

MITT ROMNEY GOVERNOR

KERRY HEALEY
LIEUTENANT GOVERNOR

RONALD PRESTON SECRETARY

CHRISTINE C. FERGUSON COMMISSIONER

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

Dear Ms. Belding:

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

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)

Very truly yours,

Sherman R. Lohnes Assistant Director

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.

Waivers Continued: Page 2

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.

Waivers Continued: Page 3

- 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 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



JANE SWIFT GOVERNOR

ROBERT P. GITTENS SECRETARY

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

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

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

September 11, 2002

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 affidavit¹, the requested waivers and the architect's checklist¹, 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

 $^{^{1}}$ 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

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.
 - 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



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.

Facility's Licensed Name or Proposed Name	Address, including zip code
If hospital or clinic satellite, name	Address, including zip code
Specific physical plant condition to be waived (e.g. room	CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensu A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement
Administrative Offices shar	re space with reception and pre-op rm
Physical plant requirements may be waived pursuant to Term Care Facilities, contingent upon the following: a) Specify how compliance would cause undue hard:	o 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long
During most of the work week	this space is empty. Staff can use
this space to answer phones,	book appointments, take messages.
	•
There will be no patients in	e the health or safety of the patients and does not limit the ional pages as necessary.*) the building when this space is
There will be no patients in the being used for administrative privacy in speaking to a staff in the pre-op counseling rooms Again, this cannot impact on property compensating features that will be instituted. Medical record cabinets are to desk. These will be looked with the looked w	the building when this space is purposes. If a supervisor needs f member they can close a door set to be there.
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PAGEO OF Y

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.

privacy in speaking to a staff member they can close a deor

desk, These will be locked when not under the direct super-



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 81/2" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc.,	150-Emory-Street, Attleboro, MA02703 Address, including zip code
If hospital or clinic satellite, name	Address, including zip code
Regulations": 105 CMR 130.000 "Hospital Licensure Regulations": 105 CMR 130.000 "Hospital Licensure Regulations of the second of	Inplete one form for each waiver request: 9.5.D5 Itities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Illations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):
Multipurpose room	
	ursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long ving: due hardship. (Attach additional pages as necessary.*)
The surgery center evening and Saturo is adequate room	day a.m. To rent additional space when there not being used is unecessary.
	n unnec essary
located next door a staff meeting wh Four Women does not sessions at this ti c) Specify compensating features that will be	is a part time practice. We will schedule en there are no patients scheduled. provide group counseling or group grief me. einstituted. (Attach additional pages as necessary.*)
in the staff chang If at a later date alternative space wo Signature of the facility's <u>clinical</u> representative	patient educational sessions were needed, ould be located for the purpose.
	ngTitle_President Tel.#508-222-7555
Proj. Eng: The Hy	Approval Approval Wconditions Denial Approval Approval Approval Wconditions Denial
Asst. Dir:	
*Attachments must include the fa	cility's name and the referenced regulation number. PAGE 3 OF 14

Project Engineer's Waiver Comments/Conditions:

I recommend waiver approval of not providing a multipurpose room.

located next door is a part time practice. We will achedule a staff meeting when there are no pattents scheduled.



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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	Four Women,	Inc., 1	50 Emory	Street,	Attleb	oro,	MA	02703	
Facility's Licensed N	Name or Proposed Name			Address, include		<u>-</u>			
If hospital or clinic s	atellite, name			Address, include	ding zip code				
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For DPH -	Division of Health	Care Quali	ty use only:	(comments/co	onditions of	approva	al on ba	ack of form)	
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ly 2001	*Attachments must i	nclude the facil	lity's name and th	ne referenced rea	ulation number	er		PAGE OF	14

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.

accessed in time for an about to appoint seat, which are sade

washers agreeting to massachusetts regulations. (o.c. Ch. c. d.

a day to a week ahead of time. All records on site will be secure



July 2001

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" 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 usedin 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 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) 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.

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.



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 81/2" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc., 150	Emory Stree	et, Att	leboro.	MA	02703	
Facility's Licensed Name or Proposed Name		luding zip code				
If hospital or clinic satellite, name	Address, inc	uding zip code	·			_
Regulation or "Guideline" section number-Complete one for 105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CM Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. Specific physical plant condition to be waived (e.g. room are	R 145.000 "Out-of-Ho "Guidelines for Design a 98 SF vs. 100 SF, r	spital Dialysis		MR 140.00		
Nurses call button at e	each bed					
Physical plant requirements may be waived pursuant to Term Care Facilities, contingent upon the following: a) Specify how compliance would cause undue hardsh					53.031(B), Lo	ng
This kind of service is	not usual	ly fou	nd in a	borti	on faci	lities
It adds to expense and procedure and recovery.	complicate	s an a	lready	uncon	nplicated	d -
	•					
The recovery room is no space for five recumber a medical assistant wit cannot leave the room we no patient is out of he they are closed to the compensating features that will be instituted.	h patients ithout the aring or s women next (Attach additiona	float into a pages as	times nurse of f curta patient necessary.*	urse . (T cover ain s not	and usually and usually and usually and usually and	<u> </u>
Women in our recovery r are usually alert and s in distress. We can pr staff if the patient new See attached policy.for	ovide a be eds help.	They	can tel comethir	ll us	if they at can a	lert
Signature of the facility's <u>clinical</u> representative		Car	olBel	dap		
Representative's Name_Carol_Belding	TitlePres					_
For DPH - Division of Health Care Quality use or	nly: (comments/	conditions of	of approval	on back	of form)	
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uly 2001 *Attachments must include the facility's name					AGE 6 OF 1	<u></u>

Project Engineer's Waiver Comments/Conditions:

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

a medical assistant with patients at all times, (The nerse cannot leave the room Without the float nerse covering ner.)
No patient is out of hearing or sign. If nurtain a are closed, they are closed to the "Somen next to a patient, not the nurses wanting features that will be instituted. (Alloy additional pages as necessary.)

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.

Four Women, Inc. 03/03



July 2001

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 81/2" x 11" sheets must be provided for clarification, as needed.

Address, including zip code Address, including zip code	Four Women, Inc., 150 Emory Street, Attleboro, MA 027	0.3
Regulation or "Guideline" section number-Complete one form for each walver 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 145.000 "Clinic Signature of The Regulations of The The Regulations of The Regulations of The The Regulations of The Regulations of The The Regulatio		
105 CMR 150.000 **Licensing of Long Term Care Facilities**; 105 CMR 140.000 **Control Licensure Requisitions**; 105 CMR 130.000 **Control Hospitals and H	If hospital or clinic satellite, name Address, including zip code	
The 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.	Regulations'; 105 CMR 130,000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Faction 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 requi	cilities" ⁰¹
be used in abortion care. Space is expensive and it would get little or no use. Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the acility'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 important the complete of the covery of the covery of the covery at the covery of t	Term Care Facilities, contingent upon the following: a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)), Long
Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the acility'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 specify compensating realty is in the 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. Again, it is not customary for a step down recovery loung recovery loung chair and leaves on the 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. Again, it is not customary for a step down recovery loung approval on back of form) For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form) Proj. Eng: Approval Approval Approval w/conditions Denial	It is not customary for a step down recovery area to be used in abortion care. Space is expensive and it	
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Proj. Eng:	lounge to be used in abortion care. A woman spends approximately 45 minutes in the recovery room chair an leaves on her own, not in a wheel chair. A step down lounge is not needed in abortion care as recompleted in abortion care as recompleted in abortion care as recompleted in the is relatively brief (Attach additional pages as necessary.*) All women receive refreshment in their recovery room compared in the control of	ecovery hair. gives e. When
Pro. Adm:	Signature of the facility's <u>clinical</u> representative Carol Beld	7
Proj. Eng:	Representative's Name <u>Carol Belding</u> Title <u>President</u> Tel.# 508-222-	7555
Proj. Eng:	For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form	
	Proj. Eng: Approval Approval Approval Mconditions De	enial
Asst. Dir:	Pro. Adm:	enial
	Asst. Dir:	enial

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

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.

approximately 45 minutes in the recovery room chair and

a person a feeling of well-being as they have one nerse. We a woman is discharged she is able to dress herself and walk out the door.



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Plans on 81/2" x 11" sheets must be provided for clarification, as needed.

Facility's Licensed Name or Proposed Name 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" 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.
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 clear Professional cleaners come in with heavy equipment and supplies of Specify compensating features that will be instituted. (Attach additional pages as necessary.) Leaned the floor touch was started to 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 <u>clinical</u> representative
Representative's NameCarol BeldingTitle_presidentTel.#_508-222-7555
For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)
Proj. Eng: Approval Approval Approval Wconditions Denial
Pro. Adm:
Asst. Dir:
*Attachments must include the facility's name and the referenced regulation number.

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.

Other housekeeping facilities will be provided, see below.

