Illinois Department of Public Health puts **WOMENSS** HEALTH *at RISS*

- A FULL REPORT -

ILLINOIS RIGHT TO LIFE

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INTRODUCTION

No woman should enter a women's abortion clinic and leave needing a tetanus shot, HIV testing, or emergency treatment at the hospital.

However, following the 2010 investigation and conviction of Kermit Gosnell – a physician in Pennsylvania who provided unsanitary services at his licensed abortion clinic¹ – concerns were raised about the health and sanitary conditions of Illinois women's abortion clinics (referred to as "women's clinics"). Illinois Right to Life conducted an investigation into the health and sanitary conditions of these centers.

What we discovered is a severe pattern of disregard for basic medical and sanitation practices among licensed women's clinics. Women's clinics are leaving patients exposed to health complications including infections requiring emergency treatment, complete hysterectomies, and/or death.

Between 2000 and 2010, 92% of all (licensed or unlicensed) women's clinics received *no health and sanitary inspections*. During this ten-year span, only three total health and sanitary inspections were conducted in three women's clinics. Nearly 86% of all women's clinics in Illinois went between nine and seventeen years without a single health or sanitary inspection.²

In 2011, the Illinois Department of Public Health's first sanitary inspections in over a decade at some licensed women's clinics revealed violations so severe that two clinics were closed on an emergency basis to protect their female patients.³ Twelve of the fourteen women's clinics inspected in 2011 through 2014 were cited with health and sanitary violations including: unsterile surgical tools, TV dinners being stored in the same refrigerator as fetal tissue, failure to have a registered nurse on staff and failure to perform CPR on a female patient who died at the clinic. One of the women's clinics that was not cited for serious health and sanitary violations had three recorded deaths prior to its inspection.⁴

Today, 54% of women's clinics are not licensed by the State of Illinois and, therefore, never receive health and sanitary inspections. The Illinois Department of Public Health has no authority over unlicensed women's clinics even if they perform surgical abortions.

This report provides an overview of women's clinic inspections in Illinois, the health and sanitary violations found within these clinics, and the suffering women have endured due to substandard medical care. Included at the end of this report are government policies that are failing women and recommended solutions to protect women's health.

OVERVIEW OF WOMEN'S ABORTION CLINICS

According to the Guttmacher Institute, there were approximately twenty-six freestanding women's clinics in Illinois in 2011.⁵

These freestanding clinics can – but are not required to – seek one of two kinds of licenses: an Ambulatory Surgical Treatment Center (ASTC) license or a Pregnancy Termination Specialty Center (PTSC) license.⁶ Once a license is obtained, the Illinois Department of Public Health is responsible for conducting regular health and sanitary inspections in the licensed women's clinics. The Illinois Department of Public Health does not conduct health and sanitary inspections in unlicensed women's clinics even if those clinics insert surgical tools into sterile areas of women's bodies during procedures.

The following facts were obtained from Freedom of Information Act (FOIA) requests submitted to the Illinois Department of Public Health:

40%	of the clinics licensed by the state between 2000 and 2014, went between 14 and 17 years without health inspections. ¹⁰
26.7%	of the clinics licensed by the state between 2000 and 2014, went 9-13 years without health inspections. ¹¹
20%	of the clinics licensed by the state between 2000 and 2014, went 5-7 years without health inspections. ¹²
63%	of the licensed women's clinics open today, have gone between two and three-and-a-half years without a health and sanitary inspection.

All five Planned Parenthood clinics that perform abortions are not licensed and therefore <u>did not</u> receive health and sanitary inspections from the Illinois Department of Public Health between 2000-2014.⁸

Between 2011 and 2014, licensed women's clinics were inspected. Some received their first inspection since opening and others for the first time in nearly two decades.

Two women's clinics were temporarily shut down on an emergency basis in 2011 following their first health inspection in fifteen years. Both clinics later voluntarily closed instead of upgrading to meet basic health and sanitary standards.⁹

TODAY, 54% OF ILLINOIS WOMEN'S CLINICS ARE UNLICENSED AND HAVE NOT RECEIVED A HEALTH AND SANITARY INSPECTION IN OVER 14 YEARS.⁷

HEALTH AND SANITARY VIOLATIONS

After the majority of licensed women's clinics went between one and two decades without health and sanitary inspections, the Illinois Department of Public Health conducted a sanitary inspection in each of the licensed women's clinics between 2011 and 2014. Approximately 193 health and sanitary and life code violations were cited in thirteen of the fourteen licensed women's clinics. The following violations were taken directly from the Illinois Department of Public Health's sanitary inspection reports.¹³

- ⁶⁴ The Recovery Room technician (E#1) was observed on 9/6/11 at approximately 9:20 am, retrieving a paper towel from a garbage receptacle and using the same paper towel to cover a tray that would serve food items to patients."¹⁴
- ⁶⁶ The suction machine in OR #1 contained clear water with specks of floating debris....five (5) of 5 recovery beds were rusty....Nine (9) medication cups, identified as containing Motrin and 10 medications cups containing Tylenol contained crumbs." ¹⁵
- ...failed to ensure medication syringes were labeled and stored in a safe, clean area. This has the potential to affect up to 100% of patients." ¹⁶
 - ^{CC} The biohazard laboratory refrigerator contained 8 products of conception (tissue). The same refrigerator also contained medications and 3 frozen TV dinners." ¹⁸
- OR #2 and #3 contained shoes stored with an open box of surgical gloves. Four (4) of 16 'gynecological cannulas' [surgical tools inserted into a woman's uterus] in OR 2 were stained with a brown substance." ¹⁷
 - Suction tubing in OR #1, identified by the staff as clean, was suspended over a biohazard container. The lid of the container when opened touched the clean tubing." ¹⁹

On 5/18/11...OR #2 was inspected and observed with loose debris on the floors, a red stain on a wall and standing water in a small bucket. The last surgical day was 5/16/11."²⁰ ...it was for 1 of 2 operating rooms (OR2) observed, the Facility failed to ensure a sanitary enviroment." ²¹

- Failed to ensure single dose vials were not available for use on multiple patients. This has the potential to affect 100% of patients."²²
- 5 of 5 records reviewed, the facility failed to ensure all patients received pre-operative and post-operative counseling." ²³

- ** Two boxes of 'Nuva Rings' (contraceptive medication) were stored in the RR refrigerator with a liter of cola." 24
- Failed to ensure the oxygen tank in the recovery room contained an adequate amount of oxygen, potentially affecting 100% of the patients....failed to provide an adequate recovery room – included 2 beds and 11 chairs."²⁵

It was determined that for 2 of 2 (E#1 and 2) Registered Nurses available, the Facility failed to ensure the presence of a circulating RN during an invasive and operative procedure." ²⁶

⁽¹ On 6/6/11...the 2 of 2 terminated RN's personnel files (E #3 & 4) were reviewed. There was no Registered Nurse currently employed." ²⁷

…in 2 of 7 (Pt #3 and #4) clinical records reviewed of patients transferred to an inpatient facility, the Facility failed to ensure required documentation accompanied the patient."²⁸

On 5/23/11...OR #2 was inspected. OR #2 contained tape on an IV pole and brown stains on the suction machine. The last surgical day was on 5/14/11." ³⁰ 66 Based on Manufacturer's Guidelines, Biological Spore Testing Log, and staff interview, it was determined that for 3 of 9 weeks in March and April 2011...the facility failed to ensure biological spore testing was verified and documented each week." 29

...it was determined that for 2 of 2 operating rooms (OR# 1 and 2) observed, the facility failed to ensure a sanitary environment."³¹

...it was determined for 4 of 6 patients...who underwent a surgical procedure on 12/02/11, the facility failed to ensure a pre-anesthesia evaluation was conducted prior to administration of anesthesia." ³²

66 Based on observation and staff interview, it was determined that for 4 of 4 rooms inspected (OR #1, exam room #1, recovery room and laboratory), the facility failed to ensure a sanitary environment and maintained supplies to prevent potential contamination." ³³

NO NOTICE TO WOMEN WHO MAY HAVE BEEN INFECTED

Approximately 193 life code and health and sanitary violations were found in thirteen women's clinics in 2011 through 2014.³⁴

The Illinois Department of Public Health failed to produce any documentation showing past female patients were notified that unsanitary conditions were found at these women's clinic. Because of these unsanitary conditions, an unknown number of women who visited these clinics could have contracted HIV, sexually transmitted diseases, staph infections, and/or tetanus.³⁵

For example, on June 7, 2011, the Illinois Department of Public Health found that Northern Illinois Women's Center located in Rockford, Illinois, was using autoclave machines that repeatedly failed biological spore tests. Autoclave machines sterilize surgical instruments, medical waste, and glassware used during abortion procedures. If spores grow, there is no certainty that sterilization of surgical tools occurred. Furthermore, the women's clinic performed quarterly instead of weekly spore testing as is directed by the Illinois Department of Public Health. The Illinois Department of Public Health's inspection report states:

