IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

May 8, 2018

Ms. Erin King, MD, Administrator
Hope Clinic for Women, Ltd., The
1602 21st Street
Granite City, IL 62040-

Re: Hope Clinic for Women, Ltd., The
Granite City
Licensure survey

Dear Ms. King, MD:

On 03/21/18 a life safety code inspection was conducted for the purpose of determining compliance with the requirements of the "Ambulatory Surgical Treatment Center Licensing Requirements" (77 Ill. Adm. Code 205) and NFPA 101, Life Safety Code, 2012 Edition. Based on POC received with the evidence of complaince, we find that the previously cited deficiencies have been corrected and the facility is no longer under monitoring for physical environment.

If you have any questions about this approval, please do not hesitate to call us at 217-785-4247 The Department's TTY number is 800/547-0466, for use by the hearing impaired.

Sincerely,

7(1)(b)

Dennis Schmitt, Supervisor
Design and Construction Section
Division of Life Safety and Construction

ok
per DS -

The Hope Clinic for Women Ltd.

May 1, 2018

Dennis Schmitt, Supervisor
Design and Construction Section
Division of Life Safety and Construction
Illinois Department of Public Health
525 W. Jefferson, 4th Floor
Springfield, IL 62761

RECEIVED-OHCR
MAY 02 2018
LIFE SAFETY & CONSTRUCTION

Dear Mr. Schmitt:

In reference to the Life Safety Survey conducted 3/21/18 and Plan of Correction (POC) returned on 3/27/18, I am following up with confirmation of the completion of the items in the POC.

See revised POC with completed dates and appendices attached.

If I may be of further assistance, or if you have further comments, please do not hesitate to phone 618-451-5722 or email: erking@hopeclinic.com

Sincerely,

7(1)(b) [redacted]

Erin King, MD
Executive Director

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL1084	A. BUILDING: 01 - MAIN BUILDING B. WING _____	03/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE CLINIC FOR WOMEN LTD THE	1602 - 21ST STREET GRANITE CITY, IL 62040

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	Initial Comments	L 000		

The Illinois Department of Public Health (IDPH) conducted a Life Safety Code inspection on 3/21/18. The facility is an Ambulatory Surgery Center (ASTC) located at 1602 21st Street, Granite City, IL. The following facility staff accompanied the surveyor during the walk through.

Purchasing Coordinator (PC)

The building was built in approximately 1998 and is a two story facility. The facility is fully sprinkler protected and is a Type II (000) construction. The Surgery Center is located on the ground floor of the building and was inspected under the Illinois ASTC Licensing Requirements and the Life Safety Code (2012). The upstairs of the building contains a waiting room, business offices and outpatient exam rooms.

The following deficiencies were identified by document review, staff interview or direct observation.

L 021	Doors/Firewalls 20.2.2.3, 21.2.2.3	L 021		

Any door with a required fire protection rating, such as stairways, exit passageways, horizontal exits, smoke barriers, or hazardous area enclosures, if held open, is arranged to close automatically by the actuation of the manual fire alarm system and either smoke detectors arranged to detect smoke on either side of the opening or a complete automatic sprinkler system. 20.2.2.3, 21.2.2.3

This Regulation is not met as evidenced by:
Based on an observation the facility failed to

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L 021	Continued From page 1 maintain hazardous content separations. This deficient practice could affect patients, staff and visitors if fire and smoke from a hazardous area were allowed to impede exiting from the facility. Finding include: On 3/21/18 at 1:30 PM while in the company of PC it was determined that the door to the Dirty Linen room failed to close and latch to the frame when tested. This does not comply with NFPA 101, 2012 Edition, Section 21.3.2 and 39.3.2.	L 021	20.2.2.3, 21.2.2.3 Self closing mechanism of the cited door to the soiled linen storage will be adjusted to close completely without assistance after being released. This door and others with a required fire protection rating will be adjusted immediately if not closing appropriately. Completion estimated by 4/15/18 COMPLETED 4/2/18	
L 046	20.2.9.1/21.2.9.1 Emergency Illumination Emergency lighting shall be provided in accordance with 7.9 and 21.2.9.2. This Regulation is not met as evidenced by: Based on document review the facility failed to test and properly document the battery operated emergency lighting. This deficient practice could affect patients, staff and visitors if during a fire event the system failed to operate properly and the exit pathway was not illuminated. Finding include: On 3/21/18 at 11:30 AM it was determined during document review that the facility failed to test and document the battery operated emergency lighting for 90 minutes over the last 12 months. This does not comply with NFPA 101, 2012 Edition, Section 7.9.3.1.1 (3).	L 046	20.2.9.1/21.2.9.1 Emergency lighting will be tested for at least 90 *minutes* annually. Testing will be documented including date, time performed and number of minutes of testing. Completion estimated by 4/15/18 COMPLETED 5/1/18	
L 130	as indicated OTHER REFERENCED REQUIREMENTS Other Referenced Requirements: NFPA 70 - 2002 NFPA 13 -1999 NFPA 25 - 1998	L 130	see appendix A	

Illinois Department of Public Health

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L 130	Continued From page 2 Illinois State Plumbing Code Illinois Accessibility Code As Indicate below: This Regulation is not met as evidenced by: Based on direct observations during the survey walk through and document review the facility failed to test and properly document the fire sprinkler system. Failure to install and maintain the system could result in the failure of the fire suppression system. This deficient practice could affect patients, staff and visitors if during a fire event the system failed to operate properly. Findings include: A. On 3/21/18 at 11:50 AM during document review it was determined that the facility conducted only one sprinkler inspection within the last 12 months. Per NFPA 25, 2011 Edition, Section 5.2.5 waterflow alarm and supervisory alarm devices shall be inspected quarterly. B. On 3/21/18 at 1:20 PM during a facility walkthrough with the PC it was determined that the sprinkler system was installed with gauge that was not identified with a date of installation. Further document review could not identify when the guage was last replaced or recalibrated. This does not comply with NFPA 25, 2011 Edition, Section 5.3.2.	L 130	5.2.5 Sprinkler inspection will be completed quarterly. Inspections will be documented. Completion estimated by 5/1/18 COMPLETED 4/23/18 see appendix B 5.3.2 Sprinkler system maintenance company will evaluate and determine date of installation of gauge. The company will calibrate and/or replace the gauge and provide documentation of these actions. Completion estimated by 5/1/18 COMPLETED 4/23/18 see appendix C	
L 178	205.1780 Emergency Power 205.1780 Emergency Electrical Service a) An emergency source of electricity shall be provided.	L 178		

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L 178	Continued From page 3	L 178		

b) Ambulatory surgical treatment centers that do not administer inhalation anesthetics in any concentration, or that have no patients requiring electrical life-support equipment, shall be permitted to use a battery system for emergency power. The following is required:

1) Illumination of means of egress as required in the NFPA Life Safety Code.
2) Illumination of procedure and recovery rooms.
3) Illumination of exit and exit directional signs.
4) Fire alarm and alarms required for nonflammable medical gas systems, if nonflammable medical gas systems are installed.

c) Ambulatory surgical treatment centers in which inhalation anesthetics are administered in any concentration to patients or that have patients requiring electrically operated or mechanical life support devices must be provided with an emergency generator. This generator must supply a limited amount of lighting and power service that is essential for life safety and orderly cessation of a procedure during the time normal service is interrupted for any reason. The maximum time of automatic transfer is 10 seconds. The following is required:

Illinois Department of Public Health

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L 178	Continued From page 4 1) Task illumination that is related to the safety of life and that is necessary for the safe cessation of procedures in progress. 2) All anesthesia and resuscitative equipment used in areas where inhalation anesthetics are administered to patients must include alarms and alerting devices. 3) Illumination of means of egress as required in the NFPA Life Safety Code. 4) Illumination of exit and directional signs. 5) Fire alarm and nonflammable medical gas system alarms, if nonflammable medical gas systems are installed. 6) General illumination and selected receptacles in the vicinity of the generator set. (Source: Amended at 18 Ill. Reg. 17250, effective December 1, 1994) This Regulation is not met as evidenced by: Based on direct observations, record review and interview, the facility failed to provide proper normal electrical power outlets in treatment locations. This deficient practice could affect patients, staff and visitors if the emergency generator failed to transfer power to the listed areas and normal power outlets were not provided.	L 178	205.1780 Electrical outlets in operating rooms will be evaluated. If normal power outlets are identified already in existence, they will be clearly marked with a different color outlet or some equally obvious method. If none are identified, the power outlets will be reconfigured so that at least one normal power outlet will be available in each operating room and be clearly marked/identifiable. Completion estimated by 5/1/18 COMPLETED 4/11/18 see appendix D	