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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 ea 105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.0 Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelin Specific physical plant condition to be waived (e.g. room area 98 SF High Speed Sterilizer	000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure
Physical plant requirements may be waived pursuant to 105 CM Term Care Facilities, contingent upon the following: a) Specify how compliance would cause undue hardship. (Att	ttach additional pages as necessary.*)
This is an added expense and abortion center.	d it is not usually found in an
b) Specify how non-compliance does not jeopardize the he facility's capacity to give adequate care. (Attach additional page	ealth or safety of the patients and does not limit the
	by the lack of a high speed sterilizer.
There are ample sterile inst	ruments to be used in any given clinic.
c) Specify compensating features that will be instituted. (Attac	ch additional pages as necessary.*)
More sets are kept in storage more patients show up than the can run several sets through	e than are needed in any day. If here are sterile wrapped sets, we the sterilizer and "flash" them. e instruments they are all inter-specialty items. We also have
Signature of the facility's <u>clinical</u> representative	extra items packed
Representative's NameCarol_Belding7	Title President Tel.# 508-222-7555
For DPH - Division of Health Care Quality use only: (ca	
Proj. Eng: Emlethy 514 F	Approval Approval w/conditions Denial
Pro. Adm:	
Asst. Dir:	Approval ☐ Approval w/conditions ☐ Denial
uly 2001 *Attachments must include the facility's name and the r	

Project Engineer's Waiver Comments/Conditions:

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



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Plans on 81/2" 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" of 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 IOOt Corridor width in OR suite 5 feet in all
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. create a vibration sound. It would be better for patients to specify how have ompliance 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.*) have a door of for quiet. Most patients go to the recovery room walking with a medical staff person. Those who have had light sedation are groggy, but room.
There is plenty of room to get someone safely out of the building in an emergency. Specify compensating features that will be instituted. (Attach additional pages as necessary.*)
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 whool about / 1 2
ignature of the facility's clinical representative
Pepresentative'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: Snl. fly Sproval Approval Approval Wconditions Denial
Pro. Adm:
Asst. Dir:
y 2001 *Attachments must include the facility's name and the referenced regulation number. PAGE OF 1

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.

awake and ere in a wheel-chair, again asoutted to the recovery

moonsafing features that will be instituted. (Alach additional bages as necessary?)



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

If hospital or clinic satellite, name	four women, Inc.	, 150 Emory Street, Attleboro, MA 02703
Regulation or "Guideline" section number-Complete one form for each walver request 9.2 1 E5 and table 9.2 105 CMR 150.000 "Learning of Long Term Care Facilities": 105 CMR 150.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; 105 CMR 150.000 "Clinic Specific Physical plant condition to be walved (e.g. room area 98 SF vs. 100 SF, minimum diamenson 46" vs. 52 part or entire requirement): 2 OX & 2 VAC Class B: intermediate surgery (sedation) Physical plant requirements may be walved 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 procedur 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. Representative's Name_Carol_Belding Title President Tel#_508-222-1555 For DPH - Division of Health Care Quality use only: (comments/conditions of approval w/conditions Denial Pro. Adm: Approval Approval Approval w/conditions Denial Denial Denial Denial		
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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 procedur table in the Ox. 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 Ox table and immediatly available in case of emergency. Representative's Name Carol Belding Title President Tel#_508_222_1555 For DPH-Division of Health Care Quality use only: (comments/conditions of approval on back of form) Proj. Eng: Approval Approval Approval w/conditions Denial Pro. Adm: // Approval Approval Approval w/conditions Denial Pro. Adm: // Approval Approval Approval w/conditions Denial Pro. Adm: // Approval Approval Approval w/conditions Denial	Regulations"; 105 CMR 130.000 "Hospital Licensure R. Specific physical plant condition to be waive	acilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure egulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" ⁰¹ 6d (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):
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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 Representative's Name Carol Belding Title President Tel# 508-222-7555 For DPH - Division of Health Care Quality use only: Approval Approval Approval w/conditions Denial Pro. Adm: Approval Approval Approval w/conditions Denial Asst. Dir: Approval Approval Approval w/conditions Denial	The cost of insta	alling a full piped in oxygen and vacuum system
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 Representative's Name Carol Belding Title President Tel# 508-222-7555 For DPH - Division of Health Care Quality use only: Approval Approval Approval w/conditions Denial Pro. Adm: Approval Approval Approval w/conditions Denial Asst. Dir: Approval Approval Approval w/conditions Denial		•
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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 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 Approval w/conditions Denial Asst. Dir: Approval Approval Approval w/conditions Denial	c) Specify compensating features that will	be instituted. (Attach additional pages as necessary.*)
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For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form) Proj. Eng: Approval Approval Approval w/conditions Denial Pro. Adm: Approval Approval Approval w/conditions Denial Asst. Dir: Approval Approval Approval w/conditions Denial	signature of the facility's <u>clinical</u> representative	- Canel Beldy
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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.

before hand, emergency gastric specificating is incredibly rare

Oxygen dosing is more often but is of short duration



July 2001

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105 CMR 150.000 *Leensing of Long Term Care Facilities** (105 CMR 140.000 *Cut-6Hospital Dialysis Units*: 105 CMR 140.000 *Clinic Licensure Regulations*: 105 CMR 130.000 *Cut-6Hospital Dialysis Units*: 105 CMR 140.000 *Clinic Licensure Regulations*: 105 CMR 130.000 *Cut-6Hospital Dialysis Units*: 105 CMR 140.000 *Clinic Licensure Regulations*: 105 CMR 130.000 Cut-6Hospital Dialysis Units*: 105 CMR 140.000 *Clinic Care Facilities** **Specific physical plant condition to be waived (e.g. room area 98 5° x*: 100 5K, minimum diamension 46° vs. 5; pard or entire requirement): 1	Four Women, Inc., 150 Emor	ry Street, Attleboro, MA 02703
Regulation or "Guidelline" section number-Complete one form for each walver request: 9.31.E5 tal 105 CMR 150.000 "Licensing of Long Term Care Facillites": 105 CMR 145.000 "Out-6-Hospital Dialysis Units: 105 CMR 150.000 "Cline Licensaus" Specific physical plant condition to be waived (e.g. room area 98 SF vz. 100 SF, minimum dimension 48" vs. 5", part or entire requirement): 1 OX & 1 VAC for each bed, Class A: Post-anesthesia recovery 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 systems \$500,000 from Coast to Coast Medical. (approximate) The 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 a are awake and alert the entire time. An oxygen tank (portabland agastric suction machine (portable) will be placed next 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 por able will be placed next to each recovery room chair. These are perfect and safe for a simple procedure such as an abortic emergency back up Signature of the facility's clinical representative Representative's Name Carol Belding Title President Tel.# 508-212-7555 For DPH-Division of Health Care Quality use only: (comments/conditions of approval on back of form) Proj. Eng: Definition of Health Care Quality use only: (comments/conditions of approval w/conditions Denial Proj. Administration of the provided provided	Facility's Licensed Name or Proposed Name	Address, including zip code
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Asst. Dir:	Asst. Dir:	/ Approval

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

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.

are awake and alert the entire time. An oxygen tank (portable)



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Plans on 81/2" x 11" sheets must be provided for clarification, as needed.

	Four	Women,	Inc.,	150	Emory	Street,	Attleboro	, MA	02703	
Facility's Licensed N	lame or Pro	posed Name				Address, includ	ing zip code			
If hospital or clinic sa						Address, includ	0 1			
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Signature of the	facility's	<u>clinical</u> repre	esentative				Caroli	Zel	dip	
Representative's	s Name_	Carol	Beldir	ı g		_TitlePre	esident	Tel.#	5 08-22	2-7555
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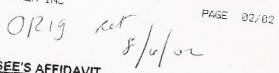
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Plans on 81/2" x 11" sheets must be provided for clarification, as needed.

	Four Women, Inc., 150 Emory Street, A	ttleboro, MA 02703
Facility's Licensed	nsed Name or Proposed Name Address, including a	zip code
If hospital or clinic	linic satellite, name Address, including a	zip code
105 CMR 150.00	or "Guideline" section number-Complete one form for each waiver request 0.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Caysical plant condition to be waived (e.g. room area 98 SF vs. 100 SF, minimum	onstruction of Hospitals and Health Care Facilities" ⁰¹
	1 OX & 1 VAC Class A: minor surgery (local anesthesia)
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	The cost of installing a full piped i was estimated to be approximately \$50 in Fall River, MA. This is not an af	0,000 by Coast to Coast Medica
b) Specify he facility's capa	how non-compliance does not jeopardize the health or safety apacity to give adequate care. (Attach additional pages as necessary to perform. Due to the nature of about to perform to perform to the nature of about to before hand, emergency gastric suction of the control of the nature of the control of the	e minutes for the surgeon rtion surgery, and fasting ning is incredibly rare.
c) Specify co	compensating features that will be instituted. (Attach additional parthere There will be at least one port procedure table in the OR. This will emergency use and checked at the begin A portable gastric suction machine.	able oxygen tank next to the be ready for immedate nning of each surgical day.
	the OR table.	Carolbeldup
Signature of to	of the facility's <u>clinical</u> representative	T. # 500 200 7555
Representativ	ative's Name <u>Carol Belding</u> Title <u>Pre</u>	sident101.#_5081-222-7555
For DP	DPH - Division of Health Care Quality use only: (comments/con	ditions of approval on back of form)
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Asst. Dir:_	ir:	al ☐ Approval w/conditions ☐ Denial
July 2001	*Attachments must include the facility's name and the referenced regu	lation number. PAGE # OF LY

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.





