be the case.

Signature of the facility's clinical representative Carol Belding

Representative's Name Carol Belding *Title* President *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned.**

Plans on 8½" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc., 150 Emory Street, Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : ~~9.5.F3~~ Policy

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" 01

Specific physical plant condition to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):

Nurses call button at each bed

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

This kind of service is not usually found in abortion facilities
It adds to expense and complicates an already uncomplicated procedure and recovery.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

The recovery room is not very large. There is designated space for five recumbent chairs. There is a nurse and usually a medical assistant with patients at all times. (The nurse cannot leave the room without the float nurse covering her.) No patient is out of hearing or sight. If curtains are closed, they are closed to the sides of women next to a patient, not the nurses.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

Women in our recovery room are under constant supervision. They are usually alert and sitting up. They can tell us if they are in distress. We can provide a bell or something that can alert staff if the patient needs help. buzzer

Signature of the facility's clinical representative Carol Belding

Representative's Name Carol Belding *Title* President *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

*Attachments must include the facility's name and the referenced regulation number.

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned.**

Plans on 8½" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc., 150 Emory Street, Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request: 9.5.F5.P

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" 01

Specific physical plant condition to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):

High Speed Sterilizer

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

This is an added expense and it is not usually found in an abortion center.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

Women would not be affected by the lack of a high speed sterilizer. There are ample sterile instruments to be used in any given clinic.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

More sets are kept in storage than are needed in any day. If more patients show up than there are sterile wrapped sets, we can run several sets through the sterilizer and "flash" them. Each set consists of the same instruments they are all interchangeable. ~~It is not as if we used~~ Specialty items are packed. ~~We also~~ have extra items packed individually

Signature of the facility's clinical representative Carol Belding

Representative's Name Carol Belding *Title* President *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

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Pro. Adm: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

*Attachments must include the facility's name and the referenced regulation number.

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned.**

Plans on 8½" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc., 150 Emory Street, Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request: ~~D.5.F2.b~~ 9.31.E5 & TABLE 9.2

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" 01

Specific physical plant condition to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):

1 OX & 1 VAC Class A: minor surgery (local anesthesia)

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

The cost of installing a full piped in oxygen and vacuum system was estimated to be approximately $500,000 by Coast to Coast Medical in Fall River, MA. This is not an affordable option.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

A typical surgical abortion takes five minutes for the surgeon to perform. Due to the nature of abortion surgery, and fasting before hand, emergency gastric suctioning is incredibly rare. Oxygen dosing is more often but is of short duration.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

~~There~~ There will be at least one portable oxygen tank next to the procedure table in the OR. This will be ready for immediate emergency use and checked at the beginning of each surgical day. A portable gastric suction machine will be set up next to the OR table.

Signature of the facility's clinical representative Carol Belding

Representative's Name Carol Belding *Title* President *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

*Attachments must include the facility's name and the referenced regulation number.

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned.**

Plans on 8½" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc., 150 Emory Street, Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : ~~9.5.F2.c~~ 9.31.E5 & TABLE 9.1

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" 01

Specific physical plant condition to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):

2 OX & 2 VAC Class B: intermediate surgery (sedation)

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

The cost of installing a full piped in oxygen and vacuum system was estimated to be approximately $500,000 by Coast to Coast Medical in Fall River, MA. This is not an affordable option.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

A typical surgical abortion takes five minutes for the surgeon to perform. Due to the nature of abortion surgery, and fasting before hand, emergency gastric suctioning is incredibly rare. Oxygen dosing is more often but is of short duration.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

We have at least one oxygen tank to be placed next to the procedure table in the OR. This will be ready for immediate emergency use and checked at the beginning of each surgical day.

A portable gastric suction machine will be placed next to the OR table and immediatly available in case of emergency.

Signature of the facility's clinical representative Carol Belding

Representative's Name Carol Belding *Title* President *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

*Attachments must include the facility's name and the referenced regulation number.

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned.**

Plans on 8½" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc., 150 Emory Street, Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

2:1 Sem provided per NFPA 9.31.E.5 TABLE 9.2

Regulation or "Guideline" section number-Complete one form for each waiver request: ~~9.5.F3~~

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" 01

Specific physical plant condition to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):

1 OX & 1 VAC for each bed, Class B: Post-anesthesia recovery room

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

The cost of installing a fully piped in oxygen and vacuum system was estimated to be $500,000 by Coast to Coast Medical in Fall River, MA.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

Abortion patients recover very quickly. The women are in the recovery room for usually 45 minutes or less. They are sitting upright or gently reclined. There are no beds in abortion recovery rooms. Due to the short nature of the procedure and fast acting anesthesia/sedation drugs, women are awake and alert much more quickly than most surgeries.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

At least one portable oxygen tank will be placed next to each recumbent recovery room chair. A portable gastric suction machine will also be placed next to each chair. Both will be ready to be used in the case of a rare emergency.

Signature of the facility's clinical representative Carol Belding

Representative's Name Carol Belding *Title* President *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

*Attachments must include the facility's name and the referenced regulation number.

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned.**

Plans on 8½" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc., 150 Emory Street, Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : ~~9.5.F3~~ 9.31.E5 + TABLE

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" 01

Specific physical plant condition to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):

1 OX & 1 VAC for each bed, Class A: Post-anesthesia recovery rm.

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

The cost of installing a full piped in oxygen and suction system was $500,000 from Coast to Coast Medical. (approximate) This is not an affordable option.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

After a local abortion procedure women walk with an attendant into the recovery room. They recover in a sitting position and are awake and alert the entire time. An oxygen tank (portable) and a gastric suction machine (portable) will be placed next to each chair and readily available in the case of an emergency.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

~~As stated above, an oxygen tank and suction machine, both port-~~able will be placed next to each recovery room chair. These ~~are perfect and safe for a simple procedure such as an abortion.~~ emergency back up

Signature of the facility's clinical representative Carol Belding

Representative's Name Carol Belding *Title* President *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng:_____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm:_____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir:_____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

Please Disregard - no Class C. Surgeries.

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

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Plans on 8½" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc., 150 Emory Street, Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : 9.31.E5

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" 01

Specific physical plant condition to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):

Medical gas outlets provided per 9.31.E5 & Table 9.2

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

We are asking for waivers for piped in oxygen and vacuum system. A medical gas system would be used only in the anesthesia work room.and it is unclear whether the work room is even required for Class A and Class B procedures.
The cost of medical gas installation is prohibitive. We can hav

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

Again, it is not clear that the work room is needed for anesthesi
Medical gases are not used in abortion care, except for oxygen.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

Oxygen tank will be provided (portable) if necessary in the anesthesia work room if that room is required.

Signature of the facility's clinical representative Carol Belding

Representative's Name Carol Belding *Title* President *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

WAIVER NOT REQUIRED

WAIVER REQUEST FORM

DPH – CQAC – DHCQ, 99 Chauncy Street, 2nd Floor, Boston, MA 02111

All waiver requests regarding a PHYSICAL PLANT REQUIREMENT MUST BE ACCOMPANIED BY REDUCED PLANS on 8½" x 11" sheets for clarification of specific physical plant condition to be waived. Physical plant waiver requests received without accompanying plans will be returned as "DENIED".

NOTE: A SEPARATE WAIVER REQUEST FORM MUST BE SUBMITTED FOR EACH REQUIREMENT FOR WHICH A WAIVER IS REQUESTED.

PLAN - at Springfield Technical Community College, 1 Armory Square, Bld 20/Suite 320, Springfield MA 01105

Facility's Licensed Name or Proposed Name — Address, including zip code

If Hospital/Clinic Satellite, Name — Address, including zip code

Hospital/Clinic Department — Building/Floor Location

I HEREBY REQUEST THE DEPARTMENT WAIVE COMPLIANCE WITH THE REGULATION OR REQUIREMENT:

1.A: FOUND AT: (Regulation/Requirement Citation) 105CMR (Section E) 140.560

1.B: THAT REQUIRES (Text of Regulation/Requirement):

2) Records on outreach patients shall be maintained on the premises of parent clinic. Records shall not be stored at the outreach site.
3) Medications shall not be stored or administered at the outreach site.
4) Mental Health regulations, 140.560 do not permit onsite lab tests.