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L 178	Continued From page 5 Findings include: On 3/21/2018 at 1:45 PM while accompanied by PC an observation determined that the following treatment locations did not contain a normal electrical power outlet. 1. Operating room 1 2. Operating Room 2 This does not comply with NFPA 70, 2011 Edition, Section 517.18.	L 178		

Annual Emergency and Exit Lighting Inspection Documentation Log

(page 1)

Date: 5/1/18 F50A → 920A

Emergency Lights 90 minute test and inspection

Location/Light #	Pass /Fail	Good Condition	Testing By
First Floor			
OR 1	P	✓	DD
OR 2	P	✓	DD
OR 3	P	✓	DD
OR 4	P	✓	DD
Back corridor	P	✓	DD
Nurses station RR	P	✓	DD
Second Floor			
Front Desk	P	✓	DD

notes: generator power off
turned off circuit breaker to areas above
Confirmed lights r x 90 min
battery only.

appendix B

GATEWAY FIRE PROTECTION SYSTEMS, INC.

1862 Borman Court • St. Louis, MO 63146 • (314) 892-7622

REPORT OF INSPECTION • SET 1 OF 2

REPORT TO HOPE CLINIC
STREET 1602 21ST STREET
CITY & STATE GRANITE CITY IL ZIP 62040
ATTN

Inspection Quarterly
Emergency Service
Repairs
DATE 4/23/2018

24-Hour Service
(314) 892-7622

	Yes	N.A. ‡	No*
1. GENERAL			
(To be answered by the Owner or Owner's representative)			
a. Have there been any changes in the occupancy classification, machinery or operations since the last inspection?			✓
b. Have there been any changes or repairs to the fire protection systems since the last inspection?			✓
c. If a fire has occurred since the last inspection, have all damaged sprinkler system components been replaced?		✓	
d. Have the piping in all dry systems been checked for proper pitch within the past five years?		✓	
Date last checked (checking is recommended at least every 5 years)			✓
e. Has the piping in all systems been checked for obstructive materials?			
Date last checked (checking is recommended at least every 5 years)		✓	
f. Have all fire pumps been tested to their full capacity through the use of hose streams or flow meters within the past 12 months?			✓
g. Are gravity, surface or pressure tanks protected from freezing?			✓
h. Are any of the sprinklers 50 years old or older? (testing and/or replacement is recommended for such sprinklers)			
i. Are any extra high temperature solder sprinklers regularly exposed to temperatures near 300°F?			
(To be answered by the inspector)			
a. Have the sprinkler systems been extended to all visible areas of the building?	✓		
b. Does there appear to be proper clearance between the top of all storge and the sprinkler deflector?	✓		
c. Are the building areas protected by a wet system, heated, including its blind attics and perimeter areas, where accessible?	✓		
d. Are all visible exterior openings protected against the entrance of cold air?	✓		
2. CONTROL VALVES			
a. Are all sprinkler system main control valves and all other valves in the appropriate open or closed position?	✓		
b. Are all control valves sealed or supervised in the open position?	✓		

Control Valves	No of Valves	Type	Easily Accessible		Signs		Valve Open		Secured? If yes, how?		(sealed?) (Locked?) (Supvd.?)	Supervision Operational?	
			Yes	No	Yes	No	Yes	No	Yes	No		Yes	No
* ON BACKFLOW													
CITY CONNECTION *	2	2" BALL VALVE	✓		✓		✓		✓		SUPVD	✓	
TANK													
PUMP													
SECTIONAL													
SYSTEM	SAME AS ABOVE												
ALARM LINE													

3. WATER SUPPLIES

a. Water supply source? City 4" UG Gravity Tank — Pressure Fire Pump & Tank — Pressure Fire Pump & City — Pressure Fire Pump & Pond

Waterflow Test Results Made During This Inspection

Test Pipe Located	Size Test Pipe	Static Pressue Before	Flow Pressure	Static Pressure After	Test Pipe Location	Size Test Pipe	Static Pressue Before	Flow Pressure	Static Pressure After
AT RISER	1¼"	50	35	40					

	Yes	N.A. ‡	No*
4. TANKS, PUMPS, FIRE DEPT. CONNECTIONS			
Do fire pumps, gravity, surface or pressure tanks appear to be in good external condition?		✓	
Are gravity, surface and pressure tanks at the proper pressure and/or water levels?		✓	
Are fire dept. connections in satisfactory condition, couplings free, caps or plugs in place and check valves tight?	✓		
Are fire dept. connections visible and accessible?	✓		
5. WET SYSTEMS			
No. of systems ONE Make & Model			
Are cold weather valves in the appropriate open or closed position?		✓	
If closed, has piping been drained?		✓	
Has the owner or owner's representative been advised that cold weather valves are not recommended by NFPA?		✓	
Have all the antifreeze systems been tested?		✓	
Date antifreeze systems were tested			
The antifreeze tests indicate protection to: system 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ temperature			
Did alarm valves, waterflow alarm indicators and retards test satisfactorily?	✓		

= Not Applicable
* Explain (No) Answers on Back of Sheet

GATEWAY FIRE PROTECTION SYSTEMS, INC.

1862 Borman Court • St. Louis, MO 63146 • (314) 892-7622

REPORT OF INSPECTION • SET 2 OF 2 — Hope Clinic (2)

	Yes	N.A. ‡	No*
6. DRY SYSTEMS			
No. of systems 0 Make & Model ____			
Date last trip tested ____			
Are the air pressure and priming water levels normal?			
Did the air compressor operate satisfactorily?			
Were all low points drained during this inspection? N/A			
Did all quick opening devices operate satisfactorily?			
Did all the dry valves operate satisfactorily during this inspection?			
Do dry valves appear to be protected from freezing?			
Is the dry valve house heated?			
7. SPECIAL SYSTEMS			
a. No. of systems 0 Make & Model ____			
Type ____ N/A			
b. Were valves tested as required:			
Did all heat responsive systems operate satisfactorily?			
c. Did the supervisory features operate during testing?			

Heat Responsive Devices: Type ____ Type of test ____

Valve No. ____ 1 ...... 2 ...... 3 ...... 4 ...... 5 ...... 6 ...... Valve No. ____ 1 ...... 2 ...... 3 ...... 4 ...... 5 ...... 6 ......
Valve No. ____ 1 ...... 2 ...... 3 ...... 4 ...... 5 ...... 6 ...... Valve No. ____ 1 ...... 2 ...... 3 ...... 4 ...... 5 ...... 6 ......
Valve No. ____ 1 ...... 2 ...... 3 ...... 4 ...... 5 ...... 6 ...... Valve No. ____ 1 ...... 2 ...... 3 ...... 4 ...... 5 ...... 6 ......
Valve No. ____ 1 ...... 2 ...... 3 ...... 4 ...... 5 ...... 6 ...... Valve No. ____ 1 ...... 2 ...... 3 ...... 4 ...... 5 ...... 6 ......