Linxwiler, Darlene <darlene.linxwiler@illinois.gov> To:</darlene.linxwiler@illinois.gov>	Tue, Sep 23, 2014 at 3:57 PM
The following FOIA requests are a "no records" response. The do yet available or no records are available to produce. The FOIA's a	
- FOIA 1504910156 - 2013 IL Abortion Stat Reports (not available a	t this time)
FOIA 1504910169 – health notices sent to patients/public followi records to provide)	ng sanitary violations for abortion clinics (no
FOIA 1503010087 – documentation defining the title/categories Stat Report (no records to provide)	used in each column of the 2012 IL Abortion
I still have one outstanding response concerning health and sanit provide this response as soon as I am presented with the response	
You may request a review of these responses by contacting the C at:	Office of the Public Access Counselor (PAC)
Public Access Counselor	
Office of the Attorney General	
500 So. Second Street	
Springfield, IL 62706	
Springfield, IL 62706 FAX: 217-782-1396	

"The effectiveness of the autoclave shall be verified and documented at least weekly ... This requirement was not met as evidence by: Based on review of the Autoclave Log, staff interview it was determined that the Facility failed to ensure weekly biological spore testing for 2 of 2 autoclave machines." The autoclave log for July 2010 to June 6, 2011 was reviewed on 6/7/11 between 11:30 and 12:20pm. The log contained documentation of biological testing for the 2 autoclave machines for the following dates: 7/7/10 (passed) 11/2/10 (failed), 11/17/11 (negative), 3/16/11 (failed), and 4/6/11 (passed)." ³⁶

Surgical tools that are not sterilized in between patients can infect sterile areas of women's bodies with many serious diseases. However, the Illinois Department of Public Health could produce no documentation showing past female patients were alerted to seek medical attention because they were potentially infected by the Northern Illinois Women's Center's unsanitary practices.

HEALTH AND SANITARY VIOLATIONS GO UNINVESTIGATED

In an email to a researcher, the Illinois Department of Public Health stated it generally only reviews the records and practices of women's clinics up to 12 to 36 months prior to the date of the health and sanitary inspection.

66 The Department conducted licensure surveys at both [abortion] facilities and cited the non compliance based on the current deficient practices identified on the date of the survey and generally will review data within the past 12-36 months if necessary."³⁷

Violations in health and sanitary standards – whether they were 37 months or 180 months prior to the health inspection date – can fall through the cracks with no accountability or repercussions for the women's clinics. ------ Forwarded message ------From: Senger, Karen <<aren. Senger@illinois.gov> Date: Tue, Dec 20, 2011 at 9:16 PM Subject: FW: Missing responses

Cc: "Johnson, Jeff W." <Jeff.W.Johnson2@illinois.gov>, "Bell, Bill" <Bill.Bell@illinois.gov>

This is response to your email and the additional information on past FOIA requests

The Department has reviewed your questions sent to the surveillance nurses. The Department does not address or interpret specific questions related to the survey findings. The Department conducted licensure surveys at both facilities and cited the non compliance based on the current deficient practices identified on the date of the survey and generally will review data within the past 12-36 months if necessary.

The National Health Care facility- The Department has accepted the plan of corrections and will continue to monitor the facilities compliance.

Northern Illinois Women's Center is still in legal process.

nail/u/0/?ui=2&ik=0257544790&vie

In relation to your follow-up questions regarding the POC for American Women's Des Plaines at the time of the FOIA, the Department did not have an acceptable POC to release. See attached POC

10/13/2014 Grnail - Fwd: FW: Missing responses

rch=ouerv&th=148f5404d4571227&siml=148f5404d4571227&...

CMP Fullerton Kimball ASTC- the Department releases only acceptable POCs the Department made several onsite visits to ensure compliance from the survey and is still awaiting a written acceptable Plan of correction and will continue to monitor compliance.

The American Women's' in Chicago POC from 4/19/96 was not found in the microfilm and the Department is only required to keep surveys for 7 years. We have no copy of the POC on file for the 4/19/96 survey.

Karen Senger, RN, B.S.N. Supervisor of Central Office Operations Division of Health Care Facilities and Programs 525 West Jefferson Street, 4th Floor Springfield, IL 62761 Phone: 217-782-0381 Fax: 217-782-0382 email: karen.senger @illinois.gov



NO ABILITY FOR WOMEN TO FILE COMPLAINTS

Women who seek abortion procedures in unlicensed clinics are given no process by the Illinois Department of Financial and Professional Regulation to report dangerous health violations that maimed or hurt them. The following documentation shows the Illinois Department of Financial and Professional Regulation does not understand its own responsibility to regulate the professionals within unlicensed women's clinics.

On July 31, 2014, an Illinois Right to Life researcher asked the Illinois Department of Public Health where a woman could file a complaint against an unlicensed women's clinic. The department directed the researcher to file a complaint with the Illinois Department of Financial and Professional Regulation.

	Gmail
FOIA Request	FOIA Request
To: "DPH.FOIA" <dph.foia@illinois.gov></dph.foia@illinois.gov>	DPH.FOIA <dph.foia@illinois.gov> Thu, Jul 31, 2014 at 4:26 PM To:</dph.foia@illinois.gov>
Ms. Linxwiler,	
Thank you for your assistance. Can you please clarify what the Department means when it says it does not regulate abortion clinics? Does this mean the Department does not have a health inspection policy for all licensed and non-licensed abortion clinics?	If a clinic is not a PSTC or ASTC, It fails under the physican's licensure regulations which are regulated by the Illinois Department of Financial and Professional Regulation. Thank you.
Is there a different Department responsible for the health regulations of abortion clinics?	From:
Thank you,	Sent: Thursday, July 31, 2014 4:16 PM
_	
[Quoted text hidden]	

On August 28, 2014, our researcher inquired with the Illinois Department of Financial and Professional Regulation where a complaint against an unlicensed women's clinic could be filed. The researcher was referred to the Illinois Department of Public Health.

	Grail
FOIA Request	FOIA Request
To: "FPR.FOIA" <fpr.foia@illinois.gov></fpr.foia@illinois.gov>	FPR.FOIA <fpr.foia@illinois.gov> Thu, Aug 28, 2014 at 12:24 P To:</fpr.foia@illinois.gov>
Hi Brendan,	
Thank you for your help. Do you know where I would file a complaint about an abortion clinic that isn't licensed by the state?	I would recommend contacting the Illinois Department of Public Health.
Thank you. Have a good day,	
(Quoted lext hidden)	Freedom of Information Act
	Division of Professional Regulation
	Illinois Department of Financial and Professional Regulation
	FPR.FOIA@Illinois.gov

On September 3, 2014, the researcher returned to the Illinois Department of Public Health to ask where a complaint can be filed against an unlicensed women's clinic. The researcher was referred back to the Illinois Department of Financial and Professional Regulation. Phone calls to both departments confirmed the same response.

Genail	Gmail
OIA Request	FOIA Request
: "Linxwiler, Darlene"	Linxwiler, Darlene <darlene.linxwiler@illinois.gov> Wed, Sep 3, 2014 at 10: To:</darlene.linxwiler@illinois.gov>
Hi Darelene,	You would need to make that request to the Illinois Department of Financial and Professional Regulation.
Attached is a FOIA request.	Thank you.
I have a question I was hoping you'd know the answer to. Do you know where I would file a complaint about an abortion clinic that isn't licensed by the state?	
Thank you for your assistance.	From: Sent: Wednesday, September 03, 2014 10:02 AM
Best,	To: Linxwiler, Darlene Subject: FOIA Request

In 1978, the *Chicago Sun-Times* and the Better Government Association conducted a five-month investigation that "documented how dangerous, inept, and illegal practices flourished inside four Chicago abortion clinics in flagrant defiance of state licensing and inspection laws, and accepted medical standards." ⁵⁴ "At least 12 women have died following legal abortions in Illinois walk-in abortion clinics," the investigation noted. ⁵⁵

The investigation showed that when women's clinics are not closely regulated by the state, women suffer. According to the *Chicago Sun-Times* and the Better Government Association, the following are some of the violations that occurred at the women's clinics:

Some [women] had dead tissue left inside them. Others had massive infections, perforated bowels or punctured uteri." 56

"Some [women] ultimately underwent complete hysterectomies – the removal of all reproductive organs." ⁵⁷

"... he [abortion doctor] rushes from abortion to abortion without washing his hands between patients or donning sterile gloves." ⁵⁸

The following lawsuits illustrate that women are still maimed and killed in today's women's clinics like they were in 1978.

FEMALE VICTIMS FILE MEDICAL MALPRACTICE LAWSUITS

For this report, Illinois Right to Life reviewed approximately 190 medical malpractice lawsuits filed against Illinois women's clinics and/or their doctors between 1978 and 2014. The following cases are a sampling that reveals how much women suffered as a result of their unregulated abortion procedure. The lawsuits say women were infected with diseases, maimed, crippled, and/or killed. The names of the female victims are withheld to respect their privacy.