2.A: DESCRIPTION OF PROPOSED ALTERNATIVE TO COMPLIANCE WITH THE REQUIREMENT:

2.B: HOSPITALS AND LONG TERM CARE FACILITIES – WHAT WILL BE DONE TO COMPENSATE; CLINIC AND HOSPICE – HOW THE PROVIDER WILL REMAIN IN SUBSTANTIAL COMPLIANCE:

2). Patient charts will be stored onsite in HIPAA compliant, locked storage space.
3). We will store hormonal birth control, emergency contraception, gonnorrhea and chlamydia treatment onsite ensuring adequate refrigeration as necessary. All items to be stored in locked cabinets.
4) We would like to provide waived laboratory tests at our new health center (PLANat Sprinfield Technical Community College (STCC) including urine pregnancy testing and HIV OraQuick tests. Each box of pregnancy tests will be controlled at the Planned Parenthood Lab at our 3055 Main Street, Springfield location before being transported to our PLAN clinic at STCC. Each test also has an internal control. Similarly, we would ensure that two external controls are preformed on site anytime we offer ORAQUICK testing at our PLAN STCC site. We would also like to collect urine samples for chlamydia and gonnorhea testing as well as blood samples for identifying herpes antibodies, syphilis and hepatitis B & C. Samples will be picked up daily at STCC by our lab provider, QUEST. We believe that the ability to provide urine and blood testing will enable Planned Parenthood to meet public health needs in another location in Springfield.

Form continues on Page 2

PLAN: A Planned Parenthood Express Center at STCC, 1 Armory Sq. Bld 20, Suite 320, Springfield MA 01105

Facility's Licensed Name or Proposed Name — Address, including zip code

Regulation/Requirement Citation:

3. PROVIDER'S EXPLANATION OF HOW MEETING THE REQUIREMENT AS WRITTEN WOULD CAUSE UNDUE HARDSHIP:

2) Storing medical records on site at STCC allows the Planned Parenthood clinician to efficiently review medical history in order to provide quality care for patients through walk-in visits.
3) Planned Parenthood dispenses hormonal contraception, emergency contraception and treatment for gonnorrhea and chlamydia on-site at all four of our health centers in the state. Contraceptive consultations with clinicians will be the primary service offered at the new PLAN Express Center at STCC and on-site dispensing is an integral part of this service to meet patient needs from a convenience perspective.
4) Providing on-site pregnancy, urine and blood testing for gonnorrhea, chlamydia, herpes antibodies, syphilis and hep B & C will enable Planned Parenthood to meet public health needs in another location in Springfield.

4. PROVIDER'S ASSURANCE THAT APPROVAL OF THE WAIVER: (A) WILL NOT LIMIT THE CAPACITY TO PROVIDE ADEQUATE CARE; AND, (B) DOES NOT JEOPARDIZE/AFFECT PATIENT OR RESIDENT HEALTH AND SAFETY:

N/A

FACILITY AUTHORIZED REPRESENTATIVE:

Name: Meagan Gallagher
Title: Chief Operating Officer/Vice President
Mailing Address: 1055 Commonwealth Avenue
Boston, MA 02215-1001

Signature: Meagan Gallagher

FACILITY CLINICAL REPRESENTATIVE:

Name: Karen Loeb Lifford, MD
Title: Medical Director
Tel #: 617-616-1620

Signature: Karen Lifford MD

For DPH Use Only: The waiver identified above is approved, approved with conditions or denied as indicated below.

Evaluated by: _____ ___/___/___ ☐ Approved ☐ Approved w/Conditions ☐ Denied

Reviewed by: _____ ___/___/___ ☐ Approved ☐ Approved w/Conditions ☐ Denied

CONDITIONS:

Note: This waiver may be evaluated during on-site visits by Department staff at the facility. The Department reserves the right to revoke the waiver approvals if deficiencies are cited that indicate that the waivers adversely affect patient or resident health and safety.

COMPLIANCE CHECKLIST

▷ Mental Health Clinics

A separate Checklist must be completed for each outpatient suite.

The following Checklist is for plan review of clinics and hospital outpatient facilities, and is derived from the AIA/HHS Guidelines for Design and Construction of Hospital and Health Care Facilities, 2001 Edition (specific sections indicated below), appropriately modified to respond to DPH requirements for projects in Massachusetts which include Hospital Licensure Regulations 105 CMR 130.000 and Clinic Licensure Regulations 105 CMR 140.000. Applicants must verify project compliance with all the requirements of the Guidelines, Licensure Regulations & Policies when filling out this Checklist, and must include the DPH Affidavit when submitting project documents for self-certification or abbreviated review.

Other jurisdictions, regulations and codes may have additional requirements which are not included in this checklist, such as:
- NFPA 101 Life Safety Code and applicable related standards contained in the appendices of the Code.
- 708 CMR, the State Building Code.
- Joint Commission on the Accreditation of Health Care Organizations.
- CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Facilities.
- Accessibility Guidelines of the Americans with Disabilities Act (ADA).
- Architectural Access Board.
- Local Authorities having jurisdiction.

Instructions:

1. The Checklist must be filled out completely with each application.
2. Each requirement line (___) of this Checklist must be filled in with one of the following codes, unless otherwise directed. If an entire Checklist section is affected by a renovation project, "E" for existing conditions may be indicated on the requirement line (___) next to the section title. If more than one space serves a given required function (e.g. patient room or exam room), two codes separated by a slash may be used (e.g. "E/X"). Clarification should be provided in that regard in the Project Narrative.

X = Requirement is met.

☒ = Check this box under selected checklist section titles or individual requirements for services that are not included in the project.

E = Functional space or area is existing and not affected by the construction project; this category does not apply if the existing space or area will serve a new or relocated service or if the facility is currently not licensed & applying for licensure.

W = Waiver requested for Guidelines, Regulation or Policy requirement that is not met (for each waiver request, complete separate waiver form & list the requirement ref. # on the affidavit).

3. Mechanical, plumbing and electrical requirements are only partially mentioned in this checklist.
4. Items in italic, if included, refer to selected recommendations of the Appendix of the Guidelines, adopted by policy.
5. Requirements referred to as "Policies" are DPH interpretations of the AIA Guidelines or of the Regulations.

Facility Name: SPRINGFIELD TECHNICAL COMMUNITY COLLEGE DEPARTMENT OF HEALTH SERVICES

Dates:

Initial: .....

Revisions: .....

Facility Address: 1 ARMORY SQUARE BLD 20/SUITE 320

Satellite Name: (if applicable) .....

DON Identification: (if applicable) .....

Satellite Address: (if applicable) .....

Project Reference: .....

Building/Floor Location: .....