Auxiliary equipment: No. ____ Type ____
Location ____
Test results ____

	Yes	N.A. ‡	No*
8. ALARMS			
a. Did the water motors and gong operate during testing?		✓	
b. Did the electric alarms operate during testing: CODE-1111 or use key	✓		
c. Did the supervisory alarms operate during testing?	✓		
9. SPRINKLERS - PIPING			
a. Do sprinklers generally appear to be in good external condition?	✓		
b. Do sprinklers generally appear to be free of corrosion, paint, or loading and visible obstructions?	✓		
c. Are extra sprinklers available on the premises?	✓		
d. Does the exterior condition of piping, drain valves, check valves, hangers, pressure gauges, open sprinklers and strainers appear to be satisfactory?	✓		
e. Does the hand hose on the sprinkler system appear to be in satisfactory condition?		✓	

10. EXPLANATION OF "NO" ANSWERS (For Sections 1 B thru 9):

11. THE INSPECTOR SUGGESTS THE FOLLOWING NECESSARY IMPROVEMENTS. HOWEVER, THESE SUGGESTIONS ARE NOT THE RESULT OF AN ENGINEERING SURVEY:

12. ADJUSTMENTS OR CORRECTIONS MADE: Replaced Pressure Guage on Riser. NFPA 25, 2011 (5.3.2)

13. LIST CHANGES IN THE OCCUPANCY HAZARD OR FIRE PROTECTION EQUIPMENT, AS ADVISED BY THE OWNER IN SECTION 1A:

14. INSPECTION AND SUGGESTED IMPROVEMENTS WERE DISCUSSED WITH THE UNDERSIGNED OWNER OR OWNER'S REPRESENTATIVE?
Signature of owner or owner's representative [redacted] Date 4/23/2018

DUPLICATE TO ____
STREET ____
CITY & STATE ____ ZIP ____
ATTN ____

‡ Not Applicable
* Explain (No) Answers on Back of Sheet

appendix C

GATEWAY FIRE PROTECTION SYSTEMS, INC.

1862 Borman Court. • St. Louis, MO 63146

(314) 892-7622 • FAX (314) 892-7448

SALESMAN		CUST. P.O. NO.	% COMP.	EST. COMP. DATE	WEEK ENDING	INVOICE DATE
			100%	4/23/2018	4/27/18	

INVOICE TO:

JOB LOCATION / SHIP TO: HOPE CLINIC

1002 21ST STREET

GRANITE CITY IL 62040

WORK DESCRIPTION

QUARTERLY FIRE SPRINKLER INSPECTION

REPLACED PRESSURE GUAGE

TERMS OF THIS AGREEMENT ARE: (SEE BELOW FOR EXPLANATION OF TERMS)

1. ☑ TIME AND MATERIAL 2. ☐ FIXED PRICE OF $ _____ 3. ☐ PRICE NOT TO EXCEED $ _____

PSN	LAB	P.O.	F.O.	IR	ITEM DESCRIPTION OR EMPLOYEE NAME	QUANTITY	U/M	UNIT PRICE	EXTENDED PRICE	PER-CENT	UNIT COST	EXTENDED COST
FAS					D. VANS	2	ST					
TRVL					50 MILES @ 0.56	5x						
MATERIAL					PRESSURE GUAGE 0-100 PSI	1x						
					2" DIAL							

AUTHORIZED CUSTOMER SIGNATURE

X 7(1)(b) [redacted]

TITLE OF PERSON SIGNING: ASST MAINT DIR

CUSTOMER TELEPHONE NO. 618-451-5722

WO 34824 DATE OF ORDER 4/23/2018

LABOR AND OTHER SUBTOTAL		
MATERIAL SUBTOTAL		MATERIAL
LOCAL TAX		LABOR
STATE TAX		OTHER
TOTAL DUE THIS INVOICE		TOTAL

WHITE - PROCESSING COPY YELLOW - ORIGINAL CUSTOMER INVOICE PINK - CUSTOMER'S ORDER COPY

appendix D

Bel-Clair
ELECTRIC, Inc.
Phone 618-539-5200 Fax 618-539-5201

April 11, 2018

The Hope Clinic for Women
1602 21st St.
Granite City, IL 62040

Re: Operating Room Receptacle

To whom it may concern,

On April 3, 2018, Bel-Clair Electric, Inc. was requested for a service call to evaluate the presence of receptacles fed from normal electrical power (non-generator power) in the four operating rooms within the space. Upon evaluation, it was confirmed that all of the receptacles in these rooms are fed from the generator. To conform to the Illinois Department of Public Health's request, one receptacle, ivory in color, from the normal electrical power source, was added in each of the four operating rooms.

Sincerely,

7(1)(b)

Eric Smith
Bel-Clair Electric, Inc.

11 Southgate Center BCE Freeburg, IL 62243

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

February 6, 2017

Erin King MD
The Hope Clinic for Women, Ltd
1602 21st Street
Granite City, IL 62040

Re: Violation of regulations based on license application, license 7001084

Dear Dr. King:

It has come to the Department's attention that your agency's Corporation membership is not in compliance with 210 ILCS 55 Ambulatory Surgical Treatment Center Licensing Act and Title 77 Il Adm. Code 205 Ambulatory Surgical Treatment Center Licensing Requirements.

Per ILCS 210 6.1. Notwithstanding any other provision of this Act, any corporation operating an Ambulatory Surgical Treatment Center devoted primarily to providing facilities for abortion must have a physician, who is licensed to practice medicine in all of its branches and is actively engaged in the practice of medicine at the Center, on the board of directors as a condition to licensure of the Center.

Section 205.118 Condition of Licensure

d) *Any corporation operating an ambulatory surgical treatment center devoted primarily to providing facilities for abortion must have a physician who is licensed to practice medicine in all of its branches and is actively engaged in the practice of medicine at the* ambulatory surgical treatment *center, on the Board of Directors as a condition to licensure of the* ambulatory surgical treatment *center.* (Section 6.1 of the Act)

Section 205.210 Ownership, Control and Management

a) The ASTC shall have a governing body that assumes full responsibility for determining, implementing and monitoring policies governing the facility's operation:

As such, The Hope Clinic for Women, Ltd. is not in compliance with the Code and its authorizing statute, the Ambulatory Surgical Treatment Center Act (210 ILCS 5/1 *et seq.*) (hereinafter "Act"). The Department thereby requires The Hope Clinic for Women Ltd to identify the names and positions of the

corporation board members who meets all requirements prescribed by the Act and Code **within 10 business days** of receipt of this letter.

Please send the names Board of Directors that includes an actively licensed physician and other members of the Board who are responsible for the operations of this ASTC to the attention of Karen Senger, Division Chief, Division of Health Care Facilities and Programs, 525 West Jefferson St., 4th Floor Springfield, IL 62761 **within 15 business days** of receipt of this letter.

Nothing herein shall be considered a waiver of any enforcement rights the Department may have against the facility, including, but not limited to, the assessment of fines and/or adverse licensure action.

If you have any questions, please contact me at 217-782-0381 or karen.senger@illinois.gov.

Sincerely,

7(1)(b) [redacted]

Karen Senger, RN BSN
Division Chief
Division of Health Care Facilities and Programs

7016 0340 0001 1775 9841

The Hope Clinic for Women Ltd.

February 14, 2017

Karen Senger. RN BSN
Division Chief
Division of Health Care Facilities and Programs
525 West Jefferson St
4th Floor
Springfield, IL 62761

Dear Karen Senger,

I am writing in response to your letter to The Hope Clinic for Women, Ltd. dated February 6, 2017.

Re: Section 205.118
The Hope Clinic for Women, Ltd. current board members:
Sally Burgess, MBA
Hector Zevallos. MD
Your letter has brought to our attention that the current board structure does not meet complete compliance with this section of the Ambulatory Surgical Treatment Center Licensing Act.
Secondary to changes in employment and leadership that have occurred in 2016, The Hope Clinic for Women, Ltd is already actively in the process of changing the board membership. Erin King, MD (myself) is being added to the board with a goal date of completion March 1, 2017. This will also immediately make the corporation compliant with Section 205.118. We will notify the Illinois Department of Public Health as soon as this has been completed.

Re: Section 205.210
The Hope Clinic for Women, Ltd. has an active Governing Body that meets all licensing requirements set forth in the Licensing Act. Please see attached documentation which includes the Governing Body structure and list of responsibilities, as well as an example of notes from a quarterly meeting in which the Governing Body is actively engaged in governing the operations of the facility. We plan to continue with the same structure and membership of the Governing Body for 2017.
Current Governing Body members: Executive Director (Interim – Erin King, MD) and Medical Director (Yogendra Shah, MD).
Both members of the Governing Body are licensed to practice medicine in all of its branches and are actively engaged in the practice of medicine at the ambulatory surgical treatment center.