ARCHITECT AND LICENSEE'S AFFIDAVIT (Check Appropriate Facility Type)

(Check Appropriate Facility Type)									
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1 It has a second of the secon									
plant improvements (please note about 10 miles)									
The undersigned Architect hereby certifies: 1. It has created the architectural plans and specifications attached hereto as Attachment 1 (the "plans") regarding physical or proposed licensed name.) The undersigned Architect hereby certifies: DIALYSIS FACILITY 1. It has created the architectural plans and specifications attached hereto as Attachment 1 (the "plans") regarding physical at (Note the facility's linguistics).									
plant improvements (please note a brief project vascription) ambulatory surgical center at (Note the facility's licensed									
Four Women, Inc. 150 Emory St., Attleboro MA 02703									
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2. The plans have been re	Viewed against		city/town						
145.000 et sen and the	MR 150,000 et segurations out	lined in applicable Massac	husaite Dane						
2. The plans have been reviewed against regulations outlined in applicable Massachusetts Department of Public Health Hospital and Health Cere Facilities as serious of the ^{2, 5, 8, 4} 2001 Edition o									
3. To the unit of separate to the facility type.									
and regulations in all material especial									
required, separate waiver form	3. To the undersigned's knowledge, information and belief, the plans meet the requirements of the above referenced codes required, separate waiver forms are attached for each item: 9.5.F5.P								
	9.5.F5.P	1	multipers) for which waivers will be						
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Signature:	Mare 11	11, A.I.A.	Architect's Stamp						
Name: Richard	eace .		Senate L						
Title: Sole Pro-	Cardarelli, A.I.	Α.	3						
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certification or approximately	roposed licensee undans		The Assert of the State of the						
Health Care Quality of the Depart	process undertaken pursuant	is and agrees that notwith:	standing the plad						
4. The undersigned Licensee/proposed licensee understands and agrees that notwithstanding the plan approval self-submitted herewith and/or inspect the work with regard thereto, and (b) withdraw its approval thereto. 5. The facility, Four Women changes required by the Common self-submitted herewith and/or inspect the work with regard thereto, and (b) withdraw its approval thereto.									
5. The facility, Four Women shared thereto, and (b) withdraw its approval thereto. changes required by the Division to comply with the above mentioned codes and regulations whether or not physical plant or clinic satellite note both the parent and satellite's name.)									
construction or alteration to	o comply with the above	shall have a con	tinuing -t is						
construction or alterations have been or clinic satellite note both the parer Facility Four Women	en completed. (Note the facility	soned codes and regulation	is whether or not physical in						
Facility	it and satellite's name.)	a masheed or proposed lice	nsed name and if it is a hospital						
Name: Four Women,	INC. A	uthorized	Carren Bood	7/12/0					
Address: 150 Emory St		Signature:	rede of result	· ·					
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Attleboro, M.	A 02703		Belding	2012					
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PLEASE SUBMIT THE ORIGINAL AFFIDAVIT, NOTA COPY. CARD									
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ARCHITECT AND LICENSEE'S AFFIDAVIT

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Four Wo facility's licensed name or proposed name	omen, Inc., 150 address	0 Emory S	Attleb	OCO MA	0.2703zip code
if hospital or clinic satellite, name	address			city/town	zip code
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and regulations in all materi required, separate waiver fo	rms are attached for each	non-conforming h item:	items (list regul	ation numbers) for which waivers will be
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Architectural Firm Name:		rdarelli,	A.I.A.		Architect's Stamp
Signature:		_			
Name: Richard	J. Cardarelli,	A.I.A.			
Title: Sole Pro					
Date:	_Revision Dates:				
4. The undersigned <u>Licens</u> certification or abbreviated re Health Care Quality of the Desubmitted herewith and/or ins 5. The facility, For changes required by the Divisionstruction or alterations have or clinic satellite note both the	partment of Public Healt pect the work with regard ur Women sion to comply with the a	th (the "Division" I thereto, and (b)	shall have cont withdraw its app	ompanying doc inuing authorit proval thereto. a continuing	cuments, the Division of y to (a) review the plans obligation to make any
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PLEASE SUBMIT THE ORIGINAL AFFIDAVIT, NOT A COPY.



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

Four Women, Inc. 150 Fmore Gt	
Four Women, Inc., 150 Emory Street, Attleboro, MA 02703	
Address, including zip code	
If hospital or clinic satellite, name	
Address, including zin 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 Licen Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities 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 of the 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 of the 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 of the 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 of the 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 of the 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 of the 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 of the 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 of the 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 of the specific physical physical plant condition to the specific physical physic	 sure s" ⁰¹ nt):
Tada width in OK Suite. 5 feet in other	
Term Care Facilities, contingent upon the following: a) Specify how compliance would cause undue hardship. (Attach additional and a specify how compliance would cause undue hardship.	ong
Space is expensive and at a promise to a space is expensive and at a promise to a space is expensive and at a promise to a space is expensive.	
Space is expensive and at a premium. We feel patients can be safely transported or safel	
recovery room with hallway widths as drawn	
Abortion care can be noisy as there are suction machines the create a vibration sound. It would be better for patients facility's conspiliance does not jeopardize the health or safety of the reference and leaves and leaves are safety of the reference are safety of t	
b) Specify how hark-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.*) have a door for quiet most patients go to the recovery room walking with a medical staff person. Those who have had light sedation are groggy, room.	t. L but ery
There is plenty of room to get someone safely out of the bui in an emergency. Specify compensating features that will be instituted. (Attach additional pages as pages as pages as the second of the built	ldin
foot corridor to the OR corridor is 8 feet. There is a short privacy. We can remove the door from the plans if you so de	six ound sire
ignature of the facility's <u>clinical</u> representative	
epresentative's Name Carol Belding	
For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)	7
7(0), Eng.	
Pro. Adm:	
Asst. Dir:	
/ Approval	
*Attachments must include the facility's name and the referenced regulation number. PAGE OF	36

PAGE ___ OF___

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.

- 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.

Instru	ctions:

- The Checklist must be filled out completely with each application.
- 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
- X = Requirement is met.

- \boxtimes = 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 W = Waiver requested for Guidelines, Regulation or Policy the existing space or area will serve a new or relocated service or if the facility is currently not licensed & applying for licensure.
 - requirement that is not met (for each waiver request, complete separate waiver form & list the requirement ref. # on the affidavit).
- Mechanical, plumbing and electrical requirements are only partially mentioned in this checklist. 3. 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

Facility Name: Four Women, Inc.	Guidelines or of the Regulations.			
		2/5/02		2/12
Facility Address: 150 Emory Street				res
Satellite Name: (if applicable) Attleboro, MA 02703		•••••••••••••••••••••••••••••••••••••••	3/3/02	
	DON Iden	ntification: (if a	pplicable)	
Satellite Address: (if applicable)	5 <u></u>	4885		
Project Reference:				
	Building/F	loor Location	1:	
	groun	d/first	floor	
OPTIONAL ASSOCIATED SERVICES IN PROJECT (CHECKLISTS ATTACHED)				
Medical Clinics / Hosp. Outpatient Depts Outpatient Diagnostic Fac	cilities	☐ End	loscopy Suites	

9.5.E2

9.5.E3

X Clean assembly/workroom

space for carts

x Clean/sterile supplies

x terminal sterilization equipment

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

		Page 3 of
0.55	ARCHITECTURAL REQUIREMENTS	MECHANICAL/PLUMBING/
9.5F		ELECTRICAL REQUIREMENTS
9.5.F1	Exam/testing room x min. 80 sf charting counter/shelf x sight/sound privacy	 X Handwashing station X Vent. min. 6 air ch./hr X Portable or fixed exam light X Min. 2 el. duplex receptacles
	 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 _x 10'-0" minimum dimension _x min. 3'-0"clearance on all sides of operating tab _W X-ray film illuminator	W 1 OX & 1 VACX Vent. min. 6 air ch./hrX positive pressure pleX Portable or fixed exam light
9.5.F3	X Post-anesthesia recovery roomX min. 1 recovery station per OR	$\underline{\hspace{0.1cm}}$ Handwashing station
7.7B2 Policy	 x min. 2'-6" clearance on sides and end of beds x cubicle curtains x beds located for direct observation from nurses station 	Access to bedpan cleaning equipment 1 OX & 1 VAC for each bed Nurses call button at each bed
	separate pediatric recovery space check if no pediatric surgery is performed space for parents Class B: intermediate surgery (sedation)	_★ Vent. min. 6 air ch./hr
9.5.F2.c	Check if service not included in project X Operating roomsx sole access through restricted corridorx min. 250 sfx 15'-0" minimum dimensionx min. 3'-6"clearance on all sides of operating table X-ray film illuminator	 X Portable or fixed exam light 8 elec. duplex receptacles (36" AFF) X Lighting, all receptacles & fixed equipment on emergency power
9.5.F3 7.7B2 Policy	 Post-anesthesia recovery room min. 2 recovery stations per OR min. 3'-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 	X Emergency communication X Handwashing station X Access to bedpan cleaning equipment 1 OX & 1 VAC for each bed Nurses call button at each bed Vent. min. 6 air ch./hr

ARCHITECTURAL REQUIREMENTS

Class C: major surgery (regional or general anesthesia)