	ARCHITECTURAL REQUIREMENTS	MECHANICAL/PLUMBING/ ELECTRICAL REQUIREMENTS
	OUTPATIENT SUPPORT AREAS **Note:** Compliance Checklist OP1 must be completed and attached to this Checklist.	
9.2.B1 140.203 9.1.H	X COUNSELING ROOMS X min. 80 sf X ensure sight & sound privacy between each counseling room and adjacent areas	X Vent. min. 6 air ch./hr
9.2.B6	X DRUG DISTRIBUTION STATION ☐ check if service not included in project X work counter X locked storage X refrigerator X under visual supervision from staff station	X Handwashing station X Duplex receptacle(s)
Policy	___ TESTING	
9.2.D	X Urine collection station ☐ check if service not included in project	
9.2.D1 9.2.D3 9.2.D4	X work counter X storage cabinets X urine collection toilet room X equipped with shelf	X Handwashing station X Handwashing station X Vent. min. 10 air ch./hr (exhaust)
	X Blood collection station check if service not included in project X patient seating space X work counter X storage cabinets	X Handwashing stations X Vent. min. 6 air ch./hr (exhaust)
Policy	___ DAY TREATMENT PROGRAM ☒ check if service not included in project ___ total number used for compliance with following space requirements = number of patients per day	
7.6.B7	Social Spaces: ___ noisy activity/dining room(s) ___ quiet activity room(s) ___ min. combined area 40 sf/patient ___ min. area each space 120 sf	___ Vent. min. 6 air ch./hr ___ Vent. min. 6 air ch./hr
7.6.B8	Group therapy space: ___ GT separate room ___ min. 225 sf **or** ___ max. 12 patients per day and ___ quiet activity room min. 225 sf ___ GT combined with quiet activity	___ Vent. Min. 6 air ch./hr
7.6.B12	Therapy/multipurpose space: ___ separate room ___ min. 15 sf/patient ___ min. 200 sf **or** ___ max. 12 patients per day ___ noisy activity room meets [7.6.B6] + 10 sf/patient ___ noisy activity & therapy functions are combined within one room	___ Vent. min. 6 air ch./hr
	___ work counter, storage, and display	___ Handwashing station

ARCHITECTURAL REQUIREMENTS

(DAY TREATMENT PROGRAM Continued)

7.2.B15 ___ Nourishment area:
- ___ work counter
- ___ storage cabinets
- ___ refrigerator
- ___ equipment for hot nourishment
- ___ space for holding dietary trays

7.6B3 ___ used by patients **or** ___ not used by patients
___ staff control of heating/cooking devices

MECHANICAL/PLUMBING/ ELECTRICAL REQUIREMENTS

___ Handwashing station conveniently accessible
___ Vent. min. 4 air ch./hr

GENERAL STANDARDS

Details and Finishes

Outpatient corridors (9.2.H1.a)
- X min. corridor width 5'-0"

Staff corridors
- X min. corridor width 44"

X Two remote exits from each outp. facility suite & floor
X Fixed & portable equipment recessed does not reduce required corridor width (9.2.H1.c)
X Work alcoves include standing space that does not interfere with corridor width
☐ check if function not included in project

Doors:
- X doors min. 3'-0" wide (9.2.H1.d)
- X all doors are swing-type (Policy)
- X doors do not swing into corridor (Policy)

X Glazing (9.2.H1.e):
- X safety glazing or no glazing under 60" AFF & within 12" of door jamb
- X safety glazing or no glazing in recreation rooms

X Thresholds & expansion joints flush with floor surface

Vertical clearances (9.2.H1.j):
- X ceiling height min. 7'-10", except:
  - X 7'-8" in corridors, toilet rooms, storage rooms

Floors (9.2.H2.c):
- X floors easily cleanable & wear-resistant
- X washable flooring in rooms equipped with handwashing stations (Policy)
- X non-slip floors in wet areas
- X wet cleaned flooring resists detergents

Walls (9.2.H2.d):
- X wall finishes are washable
- X smooth/water-resist. finishes at plumbing fixtures

Mechanical (9.31.D)

X Mech. ventilation provided per Table 7.2
X Exhaust fans located at discharge end
X Fresh air intakes located at least 25 ft from exhaust outlet or other source of noxious fumes
X Contaminated exhaust outlets located above roof
X Ventilation openings at least 3" above floor
X Central HVAC system filters provided per Table 9.1

Plumbing (9.31.E)

Handwashing station equipment
- X handwashing sink
  - X hot & cold water
  - X single lever or wrist blades faucet
- X soap dispenser
- X hand drying facilities

Sink controls (9.31.E1):
- ___ hands-free controls at all handwashing sinks
- X blade handles max. 4½" long

Electrical (9.32)

X All occupied building areas shall have artificial lighting (9.32.D3)
X Emergency power complies with NFPA 99, NFPA 101 & NFPA 110 (9.32.H)

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

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Only Use DPH-DHCQ Originals - Do Not Fax or Computer Scan Waiver Request Forms

Four Women, Inc.
Facility's Licensed Name or Proposed Name

150 Emory St. Attleboro, MA 02703
Address, including zip code

If hospital or clinic satellite, name

Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : 105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities"97

Specific regulation item to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement): #13

9.5.F5.m Housekeeping room - one housekeeping or janitors closet

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

Space is tight - one janitor's closet for this size facility will be adequate.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

due to small service time janitors closet is accessable at all times.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

see narrative and above.

Signature of the facility's clinical representative: Carol Belding

Representative's Name Carol Belding *Title* Administrator *Tel.#* 508.222.7555

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Proj. Eng: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Apr. 1999

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Four Women, Inc. — Facility's Licensed Name or Proposed Name

150 Emory St. Attleboro, MA 0270 — Address, including zip code

If hospital or clinic satellite, name

Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request :

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities"97

Specific regulation item to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement): #14

9.5.G Details & finishes : Corridor width to 5 & 6 foot width

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

Space is tight this is ambulatory surgery only — see narrative

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

We ask that corridors be waivered to smaller width. Health and safety will not be compromised

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

These sizes are larger than we use today.

Signature of the facility's clinical representative: Carol Belding

Representative's Name Carol Belding *Title* Administrator *Tel.#* 508.222.7555

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Four Women, Inc.
Facility's Licensed Name or Proposed Name

150 Emory St. Attleboro, MA 02703
Address, including zip code

If hospital or clinic satellite, name

Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : compliance checklist, OSF.
105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities"97

Specific regulation item to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement): #15 handicapped bathrooms — We would have 2 handicapped / 3 non-handicapped

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

the cost is prohibitive to provide handicapped bathrooms in every part of building. We would like 2 instead of 4.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

Most women who have physical disabilities or are wheelchair bound would be referred to the hospital for ~~care~~ care. See list in narrative where this is routine.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

With two handicapped bathrooms — one in the waiting room & one in patient changing room — We can accomodate all handicapped bathroom needs.

Signature of the facility's clinical representative: Carol Belding

Representative's Name Carol Belding *Title* Administrator *Tel.#* 508-222-7555

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150 Emory St. Attleboro, MA 02703
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Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : Compliance Checklist. O.S.F.
105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities"97

Specific regulation item to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement): # 1

9.5.D5 Multipurpose room - use other rooms.

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

Space is limited. Some spaces that could be used as a multipurpose room are rarely used.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

Due to unusual use of this facility there is flexibility in space use -

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

Adequate space is available for educational sessions & meetings.

Signature of the facility's clinical representative: Carol Belding

Representative's Name Carol Belding *Title* Administrator *Tel.#* 508.222.7555

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10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

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Four Women, Inc. 152 Emory St. Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : compliance checklist: O.S.F.

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities"97

Specific regulation item to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement): # 2

9.5.E1 Pass thru from soiled room to clear room. There are two separate rooms.

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

See narrative & explanation of waiver

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

We feel having separate clear/soiled rooms decreases cross contamination.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

see above & narrative.

Signature of the facility's clinical representative: Carol Belding

Representative's Name Carol Belding *Title* Administrator *Tel.#* 508.222.7555

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Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : compliance checklist: O.S.F.

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities"97

Specific regulation item to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement): #3

9.5.E.1 & 9.5.E3 positive & Negative pressure

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

the limited use of both clean & soiled rooms are documented in the narrative. the cost of this would create a hardship

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

Staff use safe practices in handling soiled/sterilized instruments. Fresh air exhaust will be working.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

see narrative & above.

Signature of the facility's clinical representative: Carol Belding

Representative's Name Carol Belding *Title* Administrator *Tel.#* 508.222.7555

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Four Women, Inc. — 150 Emory St. Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : compliance checklist, O.S.F

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities"97

Specific regulation item to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement): # 4

9.5.E3 Temperature / Humidity Control / Positive / Negative Pressure - req exhaust

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

This is beyond the scope of a single service facility. We are careful - and will have exhaust to the outside. The rooms are used infrequently see narrative.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

See above & Narrative.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

exhaust to outside is provided.