Please contact me if you need further information or have any questions.

Sincerely,

7(1)(b) [redacted]

Erin King, MD
Interim Executive Director
618-451-5722
erking@hopeclinic.com

Hope Clinic for Women
Governing Body

Members: *Executive Director*
Medical Director

1. Shall review and approve organizational plan.
2. Shall ensure ASTC policies and programs provide quality health care in a safe environment.
3. Shall have oversight and accountability for Quality Assessment and Performance Improvement Program and shall evaluate its effectiveness at least annually
4. Shall approve an infection control program designed to prevent, identify and manage infections and communicable diseases.
    a. Responsible for appointing qualified infection control professional; to direct the infection control program
    b. Shall evaluate effectiveness of the program at least annually
5. Shall establish, protect and promote patients rights including respect for patient's property and privacy, patient safety, the confidentiality of clinical records, and the exercise of patient rights.
    a. Designate a grievance officer
    b. Establish a documented system by which allegations will be reported, investigated and responded to.
6. Shall develop and maintain a written Disaster Preparedness Plan.
    a. Review reports and recommendations at least annually

Approved 12/1/14

Hope Clinic for Women
Consulting Committee Meeting
2016 Quarter 1
5/1/16

Committee Members:
Yogendra Shah, MD – Medical Director
Erin King, MD – Interim Executive Director
Katie Luzecky, RN
Margaret Baum, MD – Hope Clinic physician
Sally Burgess, MBA – Clinic Consultant

Updates: Reviewed
Medical AB: changed criteria include EGA up to 70 days; implemented approved protocols from last CC meeting; includes distribution of new Danco medical AB materials/consent

NEW physician: Margaret Baum, MD started 4/19/16; trained and proficient in first trimester procedures, US, moderate sedation, laminaria placement; plans to continue training/advancing skills for increasing EGA

Changes personnel: resignation of Executive Director/Director of Nursing
Interim Executive Director: Erin King, MD
Director of Nursing position OPEN: hiring now

> NOTE: all shifts will have a Supervising Nurse assigned; this person shall meet all qualifications (active RN license and experience in surgical nursing) and will direct and supervise the nursing personnel and the nursing care of patients

Consulting Committee changes: secondary to personnel changes, Katie Luzecky RN to join at least this meeting for Supervising RN role at CC
Sally Burgess present given recent changes and historical knowledge of clinic operations
When hiring completed new Consulting Committee Roles will be assigned
Organizational Plan INTERIM review/discuss/edit per Governing Body with input from CC members Reviewed and approved

In review of records since change in personnel: recommend the following be done:
DONE
Review/update Grievance Policy - Governing Body with input from CC members
Review/update QAPI - Governing Body with input from CC members
Thorough review of processes will take place this quarter by GB and any new update/revisions will be brought to attention of GB/CC for review at next mtg

Example of complete involvement of Governing Body in all operations; Page 1 of notes from Consulting Committee Meeting Quarter 1

The Hope Clinic for Women Ltd.

March 2, 2017

Karen Senger, RN, BSN
Division Chief
Division of Health Care Facilities and Programs
525 West Jefferson St.
4th Floor
Springfield, IL 62761

Dear Karen Senger,

I am writing to update our response to your letter to The Hope Clinic for Women, Ltd. dated February 6, 2017.

Re: Section 205.118
As of February 27, 2017, the current board members have been elected:

Erin King, MD
Sally Burgess, MBA

With the change in board members, the addition of Erin King, MD (myself) makes the corporation immediately complaint with section 205.118

I have attached the corporate meeting minutes that have gone out to the meeting participants.

Please contact me if you need further information or have any questions.

Sincerely,

7(1)(b) [redacted]

Erin King ,MD
Interim Executive Director
618-451-5722
erking@hopeclinic.com

She thereupon called for the nomination of the directors and the following persons were nominated for directors of this corporation to serve for the corporation's ensuing year, or until a successor may be chosen:
Sally Burgess
Erin King Eisenberg

No further nominations being made, the nominations were closed and the shareholders proceeded to vote on the nominees. The shareholders present at the meeting, having voted, the Chairman announced that the aforesaid nominees had been unanimously elected to be the directors of the corporation until the next annual meeting of the shareholders in accordance with the term provided by the By-Laws.

The Chairman stated that it was necessary to elect officers of the corporation to serve for the term provided by the By-Laws. She thereupon called for the nominations of officers, and the following persons were nominated for officers of the corporation to serve until the next annual meeting of the directors in accordance with the term provided by the By-Laws:

President	Erin King, MD
Secretary	Sally Burgess
Treasurer	Erin King, MD

It was noted that Erin King, MD is licensed to practice medicine in all of its branches and is actively engaged in the practice of medicine at the Hope Clinic for Women meeting 210 ILCS 55 Ambulatory Surgical Treatment Center Licensing Act and Title 77 Il Adm. Code 205 Ambulatory Surgical Treatment Center Licensing requirements.

No further nominations being made, the nominations were closed and the directors proceeded to vote: and the vote having been counted, the Chairman announced that the aforesaid nominees had been unanimously elected to the offices set opposite their respective names, to serve for the corporation's ensuing year, or until successor(s) may be chosen.

There being no further business to come before the special meeting, it was, upon motion duly seconded and carried, adjourned.

7(1)(b) [redacted]

Sally Burgess, Director
Chairman/Secretary

7(1)(b) [redacted]

Hector Zevallos, MD
Stockholder

Minutes of Special Meeting of Stockholders and Directors of Hope Clinic for Women, Ltd.

A special meeting of the board of directors and shareholders of the corporation was held February 27, 2017 in the corporation's offices in Granite City, IL.

The sole Director was present in person and the Stockholder was present by phone.

Sally Burgess was chosen as Chairman and Secretary of the meeting.

The Secretary presented and read the following Waiver of Notice of the meeting, signed by the Director and Stockholder.

Waiver of Notice of Meeting

The undersigned, being sole Director and Stockholder of The Hope Clinic for Women, Ltd , hereby waives notice of the time, place and purpose of a special joint meeting of the Director and Stockholder of the said corporation, and do fix the 27th day of February, 2017, at 10.00am, in the offices of the corporation in Granite City, Illinois as the time and place of such meeting.

We hereby waive all the requirements of the State of Illinois, both as to time and place of said meeting and to the publication thereof, and consent to the transaction of such business as may come before said meeting.

Dated February 27, 2017

7(1)(b) [redacted]

Hector Zevallos, MD
Stockholder

7(1)(b) [redacted]

Sally Burgess
Director

The Chairman stated that the first item of business to come before the meeting was to increase the number of directors to TWO She proposed that the By-Laws were amended accordingly to reflect this change: Article III, section 2 "Number, Tenure, and Qualifications"; "The number of directors of the corporation shall be two."

The Chairman stated it was necessary to elect the directors to serve for the term provided by the By-Laws

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

X ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ CBRR

NAME AND ADDRESS OF FACILITY: Hope Clinic for Women
1602 21st Street, Granite City, IL 62040

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
	An annual licensure survey was conducted on 11/23/16 in conjunction with complaint investigation COI161429. The Hope Clinic For Women was in compliance with Illinois Administrative Code, Title 77, Chapter I, Subchapter b, Part 205 Ambulatory Surgical Treatment Center Licensing Requirements, for this survey.		

DATE OF SURVEY 11/21/16 to 11/23/16

BY 31195, 29526, 34824 _____
(Surveyor)

_____
(Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY _____

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

X ASTC ☐ HHA ☐ HMO ☐ HOSPCIE ☐ HOSPITAL

NAME AND ADDRESS OF FACILITY Hope Clinic for Women
1602 21st Street Granite City

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
	A complaint investigation was conducted 9/8/14 through 9/10/14. Complaint # 141414 was unsubstantiated. No deficiencies cited. The Hope Clinic for Women is in substantial compliance with the Illinois Administrative Code 205 Ambulatory Surgical Center Treatment Licensing Requirements as of 9/10/14.		