MECHANICAL/PLUMBING/ **ELECTRICAL REQUIREMENTS**

check if service not included in project 9.5.F2.d ___ Operating rooms sole access through restricted corridor _ 2 OX & 3 VAC Vent. min. 15 air ch./hr ___ min. 400 sf ____ 18'-0" minimum dimension ___ positive pressure min. 4'-0"clearance on all sides of operating table ____ 2 remote return registers near ___ X-ray film illuminator 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 Post-anesthesia recovery room 7.7B2 ___ min. 3 recovery stations per OR Policy min. 4'-0" clearance on sides and end of beds Handwashing station ___ Access to bedpan cleaning ___ sight/sound privacy beds located for direct observation from nurses equipment _ 1 OX & 1 VAC for each bed station ___ Nurses call button at each bed separate pediatric recovery space check if no pediatric surgery is performed __ Vent. min. 6 air ch./hr ___ space for parents 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	Page 5 of
0.5.55	•	MECHANICAL/PLUMBING/
9.5.F5 9.5.F5.a	X SUPPORT SERVICES	ELECTRICAL REQUIREMENTS
9.5.F5.b	Control station at entrance of operating suite	
3.3.73.0	and all station	
	x refrigerator	Handwashing station
	double locked storage	
9.5.F5.c	X Scrub stations	
	X near each OR entrance	x Knee/foot controls
	each serves not more than 2 OR's	or
	The more than 2 OR's	Electronic sensor controls on
9.5.F5.d	x Soiled workroom(s)	emergency power (Policy)
	x work counter	-X Handwashing station
9.5.F5.e	waste recentacle	Clinical flushing-rim sink
3.3.F3.e	x soiled workroom(s) convenient to OR's	X Vent. min. 10 air ch./hr (exhaust)
	7, 3, 3, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,	_x negative pressure
0.550		
9.5E3	—x Clean/sterile supplies	
		X Vent. min. 6 air ch./hr
9.5.F5.f	Anesthesia workraam (X Temperature/humidity control
	Anesthesia workroom for Class C surgery	10X & 1 MA
	check if function & Class C surgery not included in project	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	3.10 04.00010
9.5.F5.g		
9.5.F5.h	X Medical gas supply & reserve storageX Equipment and stretcher storage	_x_ Vent. min. 8 air ch./hr
9.5.F5.i		_x all air exhausted to outdoors
0.0.1 0.1	_x Staff change areas	an exhausted to outdoors
	X lockers	
	_x showers	
	x toilets	x Handwashing stations
	space for donning scrub suits and booties	_x Vent. min. 10 air ch./hr (exhaust)
0.5.55:	X one-way traffic directly into surgical suite	x vont. min. 10 air ch./hr (exhaust)
9.5.F5.j	X Outpatient surgery change areas	
	x waiting room	
	x lockers	11
	-x toilets	
	-x clothing change areas	X Vent. min. 10 air ch./hr (exhaust)
0.5.55	space for administering medications	
9.5.F5.k	X Stretcher storage	
9.5.F5.I	x Staff lounge	
	x Staff toilets	
	x off surgical suite	x Handwashing station
9.5.F5.m	X near recovery area	x Vent. min. 10 air ch./hr (exhaust)
0.0.1 0.111	W Housekeeping room	
9.5.F5.n	X MATERIAL CONTRACTOR OF THE C	X Service sink
9.5.F5.o	X Wheelchair storage	_x_ Vent. min. 10 air ch./hr (exhaust)
9.5.F5.p	Access to crash carts for surgery & recovery	
- 1	High-speed sterilizer	

GENERAL STANDARDS

Details and Finishes

Corridor width:

- W min. 8'-0" corridor width in surgical suite
- _xmin. 5'-0" corridor width in other patient areas Staff corridors
- _xmin. 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
- <u>x</u> 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 Electrical (9.32) (9.2.H1.g)
 - 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
 - wet cleaned flooring resists detergents
 - 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

- (7.28.B8)
- ___ monolithic ceilings or _x washable ceiling tiles with gasketed &

clipped down joints

ELEVATORS

- Provide at least or one elevator in multistory facility
 - ___ wheelchair accessible
 - _ each elevator meets 9.30.B requirements
- X Each floor has an entrance located at outside grade level or HC accessible by ramp from outside grade level

Mechanical (9.31.D)

- Mech. ventilation provided per Table 7.2
- x Exhaust fans located at discharge end
- Fresh air intakes located at least 25 ft from exhaust outlet or other source of noxious fumes
- _X Contaminated exhaust outlets located above roof
- Ventilation openings at least 3" above floor
- 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. 41/2" long
- x blade handles at scrub, clinical sinks min 6" long
- _₩ Medical gas outlets provided per 9.31.E5 & Table 9.2
- X No flammable anesthetics

- 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 Logg for Ermen



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 81/2" x 11" sheets must be provided for clarification, as needed.

Facility's Licensed Name or Proposed Name	Emory Street, Attleb Address, including zip code	oro, MA 02703
If hospital or clinic satellite, name	Address, including zip code	1 11
Regulation or "Guideline" section number-Complete of 105 CMR 150.000 "Licensing of Long Term Care Facilities"; 10 Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; 2 Specific physical plant condition to be waived (e.g. room).	05 CMR 145.000 "Out-of-Hospital Dialysis Un	its; 105 CMR 140.000 "Clinic Licensure of Hospitals and Health Care Facilities" ⁰¹ in 4'6" vs. 5', part or entire requirement):
Multipurpose room		
Physical plant requirements may be waived pursuant Term Care Facilities, contingent upon the following: a) Specify how compliance would cause undue ha	t to 105 CMR 130.050, Hospitals; 14 rdship. (Attach additional pages as n	0.099, Clinics; 153.031(B), Long ecessary.*)
The surgery center open evening and Saturday and is adequate room not be	erates with limited ho a.m. To rent addition being used is unecessa	ours, Wed and Fri
 Specify how non-compliance does not jeopard acility's capacity to give adequate care. (Attach add 	dize the health or safety of the pa	tients and does not limit the
Staff meetings take pl Patients are not affectional located next door is a a staff meeting when t	nort time	physican office
) Specify compensating features that will be institu		
Meetings will not he h Pre-clinic announcemen in the staff changing		he surgical suite. dually or a memo post
ignature of the facility's clinical representative	Carperselding	
epresentative's NameCarol_Belding	Title_President	
For DPH - Division of Health Care Quality us	se only: (comments/conditions of a	
Proj. Eng:		val w/conditions ☐ Denial
Pro. Adm:		val w/conditions ☐ Denial
Asst. Dir:		val w/conditions ☐ Denial

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Plans on 81/2" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc., 150 Emory	Street Attloboro MA 02702
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 e 105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145.0 Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guideling Specific physical plant condition to be waived (e.g. room area 98 SF	each waiver request : 5 . D2 Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure"
shared waiting room; handica	pped toilet: bottled water
Physical plant requirements may be waived pursuant to 105 CM Term Care Facilities, contingent upon the following: a) Specify how compliance would cause undue hardship. (All	MR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long
The surgery center only oner	ohon 12 11 2 1
evening, Saturday morning.) rooms would be very expensiv	To rent additional space for waiting e for such limited use.
	•
b) Specify how non-compliance does not jeopardize the he facility's capacity to give adequate care. (Attach additional pages and the space is not used practice there will be no advised by the space is not used by the space is not used practice there will be no advised by the space is not used by the space is not used practice there will be no advised by the space is not used by the space is no	es as necessary.") d at the same time as the physician's
c) Specify compensating features that will be instituted. (Attack	badden lens)
Each provider will have a sep	parate reception area. Signage will be on clinics. Neither provider will be
Signature of the facility's <u>clinical</u> representative	arolBeldin
Representative's Name_Carol Belding	Title President Tel.# 508-222-7555
For DPH - Division of Health Care Quality use only: (care Quality use only:	
Proj. Eng:	Approval ☐ Approval w/conditions ☐ Denial
Pro. Adm:	
Asst. Dir:	Approval Approval w/conditions Denial
uly 2001 *Attachments must include the facility's name and the r	

PAGE ___ OF__



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Plans on 81/2" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc., 150 Emo	ry Street, Attleboro, MA 02703
Facility's Licensed Name or Proposed Name	Address, including zip code
f hospital or clinic satellite, name	Address, including zip code
	n for each waiver request: 9 • 5 • D6 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Buidelines for Design and Construction of Hospitals and Health Care Facilities" ⁰¹ 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):
Medical records room	
a) Specify how compliance would cause undue hardship	5 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long (Attach additional pages as necessary.*)
It is too costly to have a	another room for a limited number of
medical records.	
Lack of separate room will safety or confidentiality. accessed in time for an aba day to a week ahead of twith locked cabinets.	not jespardize patient health or Offsite medical records can be portion appointment, which are made sime. All records on site will be secur
) Specify compensating features that will be instituted.	167 (1) 167 (
patient charts. This is ap Four Women. Because the m time, and charts must be h ignature of the facility dimea representative of Massac	
epresentative's NameCarol_Belding	TitlePresidentTel.#_508-222-7555
For DPH - Division of Health Care Quality use only	y: (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
ly 2001 *Attachments must include the facility's name an	

PAGE ___ OF___

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Plans on 81/2" x 11" sheet	ts 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 105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guideline Specific physical plant condition to be waived (e.g. room area 9 CM). X-ray film illuminators	for each waiver request: 9.5.F2.b, 9.5.F2.c 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure idelines for Design and Construction of Hospitals and Health Care Facilities" of 8 SF vs. 100 SF, minimum dimension 4/6" vs. 5', part or entire resulting to the second s
 a) Specify how compliance would cause undue hardship. 	CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long (Attach additional pages as necessary.*) and unused equipment to an OR.
	squepaiene co di ok.
(mesh sadilional)	health or safety of the patients and does not limit the pages as necessary.*) affected. X-Rays are not used
	>
a light table in the d	for X-ray film illuminator. There is
	gency, but that should not be the case
Signature of the facility's <u>clinical</u> representative Representative's NameCarol_Belding	Title President Tel# 508-222-7555
For DPH - Division of Health Care Quality use only:	
Proj. Eng:/_	/ Approval Approval w/conditions T. D.
Pro. Adm:	Approval Approval Woonditions Denial
Acet Die:	Approval ☐ Approval w/conditions ☐ Denial



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 will be returned.