Signature of the facility's clinical representative: Carol Belding

Representative's Name Carol Belding *Title* Administrator *Tel.#* 508.222.7555

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Asst. Dir: ____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

Apr. 1999

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Specific regulation item to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement): # 5

9.5.F2 Operating/Procedure Room - 360 sq. feet to 245 sq. feet.

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

This room is rarely used and larger space is not needed see narrative.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

Birthing rooms are 200 sq. feet. This is a simple out pat. procedure, not abdominal surgery. Other abortion facilities in Mass. have smaller rooms and provide good service.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

See narrative & see above.

Signature of the facility's clinical representative: Carol Belding

Representative's Name Carol Belding *Title* Administrator *Tel.#* 508.222.7555

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Asst. Dir: ____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

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Four Women, Inc. — Facility's Licensed Name or Proposed Name

150 Emory St. Attleboro, MA 02703 — Address, including zip code

If hospital or clinic satellite, name

Address, including zip code

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Specific regulation item to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement): # 6

9.5.F2 X-Ray Film Illuminator - not used here.

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

it would never be used.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

there is no indication for use for abortion care. We've never had xrays.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

We have illuminated boxes to view specimen, these can be used.

Signature of the facility's clinical representative: Carol Belding

Representative's Name Carol Belding *Title* Administrator *Tel.#* 508.222.7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: ____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

*Attachments must include the facility's name and the referenced regulation number.

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned**. Plans must be provided for clarification, as needed.

Only Use DPH-DHCQ Originals - Do Not Fax or Computer Scan Waiver Request Forms

Four Women, Inc. — 150 Emory St. Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : Compliance checklist : O.S.F.
105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities"97

Specific regulation item to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement): # 7
9.5.F2 VAC in wall - instead two portable vacuum system.

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

— Expense —
We already have one vacuum pump on the anesthesia gas machine. Schuco Inc. model 130
We can get another for recovery room.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

system already in place and rarely used.
see narrative above.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

rarely used system (patients are intubated in emergency cases only) we have tested good quality pump.

Signature of the facility's clinical representative: Carol Belding

Representative's Name Carol Belding *Title* Administrator *Tel.#* 508.222.7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: ____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

Apr. 1999

*Attachments must include the facility's name and the referenced regulation number.

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned**. Plans must be provided for clarification, as needed.

Only Use DPH-DHCQ Originals - Do Not Fax or Computer Scan Waiver Request Forms

Four Woman, Inc. — 150 Emory St. Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request: compliance checklist: O.S.F.

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities"97

Specific regulation item to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement): # 8

9.5.F2 Generator - hand held vacuum aspirators & lighting

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

generators are really expensive. There is a possibility of protestors tampering with them because they are usually outside. See narrative

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

If the power goes off we won't do cases. If case has begun it can be continued with hand instruments & a light.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

battery wall lighting will be available.

Signature of the facility's clinical representative: Carol Belding

Representative's Name Carol Belding *Title* Administrator *Tel.#* 508.222.7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: ____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

Apr. 1999

*Attachments must include the facility's name and the referenced regulation number.

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned.** Plans must be provided for clarification, as needed.

Only Use DPH-DHCQ Originals - Do Not Fax or Computer Scan Waiver Request Forms

Four Women, Inc. — 150 Emory St. Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : compliance checklist: D.S.F.

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities"97

Specific regulation item to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement): # 9

9.5.F3 Recovery Room Beds - to chairs

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

Beds are inappropriate for routine abortion care - we have chairs that achieve Trendelenburg positioning.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

The recovery room chairs are the standard of care.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

See narrative & see above.

Signature of the facility's clinical representative: Carol Belding

Representative's Name Carol Belding *Title* Administrator *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: ____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

*Attachments must include the facility's name and the referenced regulation number.

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned.** Plans must be provided for clarification, as needed.

Only Use DPH-DHCQ Originals - Do Not Fax or Computer Scan Waiver Request Forms

Four Women, Inc. — Facility's Licensed Name or Proposed Name

150 Emory St. Attleboro, MA 02703 — Address, including zip code

If hospital or clinic satellite, name

Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request: Compliance Checklist. 0.5.F

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities"97

Specific regulation item to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement): 10

9.5.F3 Clinical Flushing-rim Sink — only one in facility.

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

Our facility is small — the sinks are expensive. If we have one in the soiled room, everyone has easy access to it.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

See narrative above.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

All materials are dealt with carefully for safety and regulatory reasons.

Signature of the facility's clinical representative: Carol Belding

Representative's Name Carol Belding *Title* Administrator *Tel.#* 508.222.7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: ____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

Apr. 1999

*Attachments must include the facility's name and the referenced regulation number.

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned.** Plans must be provided for clarification, as needed.

Only Use DPH-DHCQ Originals - Do Not Fax or Computer Scan Waiver Request Forms

Four Women, Inc. — 150 Emory St. Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : 105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities"97

Specific regulation item to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement): 9.5.F4 Recovery Room - one room only, no "step down" lounge.

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

Because abortion care is a quick procedure, usually 5-10 minutes, women recover quickly. It is better to have everyone in the same space for observation

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

A nurse is with patients constantly - this does not compromise their care at all.

See narrative

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

See narrative above. Women go to one recovery room that is well equipped & staffed. Average stay is 45 min.

Signature of the facility's clinical representative: Carol Belding

Representative's Name Carol Belding *Title* Administrator *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: ____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

*Attachments must include the facility's name and the referenced regulation number.

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned.** Plans must be provided for clarification, as needed.

Only Use DPH-DHCQ Originals - Do Not Fax or Computer Scan Waiver Request Forms

Four Women, Inc. — 150 Emory St. Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : 105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities"97

Specific regulation item to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement): 9.5.F.4 Recovery Room - one room only, no "step down" lounge.

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

Because abortion care is a quick procedure, usually 5-10 minutes, women recover quickly. It is better to have everyone in the same space for observation

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

A nurse is with patients constantly - this does not compromise their care at all.

See narrative

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

See narrative above. Women go to one recovery room that is well equipped & staffed. Average stay is 45 min.

Signature of the facility's clinical representative: Carol Belding

Representative's Name Carol Belding *Title* Administrator *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: ____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ____ __/__/__ ☐ Approval ☐ Approval w/conditions ☐ Denial

*Attachments must include the facility's name and the referenced regulation number.

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned**. Plans must be provided for clarification, as needed.

Only Use DPH-DHCQ Originals - Do Not Fax or Computer Scan Waiver Request Forms

Four Women, Inc. — 150 Emory St. Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : 105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities"97

Specific regulation item to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement): #12

9.5.F5.f. Anesthesia Workroom to Anesthesia Work area.

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

Space is tight and use is limited to set up 3 times per week. The space has a sink, counter, storage, locked narcotic safe etc. refrigerator.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

see above and narrative.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

all anesthesia drugs and equipment will be in same area and on locked anesthesia cart —

Signature of the facility's clinical representative: Carol Belding

Representative's Name Carol Belding *Title* Administrator *Tel.#* 508.222.7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

*Attachments must include the facility's name and the referenced regulation number.

COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE QUALITY
10 WEST STREET
BOSTON, MA 02111-1212
(617) 753-8000

APPLICATION FOR CLINIC LICENSE

Date: 4/11/2005

In accordance with the "Regulations for the Licensure of Clinic, 105 CMR 140", the undersigned hereby applies for a license to establish and/or maintain a clinic at the premises set forth below under provisions of the General Laws, Chapter 111, Section 51 and 56.