DATE OF SURVEY 9-8-9/10/14 BY 31195
SURVEYOR

If PLV, INDICATE DATE OF PRIOR SURVEY:

PROVIDER'S REPRESENTATIVE

Revised: 09/20/06:rsc

IDPH FILE COPY

DATE

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

Pat Quinn, Governor
LaMar Hasbrouck, MD, MPH, Director

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

January 31, 2014

Erin King, MD, Administrator
Hope Clinic for Women, Ltd., The
1602 21st Street
Granite City, IL 62040-

Re: Hope Clinic for Women, Ltd., The
Granite City
Licensure survey

Dear Erin King, MD:

On 04/28/12 a life safety code inspection was conducted for the purpose of determining compliance with the requirements of the "Ambulatory Surgical Treatment Center Licensing Requirements" (77 Ill. Adm. Code 205) and NFPA 101, Life Safety Code, 2012 Edition. Based on the Life Safety Code Monitoring visit on 01/29/14, we find that the previously cited deficiencies have been corrected and the facility is no longer under monitoring for physical environment.

If you have any questions about this approval, please do not hesitate to call us at 217-785-4247 The Department's TTY number is 800/547-0466, for use by the hearing impaired.

Sincerely,

7(1)(b)

Henry Kowalenko, Division Chief
Division of Life Safety and Construction

acceptable
7/19/13

PRINTED: 06/18/2013
FORM APPROVED

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL1084	A. BUILDING: 01 - MAIN BUILDING B. WING _____	R 06/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE CLINIC FOR WOMEN LTD THE	1602 - 21ST STREET GRANITE CITY, IL 62040

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 000}	Initial Comments The Illinois Department of Public Health (IDPH) conducted an onsite Life Safety Code inspection on 4/25/12 at the Hope Clinic for Women. The facility is an Ambulatory Surgery Center (ASTC) located at 1602 21st Street, Granite City, IL. Surveyor 12798 met with the facility staff to identify the purpose of the visit prior to touring the facility. The building was built about 1998 and is a two story facility. The facility is fully sprinkler protected and appears to be Type II (000) contstruction. The Surgery Center is located on the ground floor of the building and was inspected under the Illinois ASTC Licensing Requirements and the Life Safety Code (2000). The upstairs of the building contains waiting rooms and business offices. The following deficiencies were identified by document review, staff interview or direct observation. The findings listed below include the code section(s) of the deficiency for your convenience. Surveyor 13755 A Follow-up Life Safety Code survey was conducted on 2/28/13 to confirm the provider's completion of their plan of correction. Selected deficiencies were noted to be corrected. Other deficiencies remain due to lack of sufficient documentation or proper correction. Any new deficiencies were identified through document review, staff interview or direct observation. Corrected deficiencies have been removed from the survey document. Surveyor 12798 A Follow-up Life Safety Code survey was	{L 000}		

RECEIVED-OHCR
JUL 12 2013
LIFE SAFETY & CONSTRUCTION

7(1)(b)

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

TITLE: Assoc Medical Director

(X6) DATE: 7/10/13

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{L 000}	Continued From page 1 conducted to confirm the provider's completion of their plan of correction dated 3/18/13. Selected deficiencies were noted to be corrected. Other deficiencies remain due to lack of sufficient documentation or proper correction.	{L 000}		
{L 050}	21.7.1.2 FIRE DRILLS Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift, using the fire alarm system, except at night. The staff is familiar with procedures and is aware that drills are part of established routine. 21.7.1.2 This Regulation is not met as evidenced by: A. Based on record review it was determined that the facility failed to conduct fire drills as required. Fire drills are to be held at unexpected times under varying conditions, at least quarterly on each shift per NFPA 101, 21.7.1.2. This deficient practice could affect staff, visitors as well as patients. 1. corrected 6/14/13 UPDATE 2/28/13: a. corrected 6/14/13 b. corrected 6/14/13 2. Upon review of the facility's "Fire Emergency Protocol 2012" document last revised 5/12, the following irregularities are noted: a. Page 1 of 3 of the protocol references the RACE procedure but directs staff members to "Assess the fire and implement RACE." The policy states: "The fire alarms will automatically go off when there is a fire. However, in the event that the fire alarm has not gone off &	{L 050}		

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{L 050}	Continued From page 2 the fire is too large to extinguish, the staff member should immediately notify a manager or call 9-1-1. If the staff person assesses the fire and determines that the fire could be harmful, she or he should not hesitate to pull the fire alarm." This procedure appears to permit staff members to make a judgement call relative to the discovery of a fire event and could waste critical time needed for alerting other building occupants and staff for the preparation for evacuation and the summoning of fire department emergency forces. It permits the "Activate alarm" component of the RACE procedure to be omitted. It may also direct staff to attempt to "Extinguish the fire" first rather than the intended last action of the RACE procedure. UPDATE 6/14/13: Only part of the policy was revised. The procedures still appear to permit staff members to make a judgement call relative to the discovery of a fire event. b. Page 2 of 3 of the protocol states: "When the fire alarm goes off, Yale (Omni) is immediately notified (via the system) and a representative contacts the clinic to verify the fire. If necessary, Yale than notifies the fire department. If unable to immediately make contact with a clinic staff person, Yale will proceed with contacting the fire department." This "verification" procedure does not comply with the requirements of NFPA 101-2000, 9.6.4 for the automatic notification of the fire department upon alarm activation because it permits a delay in the transmission of the alarm for the summoning of emergency forces. UPDATE 6/14/13: Only part of the policy was revised. The procedures still appear to contain a delay in the transmission of the alarm.	{L 050}	**21.7.1.2** See the attached Fire Emergency Protocol updated 3/13. The employees have all received copies of this protocol and the updated version is present at all work stations in the Emergency Protocols Binders. (Unfortunately an old version of the protocol was reviewed during your visit 6/14/13). **Completed**	Attached

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(L 051)	20.3.4/21.3.2 FIRE ALARM SYSTEM A manual fire alarm system, not a pre-signal type, is provided to automatically warn the building occupants. The fire alarm system is arranged to automatically transmit an alarm to summon the fire department. 20.3.4 and 21.3.4 This Regulation is not met as evidenced by: A. Fire alarm system with approved components, devices or equipment is installed and maintained according to NFPA 101, 9.6.1.4 and NFPA 70 and 72. Non-functioning equiment may not provide staff proper notification to direct patients and visitors to a means of egress without crossing or entering the area of fire origin. This deficient practice could affect all patients as well as an indeterminable number of staff and visitors. 1. The following documentation was unavailable at the time of this inspection of the fire alarm system as required by NFPA 101, 21.3.4.1: a. Corrected 2/28/13 b. Corrected 2/28/13 c. Corrected 2/28/13 d. It could not be determined, by the information provided, if the fire dampers have been inspected or provided with maintenance in accordance with NFPA 90A, 1999, 3-4.7 Maintenance: "At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary." UPDATE 2/28/13: Ventilation systems are located on the roof in this 2-story building. Therefore, as a minimum, a shaft enclosure through the 2nd	(L 051)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{L 051}	Continued From page 4 floor exists in which dampers should exist where ducts leave the shaft enclosure. No documentation to indicate maintenance of fire or fire/smoke dampers was available. UPDATE 6/14/13: Report dated 4/24/13 indicated that 5 dampers failed. The facility is currently securing estimates to have the units replaced. The location of each damper is unclear, room numbers were given in the report for the dampers locations. The rooms at this facility are not numbered and therefore, the location of each damper could not be located with out the drawing "key". It could not be determined if the ductwork is enclosed in a shaft and that dampers are installed where the branch lines exit this shaft or where the ducts penetrate the floor. Additional information is required prior to the next onsite visit.	{L 051}	20.3.4/21.3.2 Fire damper inspection revealed 5 dampers which need replacement. A second inspection and proposal for replacement cost is being secured at this time (scheduled 7/11/13) secondary to the extremely high cost of these repairs. When all work is completed documentation will be forwarded to the Illinois Department of Public Health. The precise locations of the dampers will be obtained and kept on file at the facility. **Completion estimated by 8/30/13**	
{L 178}	205.1780 Emergency Power 205.1780 Emergency Electrical Service a) An emergency source of electricity shall be provided. b) Ambulatory surgical treatment centers that do not administer inhalation anesthetics in any concentration, or that have no patients requiring electrical life-support equipment, shall be permitted to use a battery system for emergency power. The following is required: 1) Illumination of means of egress as	{L 178}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{L 178}	Continued From page 5 required in the NFPA Life Safety Code. 2) Illumination of procedure and recovery rooms. 3) Illumination of exit and exit directional signs. 4) Fire alarm and alarms required for nonflammable medical gas systems, if nonflammable medical gas systems are installed. c) Ambulatory surgical treatment centers in which inhalation anesthetics are administered in any concentration to patients or that have patients requiring electrically operated or mechanical life support devices must be provided with an emergency generator. This generator must supply a limited amount of lighting and power service that is essential for life safety and orderly cessation of a procedure during the time normal service is interrupted for any reason. The maximum time of automatic transfer is 10 seconds. The following is required: 1) Task illumination that is related to the safety of life and that is necessary for the safe cessation of procedures in progress. 2) All anesthesia and resuscitative equipment used in areas where inhalation anesthetics are administered to patients must include alarms and alerting devices. 3) Illumination of means of egress as required in the NFPA Life Safety Code.	{L 178}		