According to a 2011 Chicago Tribune article,



In 2002, after an area woman's uterus was torn in an abortion she began hemorrhaging, went into cardiac shock and was hospitalized for three weeks. Several years later, a mother of three experienced seizure symptoms and slipped into a coma following her abortion at a city clinic. And in 2009, a teenage girl suffered respiratory and cardiac arrest and died immediately following her abortion in a northern suburb, according to court records." ³⁸

The following malpractice lawsuits were filed in Illinois courts against women's clinics:

On 1/3/13, Illinois Planned Parenthood unlicensed abortion provider was sued for medical malpractice following the death of a 24-year-old woman after an abortion. Court documents state the women's clinic did not transport this hemorrhaging woman to the hospital until five hours after her abortion. Eleven hours following her scheduled abortion, the young woman died as a result of a torn uterus leaving behind a one-year-old boy. On 1/24/14, a settlement agreement was reached for \$2 million.³⁹

On 2/27/04, Family Planning Associates abortion provider in Chicago was sued for medical malpractice following the death of a 13-year-old female patient. The lawsuit charges the women's clinic improperly monitored and failed to transport the girl to the hospital for emergency treatment. She died shortly after her abortion procedure. On 6/7/06, a settlement was reached for \$750,000.⁴¹ On 9/7/05, Family Planning Associates abortion provider in Chicago was sued for medical malpractice. The lawsuit charged the female patient suffered a brain anoxia which left her in an irreversible coma and unable to care for her three minor children. On 6/21/06, a settlement agreement was reached for \$2.97 million.⁴⁰

On 5/18/04, Illinois Planned Parenthood unlicensed abortion provider was sued for medical malpractice. The lawsuit charged the patient suffered a large ruptured to the right side of her uterus causing her to undergo a subtotal hysterectomy. On 4/14/09, an undisclosed settlement was reached.⁴²

On 12/17/02, Illinois Planned Parenthood unlicensed abortion provider was sued for medical malpractice following the death of a female patient. The lawsuit charges the clinic failed to remove all fetal parts from the patient's uterus causing severe pain and death. On 12/08/06, a settlement agreement was reached for \$4 million.⁴³

11/13/00, Illinois Planned Parenthood unlicensed abortion provider was sued for medical malpractice. The lawsuit charges surgical tools were improperly used, tearing the right uterine artery. As a result, the female patient suffered amputation of the uterus and cervix and permanent loss of reproductive capabilities. On 5/15/01, an undisclosed settlement was reached.⁴⁴

On 8/11/10, Family Planning Associates abortion provider in Chicago was sued for medical malpractice. The lawsuit charged that excessive bleeding occurred during the procedure when the patient's uterus was ruptured. As a result the female patient underwent a hysterectomy, which left her unable to have children. On 8/20/13, a settlement was reached for \$950,000.⁴⁵

On 10/7/92, Family Planning Associates licensed abortion provider in Chicago was sued for medical malpractice. The lawsuit charged the doctor with negligence during a tubal cauterization when the female patient's iliac artery was punctured. On 1/16/97, an undisclosed settlement was reached.⁴⁶ On 2/13/09, Illinois Planned Parenthood unlicensed abortion provider was sued for medical malpractice. The lawsuit charged the patient died as a result of a torn uterus during the abortion procedure. On 1/23/12, a settlement was reached for \$245,000.⁴⁷

On 4/3/08, Illinois Planned Parenthood unlicensed abortion provider was sued for medical malpractice. On 3/11/10, an undisclosed settlement was reached.⁴⁸

On 6/8/01, Family Planning Associates abortion provider in Chicago was sued for personal injury following the death of a female patient. The lawsuit charged that the female patient died of heart and lung failure from complications relating to anesthesia. On 12/21/04, a settlement was reached for \$500,000.⁴⁹

On 12/4/00, Family Planning Associates abortion provider in Chicago was sued for medical malpractice following the death of a 16-year-old female patient. The lawsuit charged that medical personnel improperly monitored the female patient and she died of a heart attack. On 3/17/05, a settlement was reached for \$300,000.⁵⁰ On 7/26/00, Family Planning Associates abortion provider in Chicago was sued for medical malpractice following the death of a female patient. The lawsuit charges the woman died as a result of a massive vaginal hemorrhage due to a torn uterus and a failure to promptly transport the patient to the hospital. On 12/20/02, a settlement agreement was reached for \$543,700.⁵¹

On 2/9/96, Family Planning Associates abortion provider in Chicago was sued for medical malpractice. On 5/13/02, an undisclosed settlement agreement was reached.⁵² On 6/23/09, Women's Aid Clinic abortion provider in Chicago was sued for medical malpractice following the death of a female patient. The lawsuit charged the clinic failed to properly monitor and resuscitate the female patient who, after coughing up blood in her mouth and nose, suffered respiratory and cardiac arrest. The female patient left behind a one-and-a-half years old child and seven-month-old child. On 9/1/10, a settlement was reached for \$555,508.⁵³

ILLINOIS STATE HEALTH AND SANITARY INSPECTION POLICIES

Despite medical malpractice lawsuits and a pattern of serious health violations, the Illinois Department of Public Health failed to conduct regular health and sanitary inspections.

Illinois Right to Life researchers requested a copy of the Illinois Department of Public Health's sanitary inspection policy for licensed women's clinics. <u>No such policy exists</u>.⁵⁹

TANNING SALONS



INSPECTED EVERY YEAR.^{59,1}

NURSING HOMES



INSPECTED A MINIMUM OF EVERY 15 MONTHS.^{59,1}

CHICAGO RESTAURANTS



INSPECTED EVERY YEAR.^{59.1}



WOMEN'S ABORTION CLINICS

NO HEALTH INSPECTION POLICY.

INSPECTED AN AVERAGE OF ONCE EVERY 9 YEARS.

FAILED ILLINOIS POLICIES ENDANGER WOMEN

In an email to Representative Jack Franks on June 28, 2011, the Illinois Department of Public Health explains why it does not conduct regular health and sanitary inspections in women's clinics:

⁴⁴ The department licensing regulations do not mandate a frequency of licensure surveys nor is there funding to perform licensure surveys. Due to the media issues regarding the events in Philadelphia, the Department has begun the survey process of conducting a health and building inspection of the 9 licensed pregnancy termination centers."⁶⁰

Illinois law requires the Department of Public Health to conduct health and sanitary inspections of licensed women's clinics "as it deems necessary."⁶¹ Between 2000 and 2010, only three total full health and sanitary inspections were conducted at three women's clinics.

FAILED POLICY #1: Illinois women's clinics are not inspected on a regular basis as required by state law.

FAILED POLICY #2: The Illinois General Assembly fails to clearly specify how often women's clinics should be inspected.

The Illinois Department of Public Health stated there is no funding in their budget to perform the health and sanitary inspections. In 2014, their budget totaled \$558 million.⁶²

FAILED POLICY #3: The Illinois General Assembly failed to issue health inspection funds or failed to ensure the Department of Public Health efficiently used taxpayer funds.

In 2010, the first time in over ten years, the Illinois Department of Public Health conducted a health and sanitary inspections in all licensed women's clinics. They stated their motivation was the negative media attention surrounding the investigation into Pennsylvania abortion doctor Kermit Gosnell who operated an unsanitary clinic injuring and killing multiple women. Nine Pennsylvania Department of Public Health officials were fired or resigned following the investigation.⁶³ **FAILED POLICY #4:** The Illinois Department of Public Health is motivated by negative media coverage rather than the health and safety of women.

Illinois law does not require women's clinics to be licensed or to have regular health and sanitary inspections even if the clinics conduct surgical abortion procedures by inserting surgical tools into sterile areas of a woman's body.

FAILED POLICY #5: 54% of women's clinics in Illinois are not licensed and therefore do not receive health and sanitary inspections.

FAILED POLICY #6: Past female patients were not notified when the Illinois Department of Public Health found serious health and sanitary violations at clinics, which could have infected the women with HIV, sexually transmitted diseases, staph, and tetanus.⁶⁴

FAILED POLICY #7: There is no state agency with the authority to accept or investigate a complaint filed against an unlicensed women's clinic that harmed women.

FAILED POLICY #8: Today, 63% of the state's licensed women's clinics have gone between two and three-and-a-half years without a health and sanitary inspection.

CONCLUSIONS

In this report, Illinois Right to Life is not concerned with the ethics of legalized abortion but for the health and safety of women. Women are unknowingly subjected to deplorable sanitary conditions during abortions, which can result in the mutilation of their bodies or their deaths. No woman in Illinois should enter a women's clinic and leave needing a tetanus shot, HIV testing, or emergency treatment at a hospital.