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

Inc., 150 Ell	ory Street, At	tleboro	MA OF	702
Facility's Licensed Name or Proposed Name	Address, including zip co	ode	MA 02	2703
If hospital or clinic satellite, name	Address, including zip co	de		
Regulation or "Guideline" section number-Complete one form 105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guideline physical plant condition to be waived (e.g. room area 9.000 CMR).	for <u>each</u> waiver request: 145.000 "Out-of-Hospital Dialys idelines for Design and Constru 8 SF vs. 100 SF, minimum dim	9.5.: is Units; 105 CM	IR 140 000 "C	linic Licensure re Facilities" ⁰¹ requirement):
Nurses call button at ea	ch bed			
Physical plant requirements may be waived pursuant to 105 Term Care Facilities, contingent upon the following: a) Specify how compliance would cause undue hardship. This kind of convices	(Attach additional pages	as necessary	*)	
This kind of service is	not usually for	und in ab	ortion	faciliti
It adds to expense and control procedure and recovery.	omplicates an a	already u	incompl:	icated
The recovery room is not space for five recumbent a medical assistant with cannot leave the room with No patient is out of hear they are closed to the specific actions.	very large. There patients at al	here is is a nu l times. nurse c	designarse and (The overing	ited Usually nurse
Women in our recovery roo	Attach additional pages as	necessary.*)	not th	e nurses
in distress. We can prov	ide a ball ar	can tel	l us if	ion. The they are can alert
ignature of the facility's <u>clinical</u> representative	Ca	rolBeld	`	
epresentative's Name_Carol_Belding			08-222	7555
For DPH - Division of Health Care Quality use only:				
Proj. Eng:				
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Asst. Dir:	_/ Approval A			
NOOL DII.	_/ ☐ Approval ☐ Ap	proval w/cor	iditions 🔲 l	Denial
y 2001 *Attachments must include the facility's name and			PAGE	



Massachusetts Department of Public Health - Division of Health Care Quality 10 West Street, 5TH Floor, Böston, 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

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 bossital as allicing a live	
If hospital or clinic satellite, name	Address, including zip code
Regulation or "Guideline" section number-Complete one 105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I Specific physical plant condition to be waived (e.g. room High Speed Sterilizer	c form for each waiver request: 9.5.F5.P CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" of area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):
a) Specify how compliance would cause undue hard	o 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long
This is an added expens	se and it is not usually found in an
· · · · · · · · · · · · · · · · · · ·	te the health or safety of the patients and does not limit the ional pages as necessary.*)
Women would not be affe	ected by the lack of a high speed sterilizer.
There are ample sterile	instruments to be used in any given clinic,
	<i>-</i>
c) Specify compensating features that will be institute	ed. (Attach additional pages as necessary.*)
can run several sets th	torage than are needed in any day. If han there are sterile wrapped sets, we rough the sterilizer and "flash" them. e same instruments they are all inter-
Signature of the facility's <u>clinical</u> representative	Carolfselding extra items packed
Representative's NameCarol Belding	Title President Tel.# 508-222-7555 wall
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:	
Asst. Dir:	// Approval Approval w/conditions Denial
ly 2001 *Attachments must include the facility's nam	

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

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 105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR 145 Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guide Specific physical plant condition to be waived (e.g. room area 98 S	each waiver request: D.5.F2.b 31.45 O00 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure lines for Design and Construction of Hospitals and Health Care Facilities" of Fvs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement.
1 OX & 1 VAC Class A: minor	surgery (local anesthesia)
Term Care Facilities, contingent upon the following: a) Specify how compliance would cause undue hardship. (A	MR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long Attach additional pages as necessary.*)
was estimated to be approxing in Fall River, MA. This is	ll piped in oxygen and vacuum system mately \$500,000 by Coast to Coast Medica not an affordable option.
b) Specify how non-compliance does not jeopardize the had facility's capacity to give adequate care. (Attach additional path of perform. Due to the nature before hand, emergency gasts oxygen dosing is more often	takes five minutes for the surgeon are of abortion surgery, and fasting
emergency use and checked at	one portable oxygen tank next to the This will be ready for immediate
the OR table.	ion machine will be set up next to
Signature of the facility's <u>clinical</u> representative	CarolBeldup
Representative's Name <u>Carol Belding</u>	Title President Tel.# 508 222 7555
For DPH - Division of Health Care Quality use only:	
Proj. Eng:	— ☐ Approval ☐ Approval w/conditions ☐ Denial
Pro. Adm:	Approval ☐ Approval w/conditions ☐ Denial
Asst. Dir:	Approval ☐ Approval w/conditions ☐ Denial
ally 2001 *Attachments must include the forms	



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Plans on 81/2" x 11" sheets must be provided for clarification, as needed.

Football 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
The state of the s
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 install:
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.
o) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the accility'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.
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 gastria wall and each surgical day.
OR table and immediatly available in case of emergency.
epresentative'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:
Pro Adm:
Acet Dim
ASSI. DIF:



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Plans on 81/2" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc., 15	0 Emory Street, Attleboro, MA 02703
Facility's Licensed Name or Proposed Name	Address, including zip code
VI.	2-1 Jun 6
If hospital or clinic satellite, name	Address, including zip code
Specific physical plant condition to be waived (e.g. rol	one form for each waiver request: 9.5.F3 05 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" of om area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement): n bed, Class B: Post-anesthesia recovery room
Physical plant requirements may be waived pursuar Term Care Facilities, contingent upon the following: a) Specify how compliance would cause undue has the court of the court	nt to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B) Long
The cost of installir	Attach additional pages as necessary.*)
system was estimated in Fall River, MA.	ng a fully piped in oxygen and vacuum to be \$500,000 by Coast to Coast Medical
 b) Specify how non-compliance does not jeopard facility's capacity to give adequate care. (Attach ad 	dize the health or safety of the patients and does not limit the ditional pages as necessary.*)
are sitting upright of abortion recovery room procedure and fast according awake and alert much recompensating features that will be instituted.	for usually 45 minutes or less. They reclined. There are no beds in ms. Due to the short nature of the ting anesthesia/sedation drugs, women are more quickly than most surgeries.
cumbant recovery room will also be placed no	oxygen tank will be placed next to each re-
Signature of the facility's <u>clinical</u> representative	Carol Beldne
Representative's NameCarol_Belding	
	se only: (comments/conditions of approval on back of form)
Proj. Eng:	// Approval ☐ Approval w/conditions ☐ Denial
Pro. Adm:	_ providi Weendidons _ Denial
Asst. Dir:	E Provid Woorlditions Defilial
uly 2001 *Attachments must include the facility's n	/ Approval Approval w/conditions Denial ame and the referenced regulation number. PAGE OF

PAGE __ OF__

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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 81/2" x 11" sheets must be provided for clarification, as needed.

	Four Women, Inc., 150 Emory Street, Attleboro, MA 02703
Facility's Licensed Na	me or Proposed Name Address, including zip code
If hospital or clinic sat	A Tradition, morading zip code
105 CMR 150.000 " Regulations"; 105 CM	uideline" section number-Complete one form for each waiver request: 9.5.F3 0,31.45 Licensing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure R 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" of 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
a) Specify how o	quirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long es, contingent upon the following: ompliance 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.
racility's capacity	non-compliance does not jeopardize the health or safety of the patients and does not limit the 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 compe	nsating 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 fa	cility's clinical representative
	lame 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:	
Pro. Adm:	
Asst. Dir:	

July 2001

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

PAGE ___ OF___

lease Distegard - no Class C.

PHYSICAL PLANT WAIVER REQUEST FORM



July

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

Plans on 8½" x 11" sheets must be provided for clarification, as needed. Four Women, Inc., 150 Emory Stre

· · · · · · · · · · · · · · · · · · ·	OTA DILEGE V++	100000 363	00
Facility's Licensed Name or Proposed Name	Att		02703
	Address, including zip co	ode	
If hospital or clinic satellite, name	,		1 (1)
	Address, including zip co	ode	
Regulation or "Guideline" section number-Complete one form 105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CMR Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Specific physical plant condition to be waived (e.g. room area Medical gas outlots as a	m for each waiver request :	9.31.E5	1 1
M = 3.1	98 SF vs. 100 SF, minimum dim	nension 4'6" vs. 5', part or	entire requirement):
The state of the s	1000 0 24		
Term Care Facilities, contingent upon the following: a) Specify how compliance would cause undue hardshir	05 CMR 130.050, Hospitals	s; 140.099, Clinics; 1	53.031(B), Long
We are asking for waiven	· (Attach additional pages	as necessary.*)	
We are asking for waivers A medical gas system wour room.and it is unclear whe Class A and Class B proces The cost of medical gas	d be used only nether the work	oxygen and va in the anest room is ever	hesia wo rk Trequired fo
incurcar yas	<u>Installation</u> is	prohibitive	. We can have
of Specify now non-compliance does not jeopardize the acility's capacity to give adequate care. (Attach additional	e health or safety of the	e patients and does	s not limit the
Again, it is not clear th	at the work roo	m is needed	for anecthor;
Medical gases are not use	d in abortion c	are except	for aneschesi
		are, except	for oxygen.
Specify compensating features that will be instituted. (Attach addition		
o montated.	Attach additional pages as	necessary.*)	
	7 7 /		
anesthesia work room if the	nat room is requ	ired hired	in the
	ro requ	arred.	
nature of the facility's all-i	(2000		
nature of the facility's <u>clinical</u> representative	Golbe	ld	
presentative's Name_Carol_Belding	Title D		
For DPH - Division of Health Care Quality	President	Tel.#_508-2	222-7555
For DPH - Division of Health Care Quality use only			H H
		proval w/conditions	
o. Adm:		oroval w/conditions	
	_/ ☐ Approval ☐ App	proval w/conditions	□ Denial
*Attachments must include the facility's name and	the referenced regulation		
	oned regulation numb	er. PAGE	E 05

PAGE ___ OF___



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

y a session Marine of Proposed Name	ommunity College, 1 Armory Square, Bld 20/Suite 320, Springfield MA 011 Address, including zip code
f Hospital/Clinic Satellite, Name	
	Address, including zip code
Hospital/Clinic Department	Duilding I'
HEREBY REQUEST THE DEPARTMENT	Building/Floor Location WAIVE COMPLIANCE WITH THE REGULATION OR REQUIREMENT:
.A: FOUND AT: (Regulation/Requirement Citation)	105(MR (Section E) 140 560
.B: THAT REQUIRES (Text of Regulation)	on/Requirement): ntained on the premises of parent clinic. Records shall not be startly in the s

- ecords 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.