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(L 178)	Continued From page 6 4) Illumination of exit and directional signs. 5) Fire alarm and nonflammable medical gas system alarms, if nonflammable medical gas systems are installed. 6) General illumination and selected receptacles in the vicinity of the generator set. (Source: Amended at 18 Ill. Reg. 17250, effective December 1, 1994) This Regulation is not met as evidenced by: A. The surveyor finds that the facility has an emergency generator inside of an enclosed garage is part of the building. The generator is not installed and maintained in accordance with NFPA 99 and 110. 1. Corrected 2/28/13 2. Corrected 2/28/13 3. Corrected 6/14/13 4. The facility has a service agreement (every 6 months) with Luby Equipment Services, the vendor failed to provide documentation as to what services are being provided, date of service, inspectors name and signature, etc. as required by NFPA 99 and 110. UPDATE 2/28/13: The documentation from the vendor is typically incomplete or inconsistently filled out by the mechanics performing the inspections. The identification of the generator does not document the electrical characteristics of the generator or that any building load was	(L 178)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(L 178)	Continued From page 7 transferred to the emergency power system during the inspections. No indication that the transfer switches were operated is given. Only a single Hour Meter reading is provided so it is not clear whether this reading is taken before or after the inspection and any run time. The information provided by the service provider does not meet the requirements for monthly operational testing in accordance with NFPA 110-1999, 6-4.2. UPDATE 6/14/13: The time to transfer the load from normal power to emergency power is not being recorded on the documentation. 5. The facility indicated that the generator runs each week. There are no documents available to verify the length of time the generator runs, if the generator is placed under load, etc. Compliance testing and documentation in accordance with NFPA 99, 3-4.4.1.1 and NFPA 110, 6-4.2 was not available. UPDATE 2/28/13: a. The documentation for the weekly run of the generator appears to be only a weekly "exercising" of the diesel engine system and not an actual transfer of load to the generator system. b. No exercising of the transfer switch is documented to indicate a load transfer. No generator testing procedures are available for staff to follow to conduct the required testing. c. Only a single "Amp" reading is provided for this 15 KW 120/208v 3-phase generator system (3-phase requires three separate readings). The single Amp readings tabulated each week range from 15 to 20 amps. This generator should document the following minimum load to meet the 30% requirement.	(L 178)	205.1780 Monthly documentation will now also include: • The test is conducted for the full 30 minutes • The time for transfer of load from normal to emergency power See attached documentation from the generator maintenance company. **Completed** Copy Attached	

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HOPE CLINIC FOR WOMEN LTD THE	1602 - 21ST STREET GRANITE CITY, IL 62040

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(L 178)	Continued From page 8 15,000 watts/120v=125 total amps (single phase) 125 total amps/3=42 amps per phase (single phase) 42 x .3 (30%)=13 amps per phase (single phase) or if 3-phase voltage is used: 15,000watts/208v=72 total amps (3-phase) 72 total amps x 1.73 (sq root of 3, to convert to single phase)=125 total amps (single phase) 125 total amps/3 = 42 amps per phase (since readings are taken for each phase) 42 x .3 (30%) = 13 amps per phase (single phase) Therefore, the minimum load of 30% of the nameplate rating could not be verified when only a single value is tabulated. It could not be determined whether the single value represented a total load or only a load on one phase. d. The documentation does not tabulate the monthly operational testing of the generator system per the suggested Operational and Testing Procedures outlined in NFPA 110-1999, A-6-4.1(b) to record the tranfer time delay from a cold start, the running time meter reading at the start and end of the test and any cool-down times to determine that the generator runs under load for a minimum of 30 minutes to comply with NFPA 110-1999, 6-4.2. UPDATE 6/14/13: The facility has hired Luby to conduct the monthly generator test. The latest report dated 5/29/13 indicates the Amps as "A=4, B=10, C-3" which does not meet the 30% requirement. A note at the bottom of this report under "comments" states: "all checks ok under 20 minute run under building load". The contractor is	(L 178)		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL1084	A. BUILDING: 01 - MAIN BUILDING B. WING _____	R 06/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE CLINIC FOR WOMEN LTD THE	1602 - 21ST STREET GRANITE CITY, IL 62040

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(L 178)	Continued From page 9 not conducting the test for the full 30 minutes which may cause wet stacking in this unit. The contractor is not documenting the time it takes to transfer the load from normal power to emergency power.	(L 178)		

Protocol: Fire Emergency Protocol
Document: Fire Emergency Protocol 2012
Department: ALL
Date: Revised 5/12, 4/11, 2/07, 11/02, 9/02, 8/02, 3/01, 6/99, 3/13

POLICY: It is the policy of **The Hope Clinic for Women, Ltd.** to ensure the safety of all employees, patients, and visitors in the event of a fire and be in compliance with NFPA codes (101, 2000, 21.7.1-2).

If a staff member staff finds a fire, the staff member should:

Implement RACE.

Rescue or removal of all occupants directly involved with the fire emergency.

Activate the fire alarm signal to warn other building occupants and summon staff.

Confinement of the effects of the fire by closing doors to isolate the fire area.

Evacuate the building./ Extiguish fire, if possible

To Activate Extinguishers:

1. Pull the pin on the handle out.
2. Aim nozzle at the base of the fire, not at the flames.
3. Squeeze handle together.
4. Sweep the bottom of the flames with the spray.

Extinguisher locations:

- Recovery Room – 1st floor
- Patient Corridor outside Procedure Rooms (1 & 2) – 1st floor
- Sterile Corridor Across from Sterilizer – 1st floor
- Doctors entrance – 1st floor
- Across from office supply cabinets – 2nd floor
- Main lobby by elevator – 2nd floor
- Administrative corridor – 2nd floor

When a staff member hears the fire alarm, the staff member should:

1. Immediately begin fire confinement and evacuation procedures.
2. Verify that the "DND" on her phone is **not** on, so she can hear pages over the intercom.