Women's clinic personnel cut corners and the Illinois Department of Public Health allowed it to happen. Health and safety laws were ignored. Women's licensed clinics didn't just slip through the cracks of our health system, they set up shop in regulatory loopholes and made a profit while causing women pain. For 15 years, the Illinois Department of Public Health had the authority to ensure licensed women's clinics were sanitary but chose not to. As a result, women were maimed, infected, and killed.

But women's pain isn't what motivated the Illinois Department of Public Health to conduct the first health and sanitary inspections in over a decade. The Department stated it was the negative media attention the Pennsylvania Department of Public Health received during the Kermit Gosnell investigation. Today, 63% of the state's licensed women's clinics have gone between two and three-and-a-half years without a health and sanitary inspection.

The 27 women listed in this report may have escaped mutilation and/or death if women's clinics followed protocols, if the Illinois Department of Public Health would have carried out necessary inspections, and if the Governor's Office and General Assembly had provided proper oversight.

Failure to enact swift legislative and policy changes abandons Illinois women to the prospect of unsterile surgical tools, dirty operating rooms, incomplete medical attention, infections, and possibly more deaths. The Illinois General Assembly and the Illinois Department of Public Health must immediately offer reforms to prevent more tragedy and exploitation of women.

The findings of this report cause us to question the Illinois Department of Public Health's ability to fulfill its professional responsibility to "promote the health of the people of Illinois through the prevention and control of disease and injury." ⁶⁶

We echo the statement issued by the 2013 Pennsylvania grand jury following its investigation into Gosnell:

"It is not our job to say who should be fired or demoted. We believe, however, that anyone responsible for permitting Gosnell to operate as he did should face strong disciplinary action up to and including termination. This includes not only the people who failed to do the inspecting, the prosecuting, and the protecting, but also those **at the top** who obviously tolerated, or even encouraged, the inaction. The Department of State literally licensed Gosnell's criminally dangerous behavior. DOH gave its stamp of approval to his facility. These agencies do not deserve the public's trust. The fate of Karnamaya Mongar and countless babies with severed spinal cords is proof that people at those departments were not doing their jobs. Those charged with protecting the public must do better." ⁶⁷

SOLUTIONS AND RECOMMENDATIONS TO IMMEDIATELY PROTECT WOMEN'S HEALTH

By ignoring the health and sanitary conditions of women's clinics, the Illinois Department of Public Health has placed women's health at severe risk.

The following actions are recommended:

1 AMEND ILLINOIS' 210 ILCS 5/ AMBULATORY SURGICAL TREATMENT CENTER ACT:

- Insert language that requires annual health and sanitary inspections for women's clinics by the Illinois Department of Public Health.
- Add a requirement that if violations are found during a health and sanitary inspection that place female patients' health at risk, the responsible women's clinic must issue a public health announcement to alert women who may now be affected. The announcement must contain the time frame when the violation took place, the location of the violation, and the issue (HIV, STD, staph infection, tetanus, etc.) that female patients need to be treated for. The women's clinic must immediately submit a copy of the notice to the Illinois Department of Public Health.
- Require any place that performs surgical abortions (defined as any abortion procedure not conducted with the use of the medical abortion pill) to obtain a license from the Illinois Department of Public Health, which will subject them to annual health and sanitary inspections.

2 THE ILLINOIS GENERAL ASSEMBLY

Ensure that appropriate funding is allocated to or within the Illinois Department of Public Health for health and sanitary inspections of these facilities.

3 ILLINOIS DEPARTMENT OF PUBLIC HEALTH:

- Immediately conduct health and sanitary inspections at the licensed women's clinics that have now gone over one year without these inspections.
- Begin issuing public notices warning women of the violations that may have affected them due to unsanitary medical practices or other violations.
- Enforce fines to cover health and sanitary inspection costs.

4 ILLINOIS CITIZENS: HAVE YOUR VOICE HEARD.

Visit www.WomensHealthComesFirst.com and sign the petition that will be presented to the Illinois Department of Public Health demanding they clean up women's facilities.

NOTES

¹ A full copy of the grand jury report can be found at: www.phila.gov/districtattorney/pdfs/ grandjurywomensmedical.pdf.

² Documents were obtained through Freedom of Information Act requests to the Illinois Department of Public Health. See Appendix A.

³ See Appendix B.

⁴ 2004-L-002365, 2000-L-008492, and 2000-L-013983

⁵ See The Guttmacher Institute at: www.guttmacher.org/pubs/sfaa/illinois. html [According to our records, there are currently 24 women's clinics open in Illinois in 2014].

⁶ 210 ILCS 5/Ambulatory Surgical Treatment Act can be found at: www. ilga.gov/legislation/ilcs/ilcs3.asp?ActID =1216&ChapterID=21&Print=True.

⁷ See Appendix A.

⁸ Ibid.

⁹ See Appendix A. Northern Illinois Women's Center voluntarily closed permanently in January 2012 and Women's Aid Clinic voluntarily permanently closed in November of 2011.

¹⁰ See Appendix B.

- ¹¹ Ibid.
- ¹² Ibid.

¹³ For specific health and sanitary inspection documents see footnoted reports. The full inspection reports can be obtained by contacting Illinois Right to Life.

¹⁴ Women's Aid Clinic located in Lincolnwood, IL 60712 - Statement of Deficiencies Report dated 9-7-2011. See Appendix C.

¹⁵ Women's Aid Clinic located in Lincolnwood, IL 60712 - Statement of Deficiencies Report dated 9-7-2011. See Appendix D.

¹⁶ National Health Care located in Peoria, IL 60614 - Statement of Deficiencies Report dated 10/2/13. See Appendix E. ¹⁷ Northern Illinois Women's Center Rockford, IL 61104 – Statement of Deficiencies Report dated 6/8/11. See Appendix F.

¹⁸ Women's Aid Clinic located in Lincolnwood, IL 60712 - Statement of Deficiencies Report dated 9-7-2011. See Appendix G.

¹⁹ Michigan Avenue Center for Health located in Chicago, IL 60616 – Statement of Deficiencies Report dated 6/23/11. See Appendix H.

²⁰ Access Health Center located in Downers Grove, IL 60516 – Statement of Deficiencies Report dated 5/18/11. See Appendix I.

²¹ Access Health Center located in Downers Grove, IL 60516 – Statement of Deficiencies Report dated 5/18/11 See Appendix J.

²² National Health Care located in Peoria, IL 60614 – Statement of Deficiencies Report dated 10/2/13. See Appendix K.

²³ American Women's Medical Center located in Des Plaines, IL 60016 -Statement of Deficiencies Report dated 6/23/11. See Appendix L.

²⁴ Women's Aid Clinic located in Lincolnwood, IL 60712 - Statement of Deficiencies Report dated 9-7-2011. See Appendix M.

²⁵ Hope Clinic for Women located in Granite City, IL 62040. Statement of Deficiencies Report dated 10/7/13 and 4/25/12. See Appendix N.

²⁶ American Women's Medical Center located in Des Plaines, IL 60016. Statement of Deficiencies Report dated 6/23/11. See Appendix O.

²⁷ Northern Illinois Women's Center Rockford, IL 61104 – Statement of Deficiencies Report dated 6/8/11. Appendix P.

²⁸ Michigan Ave Center for Health located in Chicago, IL 60616 – Statement of Deficiencies Report dated 6/23/11. See Appendix Q.

²⁹ Aanchor Health Center located in Glen Ellyn, IL 60137 – Statement of Deficiencies Report dated 5/5/11. See Appendix R. ³⁰ ACU Health Center located in Hinsdale, IL 60521 – Statement of Deficiencies Report dated 5/24/11. See Appendix S.

³¹ ACU Health Center located in Hinsdale, IL 60521 – Statement of Deficiencies Report dated 5/23/11. See Appendix T.

³² Advantage Health Care located in Wood Dale, IL 60191 – Statement of Deficiencies Report dated 10/4/13. See Appendix U.

³³ Women's Aid Clinic located in Lincolnwood, IL 60712 - Statement of Deficiencies Report dated 9-7-2011. See Appendix V.

³⁴ Full health and sanitary inspection reports can be obtained from Illinois Right to Life.

³⁵ See Appendix W.

³⁶ Northern Illinois Women's Center Rockford, IL 61104 – Statement of Deficiencies Report dated 6/8/11. Appendix X.

³⁷ See Appendix Y.

³⁸ See Appendix Z.

- ³⁹ Court case 2013-L-000076.
- ⁴⁰ Court case 2005-L-009803.
- ⁴¹ Court case 2004-L-002365.
- ⁴² Court case 2004-L-005586.
- ⁴³ Court case 2002-L-015845.
- ⁴⁴ Court Case 2000-L-013105.
- ⁴⁵ Court Case 2010-L-009209.
- ⁴⁶ Court case 1992-L-012531.
- ⁴⁷ Court case 2009-L-001757.
- ⁴⁸ Court case 2008-L-003680.
- ⁴⁹ Court case 2001-L-006896.
- ⁵⁰ Court case 2000-L-013983.
- ⁵¹ Court case 2000-L-008492.
- ⁵² Court case 1996-L-001591.
- ⁵³ Court case 2009-L-007351.
- ⁵⁴ See Appendix AA.
- ⁵⁵ See Appendix BB.
- ⁵⁶ See Appendix CC.