- DESCRIPTION OF PROPOSED ALTERNATIVE TO COMPLIANCE WITH THE REQUIREMENT:
- 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.

PLAN: A Planned Parenthood Express Center at STCC, 1 Armory Sq. Bld 20, Suite 320, Springfield MA 01105 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: FACILITY AUTHORIZED REPRESENTATIVE: FACILITY CLINICAL REPRESENTATIVE: Name: Meagan Gallagher Name: Title: Karen Loeb Lifford, MD Chief Operating Officer/Vice President Mailing Address: 1055 Commonwealth Avenue Title: Medical Director Tel*#: 617-616-1620 Boston, MA 02215-1001 Signature: Signature: For DPH Use Only: The waiver identified above is approved, approved with conditions or denied as indicated below. 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.

▶ 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.

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:

- The Checklist must be filled out completely with each application. 1.
- Each requirement line (__) of this Checklist must be filled in with one of the following codes, unless otherwise 2. 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.

- \boxtimes = 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 W = Waiver requested for Guidelines, Regulation or Policy the existing space or area will serve a new or relocated service or if the facility is currently not licensed & applying for licensure.
 - 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.

racility Name: OPKING FIELD IECHNICAL COMMINATED COLUMN	indefines or of the Regulations.
DEPARTMENT OF HEALTH SERVICES	Dates:
Facility Address:	Initial:
Satellite Name: (if applicable)	Revisions:
Satellite Name: (if applicable)	
Satellite Address: (if applicable)	DON Identification: (if applicable)
Satellite Address: (if applicable)	
Project Reference:	
Project Reference:	
	Building/Floor Location:

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

ARCHITECTURAL REQUIREMENT	ARCHI	TECTURAL	REQ	JIREMENT
---------------------------	-------	----------	-----	----------

MECHANICAL/PLUMBING/ (DAY TREATMENT PROGRAM Continued) ELECTRICAL REQUIREMENTS 7.2.B15 Nourishment area: work counter Handwashing station conveniently storage cabinets accessible refrigerator Vent. min. 4 air ch./hr 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 GENERAL STANDARDS Details and Finishes Mechanical (9.31.D) Outpatient corridors (9.2.H1.a) x Mech. ventilation provided per Table 7.2 min. corridor width 5'-0" x Exhaust fans located at discharge end Staff corridors

7	Two remote exits from each outp. facility suite & floor 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:
	★ doors min. 3'-0" wide (9.2.H1.d)
X	A all doors are swing-type (Policy) doors do not swing into corridor (Policy) Glazing (9.2 H1.5):

- X safety glazing or no glazing under 60" AFF & within 12" of door jamb
- x safety glazing or no glazing in recreation rooms 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):
 - 1 floors easily cleanable & wear-resistant k washable flooring in rooms equipped with
 - handwashing stations (Policy) X non-slip floors in wet areas
 - wet cleaned flooring resists detergents Walls (9.2.H2.d):

 - wall finishes are washable smooth/water-resist. finishes at plumbing fixtures

- Fresh air intakes located at least 25 ft from exhaust outlet or other source of noxious fumes
- Contaminated exhaust outlets located above roof
- Ventilation openings at least 3" above floor
- Central HVAC system filters provided per Table 9.1

Plumbing (9.31.E)

Handwashing station equipment

- handwashing sink
 - __ hot & cold water
- x single lever or wrist blades faucet soap dispenser
- k hand drying facilities
- Sink controls (9.31.E1):
- hands-free controls at all handwashing sinks
- ★ blade handles max. 4½" long

Electrical (9.32)

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



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_	James - Do Not Fax or Computer Scan Waiver Request Forms
tour Won	10 T
Facility's Licensed Name	150 Emons St. A41/21 22 MARS
, and a raine	e or Proposed Name Address, including zip code Address, including zip code
If hospital or clinic satellit	e, name
	Address in L. II
Regulation or "Guide	olino" anati
Regulations": 105 ONE	eline" section number-Complete one form for each waiver request :
Specific regulation in	section number-Complete one form for each waiver request: 30.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Hospit
- regulation it	insing of Long Term Care Facilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" term to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or online was a facilities.
9.5.F5.m	tem to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):
	/\ \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
Physical plant require	ements 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 com	pliance would cause undue harded to
· .	pliance would cause undue hardship. (Attach additional pages as necessary.*)
S/2a	ce's fart - no
	The fourtors closet
- tor	this size frails
	this size facility will be adequate.
b) Specify how non-	-compliance does not iconordia to
facility's capacity to	-compliance does not jeopardize the health or safety of the patients and does not limit the give adequate care. (Attach additional pages as necessary.*)
	(Attach additional pages as necessary.*)
	due to small some
	due to small service time
	penitors closet is accessable at all Times.
	() scessable
	at all v
10	I mez.
Specify compensat	ing features that will be instituted. (Attach additional pages as necessary.*)
	(Attach additional pages as necessary.*)
	see name por and along.
	era about.
ianatura of the comme	
ignature or the facility's	clinical representative: Carol Beldus
epresentative's Name_	(200 0 1.1
	Carol Delding Title Administrator Tel.# 508.222-7555
For DDU District	161.# 208 · 5.55 · 12.22
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	Mais - Bo Not Fax or Computer Scan Waiver Request Forms
four Women, Inc.	150 6 61 101
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If hospital or clinic satellite, name	
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Four Women, Inc. Facility's Licensed Name or Proposed Name	150 Emory St. Attleboro, MA 02703 Address, including zip code
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If hospital or clinic satellite, name	Address
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Facility's Licensed Name or Proposed Name	nory St. Attleboro, WA 02703 Address, including zip code
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Facility's Licensed Name or Proposed Name	2 Emory St. Attleboro, MA 02703 Address, including zip code
If hospital or clinic satellite, name	Address, including zip code
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Four Women, Inc.	150 Finance St. With I
Facility's Licensed Name or Proposed Name	150 Emory St. Attleboro, MA 02703 Address, including zip code
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Only Use DPH-DHCQ Originals - Do Not Fax or Computer Scan Waiver Request Forms

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If hospital or clinic satellite, name	Address, including zip code
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Facility's Licensed Name or Proposed Name	Emony 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
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Massachusetts Department of Public Health - Division of Health Care Quality 10 West Street, 5[™] 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.

The state of the s
Four Women, Inc. 150 Emony St. Attleboro, MA 02703
Facility's Licensed Name or Proposed Name Address, including zip code
If hospital or clinic satellite, name Address, including tip and
Address, including 2ip 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" 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.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.*)
(mastra additional pages as necessary.)
Deas are inexpropuete for nontine abortion care -
We have chairs that achieve Trendelevering
positioning.
b) Specify how non-compliance does not jeopardize the health or safety of the patients and does not limit the
(Attach additional pages as necessary.*)
The recovery room chairs are the standard of care.
) acti
c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)
see narrative & see above.
Signature of the facility's clinical representative:
Representative's Name (3-1)
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)
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_ The state of Bernar
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pr. 1999 *Attachments must include the facility's name and the referenced regulation number.

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

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Four Women, Inc.	150 Eman Ct Will I
Facility's Licensed Name or Proposed Name	150 Emory St. Atteboro, MA 02703 Address, Including zip code
If hospital or clinic satellite, name	Address, including zip code
Regulations"; 105 CMR 130.000 "Hospital Licensure Re <u>Specific</u> regulation item to be waived (e.g. roc 9.5.F3 Clinical Flushi	Complete one form for each waiver request: Compliance Checklist.o.s. acilities"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure egulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" of area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement): 10
Term Care Facilities, contingent upon the following	
Our facility is sn	rall - the sinks are utherrais.
If We have one i	in the soiled poom, everyone
has easy acress	toit.
facility's capacity to give adequate care. (A	
c) Specify compensating features that will be	be instituted. (Attach additional pages as necessary.*)
All materials a	re dealt with carefully for
Safety and 1	regulatory reasons.
Signature of the facility's <u>clinical</u> representative.	CarolBeldus
Representative's Name Can Beld	ing Title Administrator Tel.# 508.222.7555
For DPH - Division of Health Care Qu	uality use only: (comments/conditions of approval on back of form)
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Massachusetts Department of Public Health - Division of Health Care Quality 10 West Street, 5[™] 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