Evacuation of the building should be handled as follows:

1. *Evacuation* includes notifying all patients/visitors to move quickly along exit routes to the Emergency Meeting Area, checking your area thoroughly and verifying completed evacuation.
2. *Confinement* includes closing all doors in your area during the evacuation process.
3. *Emergency Meeting Area* is the ***staff parking lot*** on the southeast side of the building.
4. *Exit routes*: Maps are posted throughout the clinic to aid in the evacuation of the building.
5. Instructions for specific locations:
   a. FRONT DESK: in the main lobby
      1. Evacuate: the main lobby area & restrooms, the Patient's Only lounge, and the fee consulting office. TAKE PATIENT LIST
      2. Proceed: down the front stairs and out the main entrance.
   b. LAB:
      1. Evacuate: the sono room, lab, lab restroom and the lab lobby.
      2. Proceed: down the back stairs and out the rear door.
   c. COUNSELORS:
      1. Evacuate: the counseling offices, the special counseling offices, the education office and the 3 employee/staff restrooms in their areas.
      2. Proceed: from front counseling offices proceed down the front stairs and out the main entrance; from rear counseling offices proceed down the back stairs and out the rear door.
   d. COLLECTING:
      1. Evacuate: is responsible for evacuating the collection office.
      2. Proceed: down the back stairs and out the rear door.
   e. ADMINISTRATIVE AREA:
      1. Evacuate: offices and employee lounge. (<u>If it can be done safely</u>, someone from the administrative area should try to take any computer back-up tapes from the main computer cubicle.)
      2. Proceed: down back stairs and out rear door.
   f. RECOVERY ROOM:
      1. Evacuate: the main and the private recovery rooms; restrooms, downstairs lobby, the lobby restroom.
      2. Proceed out the front door.
   g. OPERATING ROOM:
      1. Evacuate operating room, patient dressing room and restrooms in surgical area/dressing, staff changing area/restroom, instrument room.
      2. Proceed out the nearest emergency exit. (i.e. staff changing area proceed out physician's entrance)

Fire Alarm:

1. When activated:
    a. Yale Security (Omni) is immediately notified (via the system). Yale immediately proceeds with contacting the fire department. (Yale # is 314-633-4092, ID # 2771)
    b. location of the suspected fire shows up in the "window' on the Barcom Panel
2. To Silence the Fire Alarm:
    a. The fire alarm can be silenced in two places:
        i. Edwards Panel in the Executive Director's office
        ii. Edwards Panel in the front desk area of the main lobby
3. Location of Fire Alarms:
    a. Upstairs:
        i. Main lobby by the exit door
        ii. Hallway across from the lab, beside the door down to dressing room
        iii. Directly outside of staff lounge
    b. Downstairs:
        i. Front main entrance
        ii. In the back staircase outside the patient dressing room
        iii. Recovery room
        iv. Beside emergency exit door
        v. Hallway beside the delivery door

Quarterly Fire Drills (in compliance with NFPA 101,2000, 21.7.1.2)

1. Quarterly drills will be conducted on *each shift (*day and evening) to familiarize all facility personnel with the signals and emergency action required *under varied conditions*
2. Will include:
    a. the transmission of a fire alarm signal (except between 9pm and 6am)
        i. notify Yale security (Omni) of fire drill (314-633-4092)
        ii. activate actual firm alarm system by pulling down on fire alarm
    b. simulation of *varied* emergency fire conditions
    c. exception: bedridden (recovering patients) shall not be required to be moved during drills to safe areas or to the exterior of the building (use of empty wheelchairs or stretchers can be used for simulation)
3. Documentation shall include:
    a. list of participants
    b. shift involved and time of the drill was conducted
    c. conditions of the drill
    d. fire alarm system monitoring:
        i. verification from the monitoring company (Yale security) that the fire alarm signal was received and functioning properly
        ii. verification fire alarm signal functioned properly in the clinic
    e. outcomes of the drill
4. All employees will be instructed in the life safety procedures and devices.
    a. all new employees will receive emergency protocols as part of orientation process
    b. current employees will verify and document receipt of protocols annually at Quarter 1 Fire Drill

LUBY EQUIPMENT SERVICES
Planned Maintenance Agreement
For Generator Systems

☐ 2300 Cassens Drive, Fenton, MO 63026 (636) 343-9970
☐ 199 Airport Rd., Cape Girardeau, MO 63702 (573) 334-9937
☐ 4375 Camp Butler Rd., Springfield, IL 62707 (217) 744-2233
☐ 2625 N. 24th St., Quincy, IL 62305 (217) 222-5454
☐ 8853 Petroff Dr., Caseyville, IL 62232 (618) 397-9971

☑ POTENTIAL PROBLEM
☒ URGENT PROBLEM
☑ OK
☐ ADJUST
☑ REPAIR

CUSTOMER: [illegible] CONTACT NAME: [illegible] DATE: 1/21/15
PO NO: _____ SITE: _____ RO NO: 150611 ENGINE CPL NO: _____
GENERATOR MODEL NO: [illegible] GENERATOR S/N: [illegible] ENGINE MODEL NO: J 4 C ENGINE S/N: 91954
SPEC: _____ SPEC: _____
TRANSFER SWITCH MODEL NO: [illegible] TRANSFER SWITCH S/N: 44752 HOUR METER: 2560

MAINTENANCE SCHEDULE PERFORMED ☐ INSPECTION ☐ INSPECTION & FULL SERVICE ☐ LOAD BANK

ENGINE
☐ GAS
☐ SPARK PLUGS
☐ IGNITION POINTS
☐ BELTS
☐ CHOKE
☐ DISTRIBUTOR
☑ IGNITION WIRES
☑ DIESEL
☑ BELTS
☑ SERVICE AIR CLEANER
☐ INJECTION PUMP
☐ TURBOS

OIL SYSTEM
☐ CHECK ENGINE LUBRICATION
☐ OIL FILTER
☑ LUBRICATE GOVERNOR & LINKAGE
☐ CHECK ENTIRE UNIT FOR OIL LEAKS
☐ CHECK LUBE OIL LEVEL

EXHAUST SYSTEM
☐ VISUAL INSPECTION OF EXHAUST SYSTEM FOR
☐ LEAKS & DRAIN CONDENSATION TRAP IF APPLICABLE

COOLING SYSTEM
☐ CHECK ENGINE RADIATOR COOLANT LEVEL & RECORD PROTECTION
☐ CHECK FOR LEAKS, TIGHTEN HOSE CLAMPS & HOSE CONDITION
☐ CHECK ENGINE BLOCK HEATER & RECORD WATER TEMPERATURE_____
☐ CHECK ENGINE FINS/AIR COOLED UNIT
☐ CHECK SOLENOID VALVE & FLEX WATER LINES
☐ CHECK LOUVER OPERATION
☐ CHECK WATER FILTER

DCA LEVEL [illegible]
ANTIFREEZE CONCENTRATION [illegible]

FUEL SYSTEMS
☐ CHECK FLEXIBLE FUEL CONNECTIONS & LINES
☐ CHECK DAY TANK FLOAT LEVEL
☐ CHECK FUEL TRANSFER PUMP
☑ FUEL FILTER(S)
☐ CHECK FUEL SOLENOID
☑ CHECK & RECORD FUEL SUPPLY-APPROX 1/4

STARTING SYSTEM
☑ CHECK START SOLENOID TERMINALS
☑ CHECK STARTER

ELECTRICAL
☑ CHECK ELECTRICAL CONNECTIONS
☐ CHECK AC & DC BRUSHES, IF APPLICABLE
☐ CLEAN COLLECTOR RING, IF APPLICABLE
☐ CLEAN COMMUTATOR, IF APPLICABLE
☑ CHECK DC ALTERNATOR

BATTERY
☐ CHECK BATTERY STARTING SYSTEM
☐ BATTERY CHARGER - RECORD READINGS
AMPS_____ VOLTS_____
☐ CHECK SOLUTION LEVEL
☑ CHECK CONNECTIONS & CLEAN IF NECESSARY
☑ NOTE OVERALL CONDITION OF BATTERY SYSTEM
☐ RECORD SPECIFIC GRAVITY

CELLS [illegible]

	1+	2-	3+	4-	5+	6-
B1						
B2						
B3						
B4						

OPERATING CHECK
☐ RUN GENERATOR & CONDUCT SAFETY TEST
OVERSPEED
LOW OIL PRESSURE
HIGH WATER TEMPERATURE

BUILDING LOAD TEST IF PERMITTED
ENGINE WATER TEMP [illegible]
ENGINE LUBE PRESSURE [illegible]
LUBE OIL TEMP _____
BATTERY CHARGE RATE _____
AMPS: A [illegible] B [illegible] C [illegible]
VOLTAGE _____
FREQUENCY _____
ADJUST VOLTAGE REGULATOR _____
CHECK ENGINE MOUNTS _____
CHECK EXHAUST MOUNTS & EXHAUST SMOKE _____
CHECK OIL PAN _____
CHECK ABNORMAL SOUNDS _____
CHECK VIBRATIONS _____