1. NAME OF LICENSEE Planned Parenthood Leagne of MA
2. NAME OF CLINIC Planned Parenthood/Preterm Health Services of Greater Boston
   (if same, write same)
3. ADDRESS 1055 Commonwealth Ave Boston MA 02215
   Street City or Town Zip Code
4. TELEPHONE 617-616-1600
5. LICENSE TYPE:
   (A) RENEWAL LICENSE: ✓ Date current license expires 7/13/2005
   (B) ORIGINAL LICENSE: _____
      a) Initial Establishment: _____ Projected opening date: _____
      b) Change of Location: _____ Projected move date: _____
      c) Transfer of ownership: _____ Date: _____
      d) Determination of Need Project Number: _____
      Date Approved: _____
6. SERVICES (check all that apply)

Medical ✓ Alcoholism _____ Dental _____

Surgical ✓ Physical Rehabilitation _____ Mental Health _____

Birth Center _____

DPHCQ 136
02/22/05

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH CARE QUALITY
10 WEST STREET - 5TH FLOOR
BOSTON, MA 02111
TELEPHONE: (617) 753-8000

APPLICATION FOR CLINIC LICENSE

Date: 9/29/04

In accordance with the "Regulations for the Licensure of Clinics, 105 CMR 140", the undersigned hereby applies for a license to establish and/or maintain a clinic at the premises set forth below under provisions of the General Laws, Chapter 111, Sections 51 and 56.

1. NAME OF APPLICANT FOUR WOMEN

2. NAME OF CLINIC FOUR WOMEN (if same, write same)

3. ADDRESS 150 Emory St. (Street) Athleboro (City or Town) 02703 (Zip Code)

4. TELEPHONE 508-222-7555

5. LICENSE TYPE:

(A) RENEWAL LICENSE: X Date current license expires 12/11/04

(B) ORIGINAL LICENSE: 12/11/02

a) Initial Establishment: _____ Projected opening date: _____

b) Change of Location N/A Projected move date: N/A

c) Transfer of Ownership: _____ Date: 2004 5% to Carol Belding

d) Determination of Need Project Number: 5-4885

Date Approved: 12/19/00

6. SERVICES (check all that apply)

Medical ✓ Mental Health _____ Dental _____

Surgical ✓ Physical Rehabilitation _____ Alcoholism _____

Birth Center _____

7. NAME AND ADDRESS OF ALL SATELLITE LOCATIONS MAINTAINED UNDER LICENSE:

N/A

8. NAME OF OF CLINIC ADMINISTRATOR:

Molly Finneseth

COMMONWEALTH OF MASSACHUSETTS
Department of Public Health
DIVISION OF HEALTH CARE QUALITY
99 Chauncy Street
BOSTON, MA 02111-1212
(617) 753-8000

APPLICATION FOR CLINIC LICENSE RENEWAL

Date: 2·23·07

In accordance with the "Regulations for the Licensure of Clinic, 105 CMR 140", the undersigned hereby applies for a license to establish and/or maintain a clinic at the premises set forth below under provisions of the General Laws, Chapter 111, Section 51 and 56.

1. NAME OF LICENSEE Four Women, Inc

2. NAME OF CLINIC Four Women
(if same, write same)

3. ADDRESS 150 Emory Street, Attleboro, MA 02703
Street City or Town Zip Code

4. TELEPHONE 508·222·7555

5. LICENSE TYPE:

(A) RENEWAL LICENSE ✓ Date current license expires 12/11/06

6. SERVICES (check all that apply)

Medical ✓ Alcoholism ____ Dental ____

Surgical ✓ Physical Rehabilitation ____ Mental Health ____

Birth Center ____ Mobile Medical ____ Transfusion ____

Pharmacy ____ MRI Radiology ____

7. NAME OF CLINIC ADMINISTRATOR Carol Belding, Molly Finneseth, PhD, RNC

DPHCQ 136
Rev. 10/05/05

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH CARE QUALITY
10 WEST STREET - 5TH FLOOR
BOSTON, MA 02111
TELEPHONE: (617) 753-8000

APPLICATION FOR CLINIC LICENSE

Date: 9/29/04

In accordance with the "Regulations for the Licensure of Clinics, 105 CMR 140", the undersigned hereby applies for a license to establish and/or maintain a clinic at the premises set forth below under provisions of the General Laws, Chapter 111, Sections 51 and 56.

1. NAME OF APPLICANT FOUR WOMEN

2. NAME OF CLINIC FOUR WOMEN (if same, write same)

3. ADDRESS 150 Emory St. (Street) Attleboro (City or Town) 02703 (Zip Code)

4. TELEPHONE 508-222-7555

5. LICENSE TYPE:

(A) RENEWAL LICENSE: X Date current license expires 12/11/04

(B) ORIGINAL LICENSE: 12/11/02

a) Initial Establishment: _____ Projected opening date: _____

b) Change of Location N/A Projected move date: N/A

c) Transfer of Ownership: _____ Date: 2004 5% to Carol Belding

d) Determination of Need Project Number: 5-4885

Date Approved: 12/19/00

6. SERVICES (check all that apply)

Medical ✓ Mental Health _____ Dental _____

Surgical ✓ Physical Rehabilitation _____ Alcoholism _____

Birth Center _____

7. NAME AND ADDRESS OF ALL SATELLITE LOCATIONS MAINTAINED UNDER LICENSE:

N/A

8. NAME OF OF CLINIC ADMINISTRATOR:

Molly Finneseth

SURVEYOR COPY

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH CARE QUALITY
10 WEST STREET - 5TH FLOOR
BOSTON, MA 02111
TELEPHONE: (617) 753-8000

APPLICATION FOR CLINIC LICENSE

Date: 11/25/02

In accordance with the "Regulations for the Licensure of Clinics, 105 CMR 140", the undersigned hereby applies for a license to establish and/or maintain a clinic at the premises set forth below under provisions of the General Laws, Chapter 111, Sections 51 and 56.

1. NAME OF APPLICANT Planned Parenthood League of Ma. (PPLM)

2. NAME OF CLINIC ~~Same~~ PLANNED PARENTHOOD CLINIC OF WESTERN MASS; (if same, write same)

3. ADDRESS 3550 Main Street Springfield Ma
Street City or Town Zip Code

4. TELEPHONE 413.732.1620

5. LICENSE TYPE:

(A) RENEWAL LICENSE: _____ Date current license expires _____

(B) ORIGINAL LICENSE: _____

a) Initial Establishment: _____ Projected opening date: _____

b) Change of Location ✓ Projected move date: 12.21.02

c) Transfer of Ownership: _____ Date: _____

d) Determination of Need Project Number: No number provided.

Date Approved: 9.24.02

6. SERVICES (check all that apply)

Medical ✓ Mental Health _____ Dental _____

Surgical ✓ Physical Rehabilitation _____ Alcoholism _____

Birth Center _____

7. NAME AND ADDRESS OF ALL SATELLITE LOCATIONS MAINTAINED UNDER LICENSE:
See above

8. NAME OF OF CLINIC ADMINISTRATOR: Jessica Wolff, RN/CNP

COMMONWEALTH OF MASSACHUSETTS
Department of Public Health
DIVISION OF HEALTH CARE QUALITY
99 Chauncy Street
BOSTON, MA 02111-1212
(617) 753-8000

APPLICATION FOR CLINIC LICENSE RENEWAL

Date: 4/9/2007

In accordance with the "Regulations for the Licensure of Clinic, 105 CMR 140", the undersigned hereby applies for a license to establish and/or maintain a clinic at the premises set forth below under provisions of the General Laws, Chapter 111, Section 51 and 56.