FAURIN
Four Women Ive. 150 Emony St. Attleboro, WA or Facility's Licensed Name or Proposed Name Address, including zipebde
Address, including zip ebde
If hospital or clinic satellite, name Address, including zip code
Regulation or "Guideline" section numbers complete and (see
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 the contraction of the c
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9.5.F.4 Recovery Room - one room only, no "5 typ down"/one Physical plant requirements may be waived pursuant to 105 CMP 120 050 H
Term Care Facilities, contingent upon the following: a) Specify how compliance would be following:
a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)
Secause about on care is a quick procedure, usually
5-10 minertin litere
5-10 minutes, women recover quickly. It is
better to have everyone in the same space for observation
b) Specify how non-compliance described
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 service additional pages as necessary.")
House is with patients constantly - this does
not congramie their care at all.
see narrative
c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)
Sea was all and the
room that is well equipted i staffed. Average
Stay is 45 min.
Signature of the facility's clinical representative:
Commontative A. Commandative A.
Tille 4/8 MINIS 170 Tel.# 508.222.7553
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Massachusetts Department of Public Health - Division of Health Care Quality 10 West Street, 5[™] 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

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9.5.F.4 Recovery Room - one room only, no "5 typ down" long. Physical plant requirements may be waived pursuant to 105 CMP 100 050 140
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Term Care Facilities, contingent upon the following:
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Because about on care is a quick procedure, usually
5-10 minutes, women recover quickly. It is
better to have and
better to have everyone in the same space for observation
b) Specify how non-compliance does not isopporting the training
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 damanda pages as necessary.
House is with patients constantly - this does
not confromse their care at all.
see narrative
c) Specify compensating features that will be instituted. (Attach additional pages as necessary.*)
(Attach additional pages as necessary.*)
See narrafire fabour. Women go to one recovery
Down Heat is would as it is a second
is well equipted & starfad. Agerdge
Stay is 45 mis.
Signature of the facility's clinical representative:
Representative's Name (ND) B
Title Ad ministrator Tel.# 508.222.7555
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r. 1999 *Attachments must include the facility's name and the referenced regulation number. PAGE OF

Massachusetts Department of Public Health - Division of Health Care Quality 10 West Street, 5[™] 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

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Four Women, Inc.	150	Emon St. Atte han MA 22723
Facility's Licensed Name or Proposed Name		Emony St. Attleboro, MA 02703 Address including zip code
ICI .		
If hospital or clinic satellite, name		Address, including zip code
Regulation or "Guideline" section number-Comple	ete <u>one</u> form	n for each waiver request :
Regulations"; 105 CMR 130.000 "Hospital Licensure Regulation Specific regulation item to be waived (e.g. room area	;"; 105 CMR ons"; A.I.A. "C a 98 SE vs. 1	R 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensu Guidelines for Design and Construction of Hospitals and Health Care Facilities"
9.5.F5.f. Anesthesia Wor	hrom	- to Anastresia workarea.
Term Care Facilities, contingent upon the following a) Specify how compliance would cause undur	uant to 10 g: hardship	95 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Lon
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b) Specify how non-compliance does not jour	C.	
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c) Specify compensating features that will be ins	stituted (Attach additional and
0.00 0.00 40	l.	Attach additional pages as necessary.*)
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De me same area	e a	nd on lookled aresthesia
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Signature of the facility's <u>clinical</u> representative:		arolfielding
Representative's Name Carol Beldine		Title Administratortel.# 508.222.755
	use only	(comments/conditions of approval on back of form)
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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.

of th	ne General Laws, Chapter 111, Section 51 and	56.	
1.	NAME OF LICENSEE Planned P	aventhood heagi	ne of MA
2.	NAME OF LICENSEE Planned PM NAME OF CLINIC Planned PM (if same ADDRESS 105 Lamm mwalth	venth vod Preferm	Health Services
3.	ADDRESS 1055 Lommon wealth Street	City or Town	Zip Code
4.	TELEPHONE 617-616-1660	_	
5.	LICENSE TYPE:		-11
	(A) RENEWAL LICENSE:	Date current license expires	1 [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 Nu	mber:	· · · · · · · · · · · · · · · · · · ·
	Date	Approved:	
6.	SERVICES (check all that apply)		
	Medical Alcoholism	Dental	
	Surgical — Physical Rehabilitat	tion Mental Health	1
	Birth Center ———		
Т	NPLICO 126		

DPHCQ 136 02/22/05 COMMONWEALTH OF MASSACHUSETTS
DEPARIMENT 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:
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 WONEN
2 NAME OF CLINIC FOLIR INDOAFAL
3. ADDRESS 150 Emery St. (if same, write same) Street City or Town Zip Code
4. TELEPHONE 508-222-7555
5. LICENSE TYPE:
(A) RENEWAL LICENSE: X Date current license expires 12 11 04
(B) ORIGINAL LICENSE: 12/102
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 Beldina
d) Determination of Need Project Number: 5-4865
Date Approved: 12 19 00
5. SERVICES (check all that apply)
Medical Mental Health Dental
Surgical Physical Rehabilitation Alcoholism
Birth Center
. NAME AND ADDRESS OF ALL SATELLITE LOCATIONS MAINTAINED UNDER LICENSE: \cite{NAME}
. 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

. X

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 ar d/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, attle boro, MA 02703 Street City or Town Zip Code
4. TELEPHONE 508.222.7555
5. LICENSE TYPE: (A) RENEWAL LICENSE Date current license expires 5. SERVICES (check all that apply)
Medical — Alccholism — Dental —
Surgical — Physical Rehabilitation — Mental Health — —
Birth Center — Mobile Medical — Transfusion
Pharmacy MRI Radiology
PHCQ 136 ev. 10/05/05 PhD, RNC

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:
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 WONEN
2. NAME OF CLINIC FOUR WOMEN (if same, write same)
3. ADDRESS 150 Emery St. (11 same, write same) Street City or Town 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 1102
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 Beldine
d) Determination of Need Project Number: 5-4865
Date Approved:12 19 00
5. SERVICES (check all that apply)
Medical Mental Health Dental
Surgical Physical Rehabilitation Alcoholism
Birth Center
. NAME AND ADDRESS OF ALL SATELLITE LOCATIONS MAINTAINED UNDER LICENSE: \cup{R}
. NAME OF OF CLINIC ADMINISTRATOR:
Molly Finneseth

SURVEYOR COM

COMMONWEALTH OF MASSACHUSETTS
DEPARIMENT 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 "Regulation the undersigned hereby applies for clinic at the premises set forth sections 51 and 56.	ons for the Licensure of Clinics, 105 CMR 140", or a license to establish and/or maintain a below under provisions of the General Laws,
1. NAME OF APPLICANT Planne	d Paventhood League of Ma. (PPLM)
England.	DEHILL DUILDING CLINE OF WESTERN WILL
3. ADDRESS 3550 Main	Street (if same, write same) Street Springfield Ma Street City or Town Zip Code
4. TELEPHONE 413.732.1	020
5. LICENSE TYPE:	
(A) RENEWAL LICENSE:	Date current license expires
(B) ORIGINAL LICENSE:	
7) Initial Establishment:	Projected opening date:
b) change of Location	Projected move date: 12.21.02.
o) Transfer of Ownership:	Date:
a termination of Need Pro	piect Number: No number provided.
u) bearing	Date Approved: 9.24.02
6. SERVICES (check all that appl	
Medical Mental F	MealthDental
Physical Physical	Rehabilitation Alcoholism
Birth Center	TOTAL STATISTICS INDED LICENSE.
7. NAME AND ADDRESS OF ALL SATEI	LITE LOCATIONS MAINTAINED UNDER LICENSE:
8. NAME OF OF CLINIC ADMINISTRAT	OR: JESSICA WOLFF, R.M.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 DIVISION OF CARE QUALITY

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 LICENS	EE Planned Parentho	ed League of MA
2. NAME OF CLINIC	Plannel Parenthood	Reterm Health Services
3. ADDRESS 105° Stre	(if same, write same) S Common wealth Ave et City or Toy	Of Greater Boston Boston, MA 02215 Zip Code
4. TELEPHONE <u>61</u>	7-616-1600	Zip Code
5. LICENSE TYPE:		
(A) RENEWAL LIC6. SERVICES (check all	ENSE Date current that apply)	license expires 6 23 7007
Medical	Alcoholism	Dental
Birth Center—	Physical Rehabilitation — Mobile Medical —	Mental Health
Pharmacy	MRI Radiology	
7. NAME OF CLINIC ADM	MINISTRATOR Kim Dia	inan
DPHCQ 136 Rev. 10/05/05		

Clinic Name Planned Parenther
A n = 1
8. NAME AND ADDRESS OF ALL SATELLITE LOCATIONS MAINTAINED UNDER LICENSEE: SATELLITES:
1. Name of Clinic: Planned Parenthood League of MA
Street: Suite #/Floor City/Zip Code
Suite #/Floor City/Zip Code Services offered: Medical, Suggested
Services offered: Medical, Surgical
DPS Issued 9 2 2009 Fire Issued 16 - 2007
2. Name of Clinic: Flanned agenthand I
Street: Sorve Fall 4
Telephone Number: 413 737 1620 Days and Hours of Operation: See attacked Services offered: Medical Surement
Services offered: Medical Surgical Days and Hours of Operation: See attacked DRS Issued HIM 100
DPS Issued # 117 09 Fire Issued 8 30 2006
Name of Clinic:
Street:
Telephone Number: City/Zip Code
Services offered: Days and Hours of Operation:
Fire Issued:
(Attach addendum for additional sites, if applicable)

	· Clinic Name Plannea Parenthood
	Application Date 4/9/67
9. Number of patients per year:	
Less than 5,000	
10. I certify under the penalties of perjury that I, to returns and paid all state taxes required under la OHZ698497 Social Security Number (Voluntary) or Federal Identification Number	my best knowledge and belief, have filed all state tax
Note: Your social security number will be furnished determine whether you have met tax filing or tax filing or tax payment obligations. Licensees who to license suspension or revocation. This request	shed to the Massachusetts Department or Revenue to payment obligations. Licensee who fail to correct their non-fail to correct their non-filing or delinquency will be subject is made under the authority of Mass. G. L. c.62C s.49A.
11. Signature and Seal:	
1, Dianne Luby	
say that the statements contained in this license approximy knowledge.*	, being first duly sworn on oath depose and plication are true, complete and correct to the best of
	Planned Parenthood league of MA
	Signature of Applicant (Individual or Person authorized act in behalf of the Individual Applicant) or Corporate Name
	By: Corporate Officer (if applicable)
Subscribed and sworn to before me on this	day of april 19-2007
My commission expires on	19-2007
Notary Public (Seal)	

*Note: All information contained in this application must be kept current.