57 Ibid.

⁵⁸ See Appendix DD.

⁵⁹ See Appendix EE. In an email response regarding a Freedom of Information Act request for the health and sanitary inspection policy for women's clinics, the Illinois Department of Public Health (IDPH) told Illinois Right to Life, "The Department does not have a policy." Later, the IDPH told Illinois Right to Life, "The Department attempts to survey [licensed women's clinic] every five years." However, this assertion is not substantiated by IDPH's conduct over the past 17 years or in any written reports, emails, meeting agenda, or notes requested via FOIA from the Illinois Department of Public Health.

^{59.1} Tanning Salon inspection policy: 210 ILCS 145/15 Sec. 15 (c). Nursing homes inspection policy: http://www. cms.gov/Regulations-and-Guidance/ Guidance/Manuals/downloads/ som107c07.pdf. Chicago Restaurants inspection policy: www.cityofchicago. org/city/en/depts/cdph/provdrs/ environ_health/svcs/restaurant_food_ inspection.html.

⁶⁰ See Appendix FF.

⁶¹ 210 ILCS 5/Ambulatory Surgical Treatment Act can be found at: www. ilga.gov/legislation/ilcs/ilcs3.asp?ActID =1216&ChapterID=21&Print=True.

⁶² See Illinois Department of Public Health's website at: www.idph.state. il.us/about/glance.htm#budget.

⁶³ See Appendix GG.

⁶⁴ See Appendix W.

⁶⁶ See the Illinois Department of Public Health's website at: www.idph.state.il.us/ about/newmision.htm.

⁶⁷ A full copy of the grand jury report can be found at: www.phila.gov/districtattorney/pdfs/ grandjurywomensmedical.pdf. See page 261 for quoted section in this report.

⁶⁷ 210 ILCS 5/Ambulatory Surgical Treatment Act can be found at: www. ilga.gov/legislation/ilcs/ilcs3.asp?ActID =1216&ChapterID=21&Print=True.

The Chicago-based Pro-life Action League significantly contributed to this report.

APPENDIX

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Illinois Women's Abortion Clinics

Women's Abortion Clinic	State Senate / State Rep. Districts Clinic is in	State Senate / State Rep. Districts Clinics may also serve	Licensed?	Date of last full health inspection	Date of previous full health inspection	Health Inspection Violations / Lawsuits
Loop Health Center – Planned Parenthood 18 S. Michigan Avenue, 6th Floor Chicago, IL 60603	Rep. Dunkin (District 5) Sen. Hunter (District 3)	Rep. Mitchell (District 26) Sen. Munoz (District 1)	No	Never	Never	Of the six medical malpractice lawsuits against Illinois Planned Parenthood in this report, three of these settlements total \$6,245,000.00. The remaining three settlements are undisclosed. No health and sanitary inspection has been conducted in a Planned Parenthood in Illinois since 1999.
Near North Center – Planned Parenthood 1200 N. LaSalle Street Chicago, IL 60610	Rep. Dunkin (District 5) Sen. Hunter (District 3)	Rep. Golar (District 6) Sen. Van Pelt (District 5)	No	Never	Never	On 1/3/13 Illinois Planned Parenthood women's abortion provider was sued for medical malpractice following the death of a 24-year-old woman after an abortion at the LaSalle location. Court documents state the women's elinic did not transport her to the hospital until 5 hours after her scheduled appointment. Seven hours following her scheduled abortion, the young woman hemorrhaged and died as result of a torn uterus leaving behind a two-year-old boy. A settlement agreement was reached for \$2,000,000.0
Michigan Avenue Center for Health 2415 S. Michigan Ave Chicago, IL 60616	Rep. Dunkin (District 5) Sen. Hunter (District 3)	Rep. Acevedo (District 2) Sen. Munoz (District 1)	PTSC	6/23/2011	No previous health inspection since it opened in 2004	"Two of 5 metal carts contained rust like stains and dust." Cart #2 contained an ambu bag with a brown substance and rust like stains and dust." "Two of 2 metal carts in the Recovery room contained rust like stains and dust." "Suction tubing identified by staff as clean, was suspended over a biohazard container. The lid of the container when opened touched the clean tubing."
The UIC Center for Reproductive Health 820 South Wood Street, MC 808 Chicago, IL 60612	Rep. Turner (District 9) Sen. Van Pelt (District 5)	Rep. Acevedo (District 2) Sen. Delgado (District 2)	No	Never	Never	No health and sanitary inspection conducted since 1998
Family Planning Associates Medical Group 659 W. Washington Blvd Chicago, IL 60661	Rep. Turner (District 9) Sen. Van Pelt (District 5)	Rep. Smith (District 10) Sen. Lightford (District 4)	No	Never	Never	Three female patients of Family Planning Associates women's abortion provider have died following abortions. Seven lawsuits for medical malpractice have been filed against Family Planning Associates Medical Group and have reached settlement agreeements. Six of the eight settlement agreements total \$6,013,700.00. The remaining two settlement agreeements are undisclosed
All Women's Health Chicago 2000 W. Armitage Ave Chicago, IL 60647	Rep. Smith (District 10) Sen. Van Pelt (District 5)	Rep. Turner (District 9) Sen. Delgado (District 2)	No	Never	Never	No health and sanitary inspection conducted since 1998
Family Planning Associates Medical Group - Elston 5086 N Elston Ave. Chicago, IL 60630	Rep. D'Amico (District 15) Sen. Silverstein (District 8)	Rep. Martwick (District 19) Sen. Martinez (District 20)	ASTC	6/19/2012	12/4/1995	Three women, including a 13-year-old girl and a 16-year-old student, have died following an abortion at this licensed women's abortion clinic on March 25, 2000 (lawsuit # 2000-L-008492), on December 10, 1998 (lawsuit # 2000-L-13983), and on September 5, 1992 (lawsuit # 2004-L-002365).
Women's Aid Center 4801 W Peterson Ave Suite 609 Chicago, IL 60646	Rep. D'Amico (District 15) Sen. Silverstein (District 8)	Rep. Lang (District 16) Sen. Martinez (District 20)	No	Never	Never	Same owner as Women's Aid Clinic which is currently being sued by the State of Illinois for not paying \$36,000 in health and sanitary violation fines.
Women's Aid Clinic (Closed) 4751 W. Touhy Avenue Lincolnwood, IL 60646	Rep. Lang (District 16) Sen. Silverstein (District 8)	Rep. D'Amico (District 15) Sen. Biss (District 9)	PTSC	9/7/2011	4/1/1996	"The Recovery Room technician (E#1) was observed on 9/6/11 at approximately 9:20am retrieving a paper towel from a garbage receptacle and using the same paper towel to cover a tray that would serve food items to patientsThe suction machine in OR #1 contained clear water withs specks of floating debrisfive (5) of 5 recovery beds were rustyNine (9) medication cups, identified as containing Motrin and 10 medication cups containing tylenol contained crumbs" On 6/23/09 Women's Aid Clinic women's abortion clinic provider in Chicago was sued for medical malpractice following the death of a female patient. On 9/1/10 a settlement agreement was reached for \$555,508.00. This clinic is currently being sued by Cook County for failing to pay \$36,000 in health violation fines
Ryan Center at University of Chicago 5758 S Maryland Ave Chicago, IL 60637	Rep. Mitchell (District 26) Sen. Raoul (District 13)	Rep. Dunkin (District 5) Sen. Hunter (District 3)	No	Never	Never	No health and sanitary inspection conducted since 1998
Family Planning Associates Medical Group 7845 S Cottage Grove Ave #104 Chicago, IL 60619	Rep. Sims, Jr. (District 34) Sen. Trotter (District 17)	Rep. Dunkin (District 5) Sen. Collins (District 16)	No	Never	Never	Three female patients of Family Planning Associates women's abortion provider have died following abortions. Of the eight medical malpractice lawsuits against Family Planning Associations listed in this lawsuit, have reached settlement agreements total \$6,013,700.00. The remaining two settlement agreements are undisclosed
American Women's Center – Chicago 2744 N Western Ave Chicago, IL 60647	Rep. Andrade (District 40) Sen. Martinez (District 20)	Rep. Berrios (District 39) Sen. Cullerton (District 6)	ASTC	9/21/2012	4/19/1996	"The licensing requirements are NOT MET" "Due to the number, variety, and severity of the life safety deficiencies observed during the survey walk-through, the provider shall institute appropriate interim life safety measures until all cited deficiencies are corrected."
All Women's Medical Center 3140 W Irving Park Road Chicago, IL 60618	Rep. Andrade (District 40) Sen. Martinez (District 20)	Rep. Williams (District 11) Sen. Cullerton (District 6)	No	Never	Never	No health and sanitary inspection conducted since 1998