1. NAME OF LICENSEE Planned Parenthood League of MA

2. NAME OF CLINIC Planned Parenthood | Preterm Health Services of Greater Boston
(if same, write same)

3. ADDRESS 1055 Commonwealth Ave Boston, MA 02215
Street City or Town Zip Code

4. TELEPHONE 617-616-1600

5. LICENSE TYPE:

(A) RENEWAL LICENSE ✓ Date current license expires 6/23/2007

6. SERVICES (check all that apply)

Medical ✓ Alcoholism ____ Dental ____

Surgical ✓ Physical Rehabilitation ____ Mental Health ____

Birth Center ____ Mobile Medical ____ Transfusion ____

Pharmacy ____ MRI Radiology ____

7. NAME OF CLINIC ADMINISTRATOR Kim Digman

DPHCQ 136
Rev. 10/05/05

Clinic Name Planned Parenthood

Application Date 4/9/07

8. NAME AND ADDRESS OF ALL SATELLITE LOCATIONS MAINTAINED UNDER LICENSEE:

SATELLITES:

1. Name of Clinic: Planned Parenthood League of MA

Street: 631 Lincoln St Suite #/Floor Worcester MA 01605 City/Zip Code

Telephone Number (508) 854-3300 Days and Hours of Operation: See attached

Services offered: Medical, Surgical

DPS Issued 3/2/2009 Fire Issued 1-16-2007

2. Name of Clinic: Planned Parenthood League of MA

Street: 3550 Main Street #201 Suite #/Floor Springfield MA 01107 City/Zip Code

Telephone Number: 413 732 1620 Days and Hours of Operation: See attached

Services offered: Medical, Surgical

DPS Issued 4/17/09 Fire Issued 8/30/2006

3. Name of Clinic: _____

Street: _____ Suite #/Floor _____ City/Zip Code

Telephone Number: _____ Days and Hours of Operation: _____

Services offered: _____

DPS Issued: _____ Fire Issued: _____

(Attach addendum for additional sites, if applicable)

Clinic Name Planned Parenthood

Application Date 4/9/07

9. Number of patients per year:

Less than 5,000 _____
5,000 – 25,000 _____
25,000 – 100,000 ✓
100,000 - _____

10. I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all state tax returns and paid all state taxes required under law.

042698497
Social Security Number (Voluntary)
or Federal Identification Number

Note: Your social security number will be furnished to the Massachusetts Department or Revenue to determine whether you have met tax filing or tax payment obligations. Licensee who fail to correct their non-filing or tax payment obligations. Licensees who fail to correct their non-filing or delinquency will be subject to license suspension or revocation. This request is made under the authority of Mass. G. L. c.62C s.49A.

11. Signature and Seal:

I, Dianne Luby, being first duly sworn on oath depose and say that the statements contained in this license application are true, complete and correct to the best of my knowledge.*

Planned Parenthood League of MA
Signature of Applicant (Individual or Person authorized act in behalf of the Individual Applicant) or Corporate Name

By: Dianne Luby President/CEO
Corporate Officer (if applicable)

Subscribed and sworn to before me on this 2nd day of April 19 2007.

My commission expires on June 7 19 2007.

Notary Public _____ (Seal)

*Note: All information contained in this application must be kept current.

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Division of Health Care Quality
99 Chauncy Street, Boston, MA 02111
617-753-8000

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

JUDYANN BIGBY, MD
SECRETARY

JOHN AUERBACH
COMMISSIONER

June 20, 2007

S. Howey
P.O. Box 870037
Milton, MA 02187-0037

Dear Ms. Howey:

In response to your request, enclosed please find copies of applications of all types submitted by Planned Parenthood League of Massachusetts and Four Women of Attleboro.

Should you have any questions, please feel free to contact me at 617-753-8140.

Sincerely,

Peter P. Bilodeau
Public Information Officer

C: J. Hugg
PI-07-303

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Division of Health Care Quality
10 West Street, Boston, MA 02111-1212
617-753-8000

December 29, 2003

Carol Belding
President
Four Women, Inc.
150 Emory St.
Attleboro, MA 02703

Dear Ms. Belding:

This letter is in response to correspondence regarding waivers for Four Women, Inc., located at 150 Emory St, Attleboro, MA 02703

140.609(A): The request for a waiver of the requirement to provide routine pathology is conditionally approved. In lieu of the requirement, information submitted to the Department in support of the waiver indicated that a gross examination of all tissue specimens must be performed by the clinician who performed the procedure before the patient leaves the facility. In addition, all findings must be recorded in the chart and a policy for tissue evaluation maintained.

Waiver(s) will be evaluated at the time of on-site facility surveys, and the Department reserves the right to revoke approval(s) if deficiencies are cited which indicate waiver approval(s) adversely affect patient health and safety.

If you have any questions, please call Barbara McCready at (617) 753-8226.

Very truly yours,

Sherman R. Lohnes
Assistant Director
for
Paul I. Dreyer, Ph.D.
Director

cc: Jill Mazzola
Barbara McCready
Daniel Gent
Facility File
Waiver File
FourWomenwaiver03r

JANE SWIFT
GOVERNOR

ROBERT P. GITTENS
SECRETARY

HOWARD K. KOH,M.D.,MPH
COMMISSIONER

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Division of Health Care Quality
10 West Street, 5th Floor, Boston, MA 02111
(617) 753-8000

October 31, 2002

Carol Belding
President
Four Women, Inc.
150 Emory Street
Attleboro, MA 02703

Dear Ms. Belding:

This letter is in response to correspondence regarding physical plant waivers of the A.I.A "Guidelines" for Four Women, Inc. at 150 Emory Street, Attleboro, MA 02703.

9.5.D2: The request for a waiver of the requirement to provide a separate waiting room, handicapped toilet and bottled water dispenser from the physician's practice is approved. In lieu of the requirement, information submitted to the Department in support of the waiver indicated that the hours of operation are not the same as the physician practice. In addition, signage will be placed indicating a different provider, and arrangements have been made for bottled water supplies and the cleaning of the space after the clinic's use.

9.5.D4: The request for a waiver of the requirement to provide separate administrative offices from the reception and pre-operative room is approved. In lieu of the requirement, information submitted to the Department in support of the waiver indicated that the clinic hours of operations are not the same as the physician's practice. The functional program does not impact upon patient confidentiality and safety.

9.5.D5: The request for a waiver of the requirement to provide a multipurpose room is approved. In lieu of the requirement, information submitted to the Department in support of the waiver indicated that, per agreement, the space is available within the physician's office areas for any meetings or counseling, as the physician's office is a part time practice, and patients will not be affected.

9.5.D6: The request for a waiver of the requirement to provide a medical records room is approved. In lieu of the requirement, information submitted to the Department in support of the waiver indicated that the medical records for the day will be stored in a locked file cabinet. The medical records are stored in a locked storage cabinet located in the reception area.

9.5.F2.e: The request for a waiver of the requirement to provide an X-ray film illuminator is approved. In lieu of the requirement, information submitted to the Department in support of the waiver indicated that radiology is not part of the functional program.

Department Policy: The request for a waiver of the requirement to provide a nurses call button is approved. In lieu of the requirement, information submitted to the Department in support of the waiver indicated that a nurse or medical assistant would be in the recovery room anytime a patient is present.

9.5.F4: The request for a waiver of the requirement to provide a step-down recovery area is approved. In lieu of the requirement, information submitted to the Department in support of the waiver indicated that the clinic's functional program does not require an extended recovery period.

9.5.F5.m: The request for a waiver of the requirement to provide a housekeeping room is approved. In lieu of the requirement, information submitted to the Department in support of the waiver indicated that there is a professional cleaning service agreement and access to cleaning equipment for minor spills while the clinic is in operation.

9.5.F5.p: The request for a waiver of the requirement to provide a high-speed sterilizer is approved. In lieu of the requirement, information submitted to the Department in support of the waiver indicated that there is a sterilizer available for flash sterilization of additional instruments needed during a clinic session.

9.5.H1.a: The request for a waiver of the requirement to provide 8'-0" wide operating suite corridors and 5'-0" wide general public corridors are approved. In lieu of the requirement, information submitted to the Department in support of the waiver indicated that there is adequate stretcher, wheelchair and recovery room access through the corridors.

9.31.E5: The request for a waiver of the requirement to provide two class B oxygen and vacuum systems is approved. In lieu of the requirement, information submitted to the Department in support of the waiver indicated that the clinic's functional program does not require a prolonged oxygen and vacuum system. In addition, the clinic has a portable gastric suction machine and oxygen tank to be ready for emergency use, and checked at the beginning of each day.