DEVAL L. PATRICK GOVERNOR

TIMOTHY P. MURRAY LIEUTENANT GOVERNOR

JUDYANN BIGBY, MD SECRETARY

JOHN AUERBACH COMMISSIONER 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

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



MITT ROMNEY GOVERNOR

KERRY HEALEY
LIEUTENANT GOVERNOR

RONALD PRESTON SECRETARY

CHRISTINE C. FERGUSON COMMISSIONER

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

Dear Ms. Belding:

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

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)

Very truly yours,

Sherman R. Lohnes Assistant Director

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.

Waivers Continued: Page 2

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.

Waivers Continued: Page 3

- 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 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



JANE SWIFT GOVERNOR

ROBERT P. GITTENS SECRETARY

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

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

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

September 11, 2002

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 affidavit¹, the requested waivers and the architect's checklist¹, 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

 $^{^{1}}$ 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

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.
 - 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



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.

Facility's Licensed Name or Proposed Name	Address, including zip code
If hospital or clinic satellite, name	Address, including zip code
Specific physical plant condition to be waived (e.g. room	CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensu A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement
Administrative Offices shar	re space with reception and pre-op rm
Physical plant requirements may be waived pursuant to Term Care Facilities, contingent upon the following: a) Specify how compliance would cause undue hard:	o 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long
During most of the work week	this space is empty. Staff can use
this space to answer phones,	book appointments, take messages.
	•
There will be no patients in	e the health or safety of the patients and does not limit the ional pages as necessary.*) the building when this space is
There will be no patients in the being used for administrative privacy in speaking to a staff in the pre-op counseling rooms Again, this cannot impact on property compensating features that will be instituted. Medical record cabinets are to desk. These will be looked with the looked w	the building when this space is purposes. If a supervisor needs f member they can close a door set to be there.
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PAGEO OF Y

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

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.

privacy in speaking to a staff member they can close a deor

desk, These will be locked when not under the direct super-



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 81/2" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc., Facility's Licensed Name or Proposed Name	-150-Emory-Street, Attleboro, MA 02703 Address, including zip code
If hospital or clinic satellite, name	Address, including zip code
Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations of the Walved (in Specific Physical Plant condition to be waived (in Specific Physical Plant Condition to be	plete <u>one</u> form for <u>each</u> waiver request : <u>9.5.D5</u> ies"; 105 CMR 145.000 "Out-of-Hospital Dialysis Units; 105 CMR 140.000 "Clinic Licensure ations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities" ⁰¹ e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire requirement):
Multipurpose room	
	rsuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.031(B), Long ing: ue hardship. (Attach additional pages as necessary.*)
The surgery center evening and Saturd is adequate room n	operates with limited hours, Wed and Friay a.m. To rent additional space when there of being used is unecessary.
	Munner essary
located next door is a staff meeting when Four Women does not sessions at this times. Specify compensating features that will be	ffected in any way. The physican office is a part time practice. We will schedule on there are no patients scheduled. provide group counseling or group grief instituted. (Attach additional pages as necessary.*)
in the staff changi If at a later date p alternative space wo Signature of the facility's <u>clinical</u> representative	atient educational sessions were needed, uld be located for the purpose.
	gTitle_PresidentTel.#_508-222-7555
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yly 2001 *Attachments must include the faci	lity's name and the referenced regulation number. PAGE 3 OF 14

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

Project Engineer's Waiver Comments/Conditions:

I recommend waiver approval of not providing a multipurpose room.

located next door is a part time practice. We will achedule a staff meeting when there are no pattents scheduled.



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 81/2" x 11" sheets must be provided for clarification, as needed.

	Four Women,	Inc., 1	50 Emory	Street,	Attleb	oro,	MA	02703	
Facility's Licensed	Name or Proposed Name			Address, inclu					
If hospital or clinic s	atellite, name			Address, include	ding zip code				
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For DPH -	Division of Health	Care Quali	ty use only:	(comments/co	onditions of	approva	al on ba	ack of form)	
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ly 2001	*Attachments must i	nclude the facil	lity's name and th	ne referenced rea	ulation numb	er		PAGE OF	14

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

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.

accessed in time for an about to appoint seat, which are sade

washand according to massachusetts regulations. (o.c. Ch. c. d.

a day to a week ahead of time. All records on site will be secure



July 2001

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" 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 usedin 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 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) 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

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.



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 81/2" x 11" sheets must be provided for clarification, as needed.

Four Women, Inc., 150	Emory Stree	t, Attle	eboro.	MA	02703	
Facility's Licensed Name or Proposed Name	Address, inclu					
If hospital or clinic satellite, name	Address, include	ding zip code			· -	
Regulation or "Guideline" section number-Complete one 105 CMR 150.000 "Licensing of Long Term Care Facilities"; 105 CR Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I Specific physical plant condition to be waived (e.g. room a	MR 145.000 "Out-of-Hos "Guidelines for Design a rea 98 SF vs. 100 SF, mir	oital Dialysis Un		R 140.00		
Nurses call button at	each bed					
Physical plant requirements may be waived pursuant to Term Care Facilities, contingent upon the following: a) Specify how compliance would cause undue hards					53.031(B), L	ong
This kind of service i	s not usual]	y found	in ab	orti	on faci	llities
It adds to expense and procedure and recovery	complicates	an alr	eady u	ncom	plicate	∍d
The recovery room is no space for five recumble a medical assistant with cannot leave the room no patient is out of he they are closed to the c) Specify compensating features that will be institute.	th patients without the earing or si women next d. (Attach additional	at all float no him. If to a parpages as necessarily	s a nu times. urse c curta tient, cessary.*)	over in s	and usu he nurs ing her are cl the nu	osed, erses.
Women in our recovery are usually alert and in distress. We can p staff if the patient n See attached policy.for	covide a bel	They call or sor	n tel methin	l us g tha	if the at can	y are alert
Signature of the facility's clinical representative		Carol	Beld	Lp		
Representative's Name <u>Carol Belding</u>	TitlePresi					5_
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uly 2001 *Attachments must include the facility's nam					GE 6 OF	

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

Project Engineer's Waiver Comments/Conditions:

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

a medical assistant with patients at all times, (The nerse cannot leave the room Without the float nerse covering ner.)
No patient is out of hearing or sign. If nurtain a are closed, they are closed to the "Somen next to a patient, not the nurses wanting features that will be instituted. (Alloy additional pages as necessary.)

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.

Four Women, Inc. 03/03



July 2001

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.

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Four Women, Inc., 150 Emory Street, Attleboro, MA 02	703
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 Regulations"; 105 CMR 130.000 "Hospital Licensure Regulations"; A.I.A. "Guidelines for Design and Construction of Hospitals and Health Care Facilities physical plant condition to be waived (e.g. room area 98 SF vs. 100 SF, minimum dimension 4'6" vs. 5', part or entire required Step-down recovery area	acilities" 01
Physical plant requirements may be waived pursuant to 105 CMR 130.050, Hospitals; 140.099, Clinics; 153.0310 Term Care Facilities, contingent upon the following: a) Specify how compliance would cause undue hardship. (Attach additional pages as necessary.*)	B), Long
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.	
•	
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 as leaves on her own, not in a wheel chair. A step down lounge is not needed in abortion care as time is relatively their (Attach additional pages as necessary.*) All women receive refreshment in their recovery room. They spend all the time they need in that chair. This a person a feeling of well-being as they have one nurse a woman is discharged she is able to dress herself and out the door.	recovery chair. s gives se. When
Signature of the facility's <u>clinical</u> representative Co_oldSeld	7
Representative's Name <u>Carol Belding</u> Title <u>President</u> Tel.# <u>508-222</u> .	-7555
For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of for	n)
Proj. Eng: Sale Hay Approval Approval Approval Approval Approval Approval Approval Approval	Denial
Pro. Adm:	Denial
Asst. Dir:	Denial

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

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

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.

approximately 45 minutes in the recovery room chair and

a person a feeling of well-being as they have one nerse. We a woman is discharged ene is able to dress herself and walk out the door.



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 81/2" 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" of 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.
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 professional cleaners come in with heavy equipment and supplies of Specify compensating features that will be instituted. (Attach additional pages as necessary.) leaned the floors that will be instituted. (Attach additional pages as necessary.) leaned the floors of the 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
Representative's NameCarol BeldingTitle_presidentTel.#_508-222-7555
For DPH - Division of Health Care Quality use only: (comments/conditions of approval on back of form)
Proj. Eng:
Pro. Adm:
Asst. Dir:
ly 2001 *Attachments must include the facility's name and the referenced regulation number.