ACU Health Center LTD 736 N. York Rd. Hinsdale, IL 60521	Rep. Bellock (District 47) Sen. Nybo (District 24)	Rep. Durkin (District 82) Sen. Lightfoot (District 4)	PTSC	5/24/2011	3/19/1997	On 5/23/11OR #2 was inspected. OR #2 contained tape on an IV pole and brown stains on the suction machine. The last surgical day was on 5/14/11.
Aanchor Health Center LTD 1186 Roosevelt Rd. Glen Ellyn, IL 60137	Rep. Pihos (District 48) Sen. Nybo (District 24)	Rep. Conroy (District 46) Sen. Cullerton (District 23)	PTSC	5/5/2011	No previous health inspection since it opened in 2002.	"Based on manufacturer's guidelines, Biological Spore Testing Log, and staff interview, it was determined that for 3 of 9 weeks in March and April 2011the facility failed to ensure biological spore testing was verified and documented each week."
Apollo Surgical Center 2750 River Road Des Plaines, IL 60016	Rep. Moylan (District 55) Sen. Kotowski (District 28)	Rep. Harris (District 53) Sen. Mulroe (District 10)	ASTC	N/A	No health inspection since it opened in 2014	"Based on document review and interview, it was determined, the facility failed to ensure the surgical county policy was accurate, affecting all future surgical patients."
Dimensions Clinic (Closed) 1455 Golf Road Des Plaines, IL 60016	Rep. Moylan (District 55) Sen. Kotowski (District 28)	Rep. Harris (District 53) Sen. Mulroe (District 10)	ASTC	3/15/2001	5/11/1995	Closed in 2011 before receiving a health inspection.
American Women's Center 110 S River Road Suit 7 Des Plaines, IL 60016	Rep. Moylan (District 55) Sen. Kotowski (District 28)	Rep. McAuliffe (District 20) Rep. Nekritz (District 57) Sen. Biss (District 9)	PTSC	6/23/2011	No health inspection since it opened in 2004	"5 of 5 records reviewed, the facility failed to ensure all patients received pre- operative and post-operative counseling" "Facility failed to ensure the presence o a circulating RN suring an invasive and operative procedure." "For patients requiring a Laminaria Insertion, the facility failed to ensure operative reports were complete and accurate."
Forest View Meidcal Center (Closed) 2750 S. River Road, Des Plaines, Illinois 60018	Rep. Moylan (District 55) Sen. Kotowski (District 28)	Rep. Nekritz (District 57) Sen. Murphy (District 27) Sen. Biss (District 9)	PTSC	6/1/2011	No previous health inspection since it opened in 2005	"Based on personnel file review and staff interview, it was determined that for 5 of 5 employee files reviewed (E#1-5), the Facility failed to ensure background checks with the Health Care Registry prior to hiring."
Northern Illinois Women's Center (Closed) 1400 Broadway Rockford IL 61104	Rep. Wallace (District 67) Sen. Stadelman (District 34)	Rep. Cabello (District 68) Sen. Syverson (District 35)	PTSC	6/8/2011	8/2/1996	"OR#2 and #3 contained shoes stored with an open box of surgical gloves. Four (4) of 16 gynecological cannulas [surgical tools inserted into a woman's uterus] in OR 3 were stained with a brown substance" In September of 2011, this women's abortion clinic was closed on an emergency basis and its license was temporarily suspended following the discover of geregious health and sanitary violations. This was the center's first health and sanitary inspection in 15 years. On January 4, 2012, the women's abortion elinic was allowed to re-open albeit pay a \$9,750 fine and be subject to immediate license revocation if the clinic lapsed on certain state regulations. The abortion provider instead paid a \$1,000 fine and voluntarily relinquish its operating license and permanently closed.
National Health Care 7405 N. University St Peoria, IL 61614	Rep. Leitch (District 73) Sen. LaHood (District 37)	Rep. Moffitt (District 74) Sen. Brady (District 44)	PTSC	10/2/2013	6/16/11 8/14/02	"Failed to ensure medication syringes were labeled and stored in a safe, clean area. This has the potential to affect up to 100% of patients." Facility used single vial medical meant for only one patient on multiple patients directly violating the Center for Disease Control's practice that "protects patients from life-threatening infections that occur when medications get contaminated from unsafe use."
Advantage Health Care LTD 203 Irving Park Rd Wooddale, IL 60191	Rep. Willis (District 77) Sen. Harmon (District 39)	Rep. Reboletti (District45) Sen. Kotowski (District 28)	ASTC	10/4/2013	10/12/12 8/21/97	Facility failed to ensure a pre-anesthesia evaluation was conducted prior to administration of anesthesia"could result in death.
Access Health Center 1700 75th St. Downers Grove, IL 60516	Rep. Sandack (District 81) Sen. Rodogno (District 41)	Rep. Bellock (District 47) Sen. Nybo (District 24)	PTSC	5/18/2011	10/1/1998	"On 5/18/11OR #2 was inspected and observed with loose debris on the floor, a red stain on a wall and standing water in a small bucket. The last surgical day was 5/16/11."
Planned Parenthood Aurora Health Center 3051 E New York Street Aurora, IL 60504	Rep. Kifowit (District 84) Sen. Holmes (District 42)	Rep. Chapa LaVia (District 83) Sen. Bertino-Tarrant (District 49)	No	Never	Never	Of the six medical malpractice lawsuits against Illinois Planned Parenthood in this report, three of these settlements total 56,245,000.00. The remaining three settlements are undisclosed. No health and sanitary inspection has been conducted in a Planned Parenthood in Illinois since 1999.
Springfield Health Center – Planned Parenthood 1000 E Washington Springfield, IL 62703	Rep. Scherer (District 96) Sen. Manar (District 48)	Rep. Mitchel (District101) Sen. Brady (District 44)	No	Never	Never	Of the six medical malpractice lawsuits against Illinois Planned Parenthood in this report, three of these settlements total \$6,245,000.00. The remaining three settlements are undisclosed. No health and sanitary inspection has been conducted in a Planned Parenthood in Illinois since 1999.
Women's Health Practice 2125 S. Neil St. Champaign, IL 61820	Rep. Jakobsson (District 103) Sen. Frerichs (District 52)	Rep. Brown (District 102) Sen. Rose (District 51)	No	Never	Never	No health and sanitary inspection conducted since 1998
Champaign Health Center – Planned Parenthood 302 E Stoughton Champaign, IL 61820	Rep. Jakobsson (District 103) Sen. Frerichs (District 52)	Rep. Mitchell (District 101) Rep. Hays (District 104) Sen. Rose (District 51)	No	7/29/1999	Unknown	Of the six medical malpractice lawsuits against Illinois Planned Parenthood in this report, three of these settlements total \$6,245,000.00. The remaining three settlements are undisclosed. No health and sanitary inspection has been conducted in a Planned Parenthood in Illinois since 1999.
The Hope Clinic for Women 1602 21st St. Granite City, IL 62040	Rep. Hoffman (District 113) Sen. Clayborne, Jr., II (District 57)	Rep. Kay (District 112) Sen. Haine (District 56)	ASTC	10/7/2013	3/9/2012	"Failed to ensure the oxygen tank in the recovery room contained an adequate amount of oxygen, potentially affecting 100% of the patients." On 7/19/06 Hope Medical Clinic women's abortion clinic provider was sued for medical malpractice On 4/2/08 an undisclosed settlement agreement was reached.

Daily Herald

Illinois updated: 1/21/2012 5:54 PM

Illinois cracks down on abortion clinics



After revelations in Philadelphia, Ill., inspectors visited all nine licensed abortion clinics that are designated as pregnancy termination centers, a regulatory category that limits those nine clinics to performing first-trimester abortions and no other procedures. The Northern Illinois Women's Health Center in Rockford, above, and the Women's Aid Clinic in Lincolnwood were among those nine inspected clinics. The state found health and safety violations and issued emergency license suspensions for both clinics.

Associated Press, November 2008

Associated Press

An increased scrutiny of Illinois abortion clinics in the wake of revelations about a "house of horrors" in Philadelphia revealed that some facilities had gone up to 15 years without inspections, and two now have closed after regulators found health and safety violations.

The renewed oversight by state regulators led to the permanent closure of a clinic in Rockford earlier this month, following the closing of a clinic in suburban Chicago last October, according to documents obtained by The Associated Press through a Freedom of Information Act request.

One of those facilities -- the Women's Aid Clinic in Lincolnwood -- closed when the owner decided to surrender its license rather than pay a \$36,000 fine or endure an expensive legal fight with the state. The fine was for violations including the clinic's failure to perform CPR on a patient who died after a procedure. Its owner told the AP her clinic was safe and she felt victimized by the surprise inspection after 15 years.