9.31.E5-Table 9.2: The request for a waiver of the requirement to provide class A oxygen and vacuum for each post-anesthesia recovery room bed is approved. In lieu of the requirement, information submitted to the Department in support of the waiver indicated that the clinic's functional program does not require prolonged sedation and that portable gastric suction and oxygen is readily available, in the case of an emergency.

9.31.E5-Table 9.2: The request for a waiver of the requirement to provide class B oxygen and vacuum for each post-anesthesia recovery room bed is approved. In lieu of the requirement, information submitted to the Department in support of the waiver indicated that the clinic's functional program does not require prolonged sedation and that portable gastric suction and oxygen is readily available, in the case of an emergency.

9.31.E5-Table 9.2: The request for a waiver of the requirement to provide class A oxygen and vacuum for minor surgery is approved. In lieu of the requirement, information submitted to the Department in support of the waiver indicated that the clinic's functional program does not require prolonged sedation and that portable gastric suction and oxygen is readily available, in the case of an emergency.

Waiver(s) will be evaluated at the time of on-site facility surveys, and the Department reserves the right to revoke approval(s) if deficiencies are cited which indicate waiver approval(s) adversely affect patient health and safety.

If you have any questions, please call Emile Guy at (617) 753-8178.

Very truly yours,

Jean Pontikas

Jean Pontikas
Assistant Director
for
Paul I. Dreyer, Ph.D.
Director

cc: Nina Edwards
Richard Cardarelli
Donna Allen
Barbara McCready
Emile Guy
Facility File
Waiver File
4women waiver let02

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Division of Health Care Quality
10 West Street, 5th Floor, Boston, MA 02111
(617) 753-8000

JANE SWIFT
GOVERNOR

ROBERT P. GITTENS
SECRETARY

HOWARD K. KOH,M.D.,MPH
COMMISSIONER

September 11, 2002

Carol Belding
President
Four Women, Inc.
150 Emory Street
Attleboro, MA 02703

RE: DoN Project #5-4885
and DoN .308 Exemption

Dear Ms. Belding:

I am pleased to inform you that the support documentation which you and your architect, *Richard Cardarelli, AIA*, submitted for **Four Women, Inc. a proposed new single-specialty freestanding ambulatory gynecological surgery center with two operating rooms, to be located at 150 Emory Street, Attleboro, MA 02703**, has been reviewed and meets the Department's criteria for plan approval under our "self-certification" process.

Based on the affidavit[1], the requested waivers and the architect's checklist[1], the plans submitted to this office on July 15, 2002 with revisions received on August 29, 2002 and September 6, 2002 are approved. This approval is not based on an actual plan review by this Department.

The requested waivers of the shared functional areas with a physician's practice; the combined reception/administrative office space; the multipurpose room; the medical records room; the x-ray film illuminator; the nurse call signals at each recovery bed; the step down recovery area; the housekeeping room size; the high speed sterilizer; the corridor width; and medical gas outlets will be addressed separately. Plan approval is contingent upon receiving waiver approval and meeting the waiver approval conditions.

You are reminded that it is your responsibility and that of your design representatives to design and construct the facility in accordance with the Department's applicable physical plant requirements. If at a later date this Department either reviews the plans or inspects the completed project and physical plant deficiencies are

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[1] The submitted forms were for compliance with the 2001 Edition of the AIA *Guidelines for Design and Construction of Hospital and Health Care Facilities*.

cited, it will be your responsibility to correct the areas of concern and to comply with the referenced regulations.

This plan approval format is for the Department of Public Health's Regulations only. It is still your responsibility to have the plans reviewed by the Department of Public Safety and the Attleboro Building Inspector.

This approval is limited to project development and does not provide for occupancy or utilization of the completed project.

I. PLAN APPROVAL CONDITIONS: PHYSICAL PLANT

This approval is contingent upon providing the required locked cabinets and medication refrigerator at the drug distribution stations.

You should also be aware that additional revisions to the plans may be needed to ensure compliance with the **Accessibility Guidelines of the Americans with Disabilities Act (ADA)**. This office, however, is not responsible for enforcing these guidelines.

Please note that, for Medicare/Medicaid Certification, it is the responsibility of the facility's owners and of their design representatives to design and construct the facility in strict compliance with the **National Fire Protection Association Life Safety Code (1985 Edition)** and the applicable related standards contained in the appendices of the Code.

II. PLAN APPROVAL CONDITIONS: DETERMINATION OF NEED

The following are conditions to plan approval, for compliance with Determination of Need approval conditions:

A. Pursuant to **DON Regulation 105 CMR 100.551(I)**, firm figures specifying the actual capital cost for this project must be submitted to the Determination of Need Program Director no later than 180 days after the receipt of this letter. This submission of final figures shall consist of: (1) A completed **Form 4 (Capital Cost Estimate)** and (2) Documentation (i.e., executed construction contract, equipment purchase agreement, etc.) of the major costs listed on **Form 4**.

Note: Division of Health Care Finance and Policy approval of the project's costs and charges cannot be obtained without submission of these final figures to the DON Program Director. Should you fail to submit these final figures within the specified time period, final approved project costs shall be deemed to be those set forth in the Notice of Determination of Need and any of its subsequent amendments, with the addition of inflation to the date of final plan approval.

B. Any amendment request for a cost increase must be submitted to the DON Program Director within 180 days of receipt of this plan approval letter.

C. Construction of this project must commence no later than the expiration date for the Determination of Need authorization period.

D. Contract change orders which alter or modify the scope of work as contained in the Notice of Determination of Need must be submitted to this office for prior approval.

E. A **Construction Status Report** form (copy enclosed) must be submitted to this office as follows:

1. The initial report is due no later than 30 days after receipt of this letter.

2. A quarterly report is due on a calendar basis, e.g. every January 1st, April 1st, July 1st, and October 1st.

3. The final report is due upon completion of the project.

For your convenience, you should reproduce a sufficient number of copies of the **Construction Status Report** form to cover the full period of construction.

III. SURVEY AND LICENSURE PROCESS

In order to initiate the survey and licensure process, it is your best interest to notify this Division in writing at least four (4) months before the anticipated dates of completion of construction and of occupancy of the new facility. This notification should be addressed to David Brown, Program Coordinator, Division of Health Care Quality, Department of Public Health, 10 West Street, 5th Floor, Boston, MA 02111.

If you have any questions, please call at (617) 753-8178.

Very truly yours,

Emile J. Guy
Project Engineer

Enc.

cc: Nina Edwards
Richard Cardarelli
Barbara McCready
David Brown
Clinic file

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned.**

Plans on 8½" x 11" sheets must be provided for clarification, as needed.

Four Women, INc, 150 Emory Street, Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : 9.5.D4

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities"[01]

Specific physical plant condition to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):

Administrative Offices share space with reception and pre-op rm

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

During most of the work week this space is empty. Staff can use this space to answer phones, book appointments, take messages.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

There will be no patients in the building when this space is being used for administrative purposes. If a supervisor needs privacy in speaking to a staff member, they can close a door in the pre-op counseling rooms.
Again, this cannot impact on patients as they will not be there.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

Medical record cabinets are to be placed behind the reception desk. These will be locked when not under the direct supervision of a staff person. A sign is planned to indicate this is a staff only area.

Signature of the facility's clinical representative _____

Representative's Name CArol Belding *Title* President *Tel.#* 508-222-

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: Emile Abry 9/19/02 ☒ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

*Attachments must include the facility's name and the referenced regulation number.

Four Women, Inc.
150 Emory Street
Attleboro, MA 02703

Waiver #2

Project Engineer's Waiver Comments/Conditions:

I recommend waiver approval to allow the administrative and business offices to be combined with the reception and pre-op areas in lieu of having separate functional areas away from public and patient areas.

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned**.