AUTOMATIC SWITCH
☑ INSPECT INSTRUMENT & GAUGES
☐ CHECK BATTERY CHARGER
☐ CHECK EXERCISER CLOCK
☐ CHECK SELECTOR SWITCH
☑ START AND STOP UNIT FROM SWITCH
☐ CHECK TIME DELAYS

RECOMMENDED ADDITIONAL WORK OR COMMENTS [illegible]

MECHANIC SIGNATURE _____ CUSTOMER SIGNATURE 7(1)(b) _____

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

☒ ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

NAME AND ADDRESS OF FACILITY: Hope Clinic For Women Ltd.,1602 21st Street, Granite City, Illinois 62040

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.410 Equipment	**Equipment shall be in good working order and shall be available in numbers sufficient to provide good patient care based on the procedures to be performed in the facility.** Based on observation, document/record review and staff interview, it was determined the Ambulatory Surgical Treatment Center (ASTC) failed to ensure the oxygen tank in the recovery room contained an adequate amount of oxygen, potentially affecting 100% of the patients. Findings include: 1. On 10/7/13 at 11:00 AM a tour of the ASTC was conducted while being escorted by the Nurse Administrator (E#1).	205.410 The oxygen tank was replaced with a full tank prior to next patient care day per existing protocol. Completed	

2/25/14 Or

DATE OF SURVEY 10/07/13-10/8/13 BY 25926,25927,32822,31195 (Surveyors) 7(1)(b) (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY 3/9/12

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

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NAME AND ADDRESS OF FACILITY: Hope Clinic For Women Ltd.,1602 21st Street, Granite City, Illinois 62040

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2/25/14 pr

DATE OF SURVEY 10/07/13-10/8/13 BY 25926,25927,32822,31195 (Surveyors) _____ (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY 3/9/12 Page1 of 4

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
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LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
Section 205.410 Equipment (Continued)	In the Recovery Room, a portable oxygen (O2) tank, used for emergencies, was checked for adequate oxygen. The O2 valve was turned to the open position and the O2 regulator indicated "Refill". 2. On 10/7/13, a review of Policy "Medical Emergency Protocol", revised 4/11, was conducted. Under "POLICY: 3b Oxygen tanks in .....Recovery Room have adequate amounts of oxygen" 3. On 10/7/13 at 11:20 AM and interview with E#1 was conducted. E#1 confirmed the O2 tank regulator indicated the tank needed replacing. E#1 stated "We check the oxygen tanks weekly. It was checked last week and will be checked again tomorrow before patients arrive."		

DATE OF SURVEY 10/7/13-10/8/13 BY 25926,25927,32822,31195 (Surveyors) 7(1)(b) (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY 3/9/12

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
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NAME AND ADDRESS OF FACILITY: Clinic For Women Ltd.,1602 21st Street, Granite City, Illinois 62040

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.530 (c) Examination of Removed Tissues (Continued)	(2) A copy of the pathology report shall be filed in the patient's clinical record within seven days. Based on document/record review and interview 2 of 5 records (Pts #7, #9) of patients receiving surgical services failed to include the pathology report in the patient record within 7 days. Findings include: 1. A review of the clinic policies was completed during the survey. The clinic policy titled "Tissue Evaluation" dated 4/3/11 indicates under bullet point 4, "A copy of the pathology report shall be filed in the patient's clinical record within seven days." 2. The clinical record of Pt #7 was reviewed on survey day 10/7/13. Pt #7 was admitted for services on 4/16/13 for termination of pregnancy at 18 weeks. The Operative Report indicates a second trimester surgical abortion was completed and products of conception were sent to pathology and received on 4/24/13. The pathology report was received on 4/25/13, after the 7 day time frame.	205.530 The existing protocol was reviewed and clarified to reflect that the report will be filed in the chart within seven days of receipt from Pathologist. See the attached Tissue Evaluation Protocol updated 2/14. Completed	

DATE OF SURVEY 10/7/13 -10/8/13 BY 25926,25927,32822,31195 (Surveyor)

7(1)(b) [redacted] (Provider's Representative)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY 3/9/12

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
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NAME AND ADDRESS OF FACILITY: Clinic For Women Ltd.,1602 21st Street, Granite City, Illinois 62040

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2/25/14 RV

DATE OF SURVEY 10/7/13 -10/8/13 BY 25926,25927,32822,31195 (Surveyor) (Provider's Representative)

NOTE: IF FLV, INDICATE DATE OF PRIOR SURVEY 3/9/12

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
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NAME AND ADDRESS OF FACILITY: Hope Clinic For Woman Ltd.,1602 21st Street, Granite City, Illinois 62040

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.530 (c) **Examination of Removed Tissues (Continued)**	3. The clinical record of Pt #9 was reviewed on survey day 10/7/13. Pt #9 was admitted for services on 12/12/12 for termination of pregnancy at 18 weeks. The Operative Report indicates a second trimester surgical abortion was completed and products of conception were sent to pathology and received on 12/17/12. The pathology report was received on 12/20/12, after the 7 day time frame. 4. On 10/8/13 at 10:40 AM in an interview with the clinic Administrator (E#2), the pathology reports for Pt #7 and #9 were reviewed and eE#2 confirmed the reports were over the 7 day time frame for incorporation into the clinical record.		

DATE OF SURVEY 10/7/13-10/8/13 BY 25926,25927,32822,31195 (Surveyor)

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY 3/9/12

7(1)(b) [redacted] (Provider's Representative)

Protocol: Tissue Evaluation
Document: Tissue Evaluation 4-11
Department: surgical
Date: 4/3/11; revised 2/14
Reviewer: Consulting Committee 5/11

Purpose: Complete removal and identification of products of conception help prevent complications of abortion.

- Completion of abortion will be confirmed prior to the patient leaving the facility.

- First trimester abortion:
    1. The following methods may be used:
        - tissue exam
            - flotation of tissue with backlighting to identify products of conception, including villi, gestational sac, and/or appropriate fetal tissue
        - and/or ultrasound exam
    2. When insufficient tissue or incomplete products of conception are obtained, or ultrasound findings unclear, the patient will be reevaluated.
        - The following methods may be used:
            - Follow-up pelvic ultrasonographic examination
            - Reaspiration
            - Serial quantitative hCG
                - a 48-hour post-procedure serum quantitative hCG test should decrease by 50% or more
        - The patient must be informed and given information about the possibility of continuing pregnancy or undiagnosed ectopic pregnancy
        - The patient must not be released from follow-up care until a clear diagnosis has been made

- Second trimester abortion:
    1. Placenta and all major fetal parts must be identified after removal from the uterus
    2. If not identified, ultrasonographic evaluation and repeat uterine exploration under ultrasound guidance should be considered.
    3. The clinician will continue follow-up care of the patient until completion of the abortion has been determined.

- Pathological examination of evacuated uterine contents is required by Illinois Department of Public Health
  (Illinois Department of Public Health – Administrative Code – Section 205.530 "Operative Care" c) Examination of Removed Tissues)
    1. "All tissues removed during surgery shall be examined by a consulting pathologist, who shall provide a written report of the examination to the attending physician."
    2. "A copy of the pathology report shall be filed in the patient's clinical record within seven days" of receipt of the report at the Hope Clinic.
- All evacuated tissue will be sent for pathologic evaluation:

  Pathology Services, Inc.
  Surgical Pathology & Cytology Laboratory
  2916 S. Brentwood Blvd
  St. Louis, MO 63144
  Phone 314-963-1745; fax 314-963-1808
  Confirmation received 5/9/11: Waste Management (medical waste provider) will transport all specimens from Pathology Services, Inc. to an incineration facility

References:
1. National Abortion Federation *Clinical Policy Guidelines 2011* "Evaluation of Evacuated Uterine Contents" p51-52
2. Illinois Department of Public Health – Administrative Code – Section 205.530 "Operative Care" c) Examination of Removed Tissues