While Illinois is working on the backlog of neglected inspections, the documents reviewed by the AP show that a few abortion clinics in the state still haven't been checked in more than a decade. One in Chicago hasn't been inspected in 16 years. Another in the suburb of Wood Dale was last inspected nearly 15 years ago.

State officials attribute the lag to a lack of funds and resources, noting that the state's 24 trained health inspectors are responsible for inspecting nearly 2,000 facilities.

Anti-abortion activist Eric Scheidler, executive director of the Chicago-based Pro-Life Action League, said Illinois is "one of the most pro-abortion states in the nation" and he believes it gave the clinics "a pass." The state has shown "a systematic unwillingness to step away from the ideology and look at these facilities objectively," he said, calling for more stringent inspections.

State regulators say ideology isn't involved.

The closure of the two clinics has invigorated the efforts of anti-abortion groups to shut down others throughout the state. Abortion-rights advocates are worried the state's heightened surveillance will restrict access to abortion for Illinois women. The closed Rockford clinic was Winnebago County's only abortion provider, making the closest ones now in Madison, Wis., or the Chicago suburbs.

Other states -- Kansas, Virginia, Pennsylvania and Utah -- are tightening regulations for abortion clinics following the 2010 raid on a Philadelphia abortion provider that regulators had ignored for years.

Authorities there described a filthy "house of horrors" where late-term abortions were routinely performed by untrained staff, and viable newborns died by having their spinal cords cut with scissors. Dr. Kermit Gosnell, 70, is awaiting trial on charges he killed seven newborns and one patient. He has denied the allegations. His wife and six clinic employees have pleaded guilty to lesser roles in the clinic operation.

Those reports also spurred the Illinois Department of Public Health into action, said Karen Senger, who supervises licensing and regulation of health care facilities in the state. The documents show the state began quietly increasing the inspections of its clinics last year.

"It was a departmental decision," Senger said, adding the Philadelphia case "gave us a focus" and motivation to find out "when was the last time we were in these facilities?"

Not for years, it turned out.

In 2011, Illinois inspectors visited all nine licensed abortion clinics that are defined as pregnancy termination centers, a category that limits them to first-trimester abortions and no other procedures.

The Northern Illinois Women's Center in Rockford and the Women's Aid Clinic in Lincolnwood were among those. The state found health and safety violations and issued emergency license suspensions that closed both temporarily. The clinics' operators have opted to remain closed.

Owners of the clinic in Rockford worked out a settlement with the state that would have allowed it to reopen with a reduced fine of \$9,750. But they announced this month that trouble hiring new staff and lack of support from some in the Rockford community had persuaded them to close for good. The clinic operators did not respond to messages conveyed through an attorney.

Larissa Rowansky, a co-owner of the Women's Aid Clinic in Lincolnwood, said her clinic helped women and provided the best care that a professional clinic could provide.

But Illinois inspection reports detail citations for practices such as frozen TV dinners stored in a biohazard lab refrigerator that also held placental or fetal tissue. The clinic's dusty equipment, lack of a supervising registered nurse and failure to perform CPR on a patient who later died also drew citations.

Rowansky said that patient didn't need CPR because she was speaking to emergency workers when she was taken to a hospital after her abortion. The patient "lied about her condition," Rowansky added, saying the woman had bronchial pneumonia and was too ill to have an abortion. The other violations uncovered by the state inspectors were technicalities, Rowansky said.

"It was unfair," she said of the state's inspection last year, the first in 15 years.

A separate inspection of the building resulted in more citations for fire hazards. Fixing the problems and paying the fine would have cost more than a year's revenue, Rowansky said.

"I tried to help women to get legal abortions," she said. "If someone wants to work against that, there's nothing I can do."

The inspection sweep of the nine clinics didn't include other centers that perform more services than first-trimester abortions and are classified as ambulatory surgery centers. Anti-abortion groups said there are four such centers. Senger said she doesn't know how many surgery centers perform abortions.

State records reviewed by the AP show some of those centers have gone uninspected since the mid-1990s. Senger said the department intends to inspect those and other surgery centers this year.

The state's inspectors are spread thin, responsible for on-site safety and health inspections of facilities ranging from hospitals to dialysis centers to home health agencies. Lack of money prevents the state from hiring more inspectors, said health department spokeswoman Melaney Arnold.

"The department would like the regulation of all licensed health care facilities to be on par with how long-term care facilities are regulated," she said, "meaning a survey is done at each facility every year and whenever we receive a valid complaint."

Illinois law doesn't specify how frequently either type of abortion clinic must be inspected. Both kinds must renew their licenses annually, but no inspection is required with that. After an initial licensure fee of \$500, a renewal costs \$300.

A third type of health facility providing abortions isn't licensed or inspected in Illinois. These clinics are considered to be similar to doctors' offices, which aren't licensed by the state, and the majority of their services aren't surgical procedures. Planned Parenthood clinics fall into this category.

"Let's bring them all under some sort of regulation regime," Scheidler said.

Sharon Levin, vice president of the National Abortion Federation, a standard-setting body for providers, said the Philadelphia case is unusual and shouldn't be used as a basis for a crackdown.

State regulators should inspect abortion clinics as often as they do other similar medical facilities, Levin said, but 15 years between inspections is excessive.

"We have clinical policy guidelines and we regularly inspect our members ... " she said, "but we would consider 15 years too long."

Illinois Rep. Jack Franks, a Marengo Democrat who supports abortion rights, is glad the state has stepped up its inspections.

"Abortions are legal in this state. They need to be safe," Franks said. "I want to make sure women getting these aren't being treated improperly."

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LE ANIC L HHA L HMO NAME AND ADDRESS Women's Aid Clinic West Toughy Ave Linouhwood, II 60712 OF FACHLITY LIST RULE ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY VIOLATED WHAT IS WRONG	Sanitary *The suction machine in OR #I contained clear water with specks of floating debris. Three stacks of gauze, out of the original package, was observed on a table. Five (5) insulin syringes were out of the protective packages. The anesthesia cart was dusty including the 4 drawers that contained medications. The blades of a floor fan had an accumulation of black substance. *The recovery room (RR) contained 5 beds and 2 recovery chairs. Five (5) of 5 recovery beds were rusty. The suction machine was observed with dust. The medication drawer in the RR contained a box of saltine crackers. Nine (9) medication cups, identified as containing Motrin and 10 medication cups containing Tylenol contained crumbs.
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Section 205.410 Equipment	D. Based on observation, document review, and staff interview, it was determined the PTC failed to ensure medication syringes were labeled and stored in a safe, clean area. This has the potential to affect 100% of patients.		
	C, conducted on the Sterilizing ? cc syringes ! were observed e "Clean" side of he Sterilizing	205.410 Label Medication 1. All lidocaine syringes are labeled and dated. That was our protocol and the nurse made a mistake and she has been showed the proper way to label medications.	10/12/13
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ILLINOIS DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH FACILITIES STANDARDS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION 4

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

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NAME AND ADDRESS Women's Aid Clinic 4751 West Toughy Lincolnwood II 60712 OF FACILITY

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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
205.420 (a) cont		*The biohazard laboratory refrigerator contained 8 products of conception (tissue). The same refrigerator also contained medications and 3 frozen TV dinners.	•	
	4 4 	2. The above findings were confirmed with the Owner/Administrator during an interview on 9/6/11 at approximately 10:00AM.		
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DATE OF SURVEY977/1 NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY	BY 07105 (Surveyor)	(Provider's Representative)
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	ALE	COMPLETION DATE	7/30/2011 -6/ 3 0/2011			,	Record)	k. chald [8]			Willonel/PB ative)	Unic Diliant/15
BLIC HEALTH SS STANDARDS AN OF CORRECTION	D HOSPICE D HOSPITAL	hicago Illinois 60616 PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	and a series of the series of	A meeting was held with the center managers, nurse supervisors , staff RNs and medical assistants to discuss the following plan of action:	 The "brown substance" is betadine which can be very difficult to remove from certain surfaces. A new betadine stain remover will be evaluated by the center. 	 The nurse supervisor has discussed our rieaning nursered with the terminal 	 Medical assistants will be responsible for dusting/cleaning of medical equipment, carts, etc. as well as "spot cleaning" 	between cases. (אבר לאבר אבר אבי אד 4. The biohazard container has been moved to another location. Staff have been	Instructed to keep this area clear. (300	The Nurse Supervisor will be responsible for monitoring compliance of the cleaning protocols.	(Provider's Representative)	Climit
ILLINOIS DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH FACILITIES STANDARDS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	D HMO	- Health, Ltd. 2415 S. Michigan Avenue Chic OF REQUIREMENT AND SPECIFICALLY PR			of 2 of 2 operating rooms om, it was determined equipment was		i .				BY 07105 (Surveyor)	
ILLINOIS DIVISION (STATEMENT OF)	SUB ACUTE D HHA	Michigan Avenue Center for Health, Ltd. 2415 S. Michigan Avenue Chicago Illinois 60616 ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY PROVIDER'S PLAN OF WHAT IS WRONG DATE OF REQUIREMENT AND SPECIFICALLY DATE TO BE COMPLE	Sanitary Facility The ambulatory surgical treatment center shall insure maintenance of a sanitary facility	This requirement was not met as evidenced by:	Based on an observational tour of 2 of 2 operating rooms (#1 and #2) and one recovery room, it was determined that the Facility failed to ensure equipment was maintained in a sanitary manner.	Findings include:	On 6/22/11 at approximately 11:35AM Operating rooms #1 and #2 and the recovery room was inspected with the following observations:	1. Three (3) of 4 metal carts in OR #1 contained rust like stains, residue and dust.	The Anesthesia Machine in OR#1 was dusty.	Suction tubing in OR #1, identified by staff as clean, was suspended over a biohazard container. The lid of the container when opened touched the clean tubing.		15 OF FMOK SURVEI
		NAME AND ADDRESS OF FACILITY Michig LIST RULE VIOLATED	205.420 (a)								 DATE OF SURVEY	NOTE: IF PLV, INDICATE DATE OF FRIOK SURVED