Plans on 8½" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc., 150 Emory Street, Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : 9.5.D5

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" 01

Specific physical plant condition to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):

Multipurpose room

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

The surgery center operates with limited hours, Wed and Fri evening and Saturday a.m. To rent additional space when there is adequate room not being used is unnecessary.

unnecessary

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

Staff meetings take place when the entire office is empty. Patients are not affected in any way. The physican office located next door is a part time practice. We will schedule a staff meeting when there are no patients scheduled. Four Women does not provide group counseling or group grief sessions at this time.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

Meetings will not be held anywhere inside the surgical suite. Pre-clinic announcements may be made individually or a memo posted in the staff changing room. If at a later date patient educational sessions were needed, alternative space would be located for the purpose.

Signature of the facility's clinical representative Carol Belding

Representative's Name Carol Belding *Title* President *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: Emil Ay 8/4/02 ☒ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

*Attachments must include the facility's name and the referenced regulation number.

Four Women, Inc.
150 Emory Street
Attleboro, MA 02703

Waiver #3

Project Engineer's Waiver Comments/Conditions:

I recommend waiver approval of not providing a multipurpose room.

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned.**

Plans on 8½" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc., 150 Emory Street, Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : 9.5.D6

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" 01

Specific physical plant condition to be waived *(e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):*

Medical records room

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

It is too costly to have another room for a limited number of medical records.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

Lack of separate room will not jeopardize patient health or safety or confidentiality. Offsite medical records can be accessed in time for an abortion appointment, which are made a day to a week ahead of time. All records on site will be secure with locked cabinets. Charts are numbered and have no names, they are out of reach of patients behind a desk in staff area.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

Two locking 36 inch wide medical record storage cabines will be placed in the reception area. They hold 3,300 typical abortion patient charts. This is approximately a year's worth of charts fo Four Women. Because the majority of women may only visit us one time, and charts must be held for many years, charts will then be stored according to Massachusetts regulations.

Signature of the facility's clinical representative Carol Belding

Representative's Name Carol Belding *Title* President *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: Emil Ruz 9/4/02 ☒ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Four Women, Inc.
150 Emory Street
Attleboro, MA 02703

Waiver #4

Project Engineer's Waiver Comments/Conditions:

I recommend waiver approval to allow the medical records to be stored within locked cabinets in the reception area in lieu of having a separate medical records storage area.

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned.**

Plans on 8½" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc., 150 Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : 9.5.F2.e

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" 01

Specific physical plant condition to be waived *(e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):*

X-ray film illuminator

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

This adds unnecessary and unused equipment to an OR.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

~~Patients will not be affected. X-Rays are not used~~ in abortion care.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

None, there is no need for X-ray film illuminator. There is a light table in the dirty room that could be cleaned and used in some odd emergency, but that should not be the case.

*Signature of the facility's **clinical** representative* Carol Belding

Representative's Name Carol Belding *Title* President *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: Emil Gery 8/4/02 ☒ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Four Women, Inc.
150 Emory Street
Attleboro, MA 02703

Waiver #5

Project Engineer's Waiver Comments/Conditions:

I recommend waiver approval of not having x-ray film illuminators in the ORs as x-rays are not used in the abortion process.

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned**.

Plans on 8½" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc., 150 Emory Street, Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : ~~9.5.F3~~ Policy

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" 01

Specific physical plant condition to be waived *(e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):*

Nurses call button at each bed

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

This kind of service is not usually found in abortion facilities
It adds to expense and complicates an already uncomplicated procedure and recovery.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

The recovery room is not very large. There is designated space for five recumbent chairs. There is a nurse and usually a medical assistant with patients at all times. (The nurse cannot leave the room without the float nurse covering her.) No patient is out of hearing or sight. If curtains are closed, they are closed to the sides of women next to a patient, not the nurses.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

Women in our recovery room are under constant supervision. They are usually alert and sitting up. They can tell us if they are in distress. We can provide a bell or something that can alert staff if the patient needs help. buzzer
See attached policy for the recovery room.

*Signature of the facility's **clinical** representative* Carol Belding

Representative's Name Carol Belding *Title* President *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: Emil Ptey 9/8/02 ☒ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Four Women, Inc.
150 Emory Street
Attleboro, MA 02703

Waiver #6

Project Engineer's Waiver Comments/Conditions:

I recommend waiver approval of the policy requiring a nurse call sending station at each recovery bed.

FOUR WOMEN, INC.

TITLE: RECOVERY ROOM STAFFING/ SAFETY

PURPOSE: To maintain patient safety during recovery period.

POLICY: **I. Location**

It is the policy of Four Women, Inc. to maintain the safety of all patients. The recovery room has designated space for five recumbent chairs. The recovery room layout at Four Women, Inc. provides an unobstructed view of all patients, therefore women in the recovery room are under constant supervision.

When privacy becomes necessary for a patient, the curtain between the recumbent chairs can be drawn. Although the closing of curtains between patients maintains the privacy of the women in the recovery room, it does not obstruct the staff's view of the other patients.

II. Staff

The recovery room staff consists of at least one R.N. and a medical assistant for up to 5 patients. The R.N. must remain in the recovery room at all times, unless relieved by another R.N. or other licensed staff.

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned.**

Plans on 8½" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc., 150 Emory Street, Attleboro, MA 02703

Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : 9.5.F4

105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" [01]

Specific physical plant condition to be waived *(e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):*

Step-down recovery area

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

It is not customary for a step down recovery area to be used in abortion care. Space is expensive and it would get little or no use.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

Again, it is not customary for a step down recovery lounge to be used in abortion care. A woman spends approximately 45 minutes in the recovery room chair and leaves on her own, not in a wheel chair.
~~A step down lounge is not needed in abortion care as recovery~~ time is relatively brief.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

All women receive refreshment in their recovery room chair. They spend all the time they need in that chair. This gives a person a feeling of well-being as they have one nurse. When a woman is discharged she is able to dress herself and walk out the door.

*Signature of the facility's **clinical** representative* Carol Belding

Representative's Name Carol Belding *Title* President *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: [signature] 9/4/02 ☒ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Four Women, Inc.
150 Emory Street
Attleboro, MA 02703

Waiver #7

Project Engineer's Waiver Comments/Conditions:

I recommend waiver approval of not providing a step down recovery area as it is nor required by the service as described by the facility.

PHYSICAL PLANT WAIVER REQUEST FORM

Massachusetts Department of Public Health - Division of Health Care Quality
10 West Street, 5TH Floor, Boston, MA 02111 - (617) 753-8000

Please note: Any waivers which are approved will be evaluated at the time of the facility's on-site survey and the Department reserves the right to revoke an approval if deficiencies are cited that indicate a waiver approval adversely affects the patients' health and safety. Waiver requests must clearly state the nature of the request and provide suitable supporting documentation under parts a, b, and c below. **Incomplete forms will be returned.**

Plans on 8½" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc. 150 Emory Street, Attleboro, MA 02703
Facility's Licensed Name or Proposed Name — Address, including zip code

If hospital or clinic satellite, name — Address, including zip code

Regulation or "Guideline" section number-Complete one form for each waiver request : 9.5.F5.m
105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" 01

Specific physical plant condition to be waived *(e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):*

Housekeeping room

Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Term Care Facilities, contingent upon the following:

a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)

Space for the center is at a premium and an entire room could not be dedicated for housekeeping. It was too costly.

b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the facility's capacity to give adequate care. (Attach additional pages as necessary.*)

Patients will not be affected by the lack of a housekeeping room
Other housekeeping facilities will be provided, see below.
The housekeeping equipment is used for touch ups and small cleaning jobs: Professional cleaners come in with heavy equipment and supplies to clean floors and walls. Service Master has cleaned the floors and Naps from Attleboro.

c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)

Two smaller housekeeping closets are provided. Sinks are in each closet, racks will be provided to hang mops, brooms, and other housekeeping supplies. A rolling bucket will be purchased to fit under the sink.

*Signature of the facility's **clinical** representative* Carol Belding

Representative's Name Carol Belding *Title* President *Tel.#* 508-222-7555

For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)

Proj. Eng: [signature] 2/12/02 ☑ Approval ☐ Approval w/conditions ☐ Denial

Pro. Adm: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial

Asst. Dir: ___/___/___ ☐ Approval ☐ Approval w/conditions ☐ Denial