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

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Grave. 11. 60516 nter 1700 75^{di} Street Dr Access Health Ce NAME AND ADDRESS

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	ENTERSUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S FLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.420 (a)	Sanitary Facility	The Administrator has contacted the	06/30/2011
	The policy included, ": cleaning of the operating suite will occur at the end of every surgery day."	cleaning company which is responsible for terminal cleaning at the end of the day. Their supervisor has discussed the situation with their cleaning staff.	
	2.On 5/18/11 at approximately 11:15AM OR #2 was inspected and observed with loose debris on the floors, a red stain on a wall and standing water in a small bucket. The last surgical day was on 5/16/11.	The Mursing Supervisor will be responsible to monitor and ensure compliance by the deaing company. In addition, they will also assign the medical assistants to do "spot-deating" as well as "spot-check" between patients and at the end of the day prior to terminal cleaning.	·
	3.The above findings were confirmed by the Nurse Manager during an interview on 5/18/11 at approximately 11:15AM.		
Date of survey 5/18/11	By _07105		

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

205.420 (a) Sanitary Facility The ambulatory surgical treatment center shall insure maintenance of a sanitary facility This requirement is not met as evidenced by: Based on Facility policy review, observation and staff interview, it was determined that for 1 of 2 operating rooms (OR2) observed, the Facility failed to ensure a sanitary environment. Findings include: 1 On 5/18/11 at approximately 11:30AM , Facility policy titled," Terminal Cleaning of the Operating Suite" was reviewed.	VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
iy: for 1 of file)5.420 (a)	Sanitary Facility The ambulatory surgical treatment center shall insure maintenance of a sanitary facility	See Next Page	
It inent.		This requirement is not met as evidenced by:		
ynoximately 11:30AM, , ed," Terminal Cleaning of the was reviewed.		Based on Facility policy review, observation and staff interview, it was determined that for 1 of 2 operating rooms (OR2) observed, the Facility failed to ensure a sanitary environment.		
1 On <i>S/</i> 1 <i>8/</i> 11 at approximately 11:30AM , Facility policy titled," Terminal Cleaning of the Operating Suite" was reviewed.		Findings include:		37_
		1 On S/18/11 at approximately 11:30AM , Facility policy titled," Terminal Cleaning of the Operating Suite" was reviewed.		

MAY-20-2011 15:46

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ILLINOIS DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH FACILITIES STANDARDS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION 1

LIST RULE	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY	PROVIDER'S PLAN OF CORRECTION AND DATE TO RE COMPLETED	COMPLETION DATE
	when they were last checked for		
	outdates.		
Section 205.410 Equipment	C. Based on observation, document review, and staff interview, it was determined		
	the PTC failed to ensure single dose		
	multiple patients. This has the potential		
	to affect 100% of the patients.		
	Findings include:		
	1. During a tour of the PTC, conducted on	205.410 Single Dose Vials	
	10/2/13 at 12:00 PM with the		
	Administrator, the following single dose	1. We have since changed our	11-4-2013
	vials were observed in the narcotic	Fentanyl.	
	drawer available for use on multiple		
	patients: 21 vials of 10 ml Fentanyl		
	Citrate 500 mcg/ 10 ml.		
	2. During a staff interview, conducted with		
	the Recovery Room Nurse it was		
	verbalized that the RN draws up the		
	medication ordered and administers it to		
	the patient. When asked how many		

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NAME AND ADDRESS OF FACILITY	merican Won	nen's Health DBA Western Dive	ersev Surnical Center 1	.10 S. River Road. DesPlaines.	11.60116	
	WHAT	ENTER SUMMARY OF REQUIREMENT AND SPECTFICALLY PROVIDERS PLAN OF CORRECT WHAT IS WRONG	YAND SPECIFICALLY	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	ORRECTION AND	COMPLETION DATE
205 610 (c) (c)	Clin	Clinical Records		Pro-op/Post-op counselling form were created and implemented July 26, 2011	ing form were d July 26, 2011	7/30/2011
	Acci mair	Accurate and complete records shall be maintainedthe record shall include c) pre- connection notes c) nost connection notes	s shafl be nclude c) pre- mseling notes	The form will be assessed and avairated periodically and edited as needed for effectiveness.	ed end nd edited as t	
	This	This requirement was not met as evidenced by:	ä	Pre-op and post op counselling were also incorporated in the "Chart Review"	rselling were "Chart Review"	r.
	A. B	A. Based on clinical record review and staff	riew and staff	improvement Activities.	S.	
	inter reco Faci	interview, it was determined that in 5 of 5 records reviewed (Pt ± 1 , 2, 3, 4 & 5), the Facility failed to ensure all patients received pre-operative and post-operative counseling.	ant in 5 of 5 4 & 5), the ients received ive counseling.	In-service were conducted for the staff in-service were conducted for the staff con how to counsel the patient utilizing the form, handcuts are utilized as theoftum of instruction, of discussed	ed for the staff etient utilizing utilized cs It discussed	7725/2011
	Find	Findings include:		items in the counselling are made eveitable to show sample for patients	ere made e for patients	
	1. O clini for I and	 On 6/21/11 at approximately 9:00 A.M., clinical records 1-5 were reviewed. The records for Pt. (#1, 2, 3, 4 & 5) lacked pre-operative and post-operative counseling notes. 	y 9:00 A.M., wed. The records 1 pre-operative notes.	sucar as contractionary menous Please see in-service content and sign in sheet dated 07-25-11. Addendum D-1 and D-2. Deconsolitier, M. Europe	content and 5-11.	
				Manager Manager	er A	
Vanation On of the Vanation of	111202	BY	16853		1 //A A	A YODOHOV R

08/04/2011 THU 14:38 FAX FULLERTON MEDICAL CENTER

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NAME AND ADDRESS Women's Aid Clinic 4751 West Toughy Ave Lincolwood, II 60712

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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
205.420 (a)	Sanitary		
Cont	 *The Recovery Room technician (E#1) was observed on 9/6/11 at approximately 9:20AM, retrieving a paper towel from a garbage receptacle and using the same paper towel to cover a tray that would serve food items to patients. *The exam room contained 6 speculums and 20 pipettes that were out of the protective package. A rip in the exam table was covered with clear tape. 		
	*Two boxes of "Nova Rings" (contraceptive medication) were stored in the RR refrigerator with a liter of cola.		

DATE OF SURVEY	BY 07105 (Surveyor)	(Provider's Representative)
NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY	(burreyorg) and a state state.	



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PRINTED: 05/01/2012 FORM APPROVED

Illinois Department of Public Health

	t of deficiencies of correction	(X1) PROVIDER/SUPPLIDENTIFICATION N	IUMBER:	A, BUILDING		(X3) DATE S COMPL	BURVEY ETED 25/2012
9-9-14-	Rovider or supplier		1602 - 21	DRESS, CITY, S ST STREET CITY, IL 62	DTATE, ZIP CODE		3
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENC CY MUST BE PRECEDED I LSC IDENTIFYING INFOR	BYFULL	id Prefix Tag	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X6) COMPLETE DATE
L136D	A. The recovery r chairs. The beds with proper cleara to comply with this	b) s not met as evidence room contains 2 bed and chairs are not p inces between beds s section.	s and 11 rovided	L136D			
STATE FOR	tment of Public Health A			6499 61	EX921	if continuation	on sheet 13 of 13

if continuation sheet 13

NAME AND ADDRESS	SUB ACUTE, D HHA D HMO	- DHOSPICE DHOSPITAL	TAL
OF FACILITY : American Women's Health DEA Western Diversey Surgical Center 110 S. River Rd. LIST RULE ENTER VIOLATED VHAT IS WRONG	A Western Diversey Surgian Center 110 S. LARY OF REQUIREMENT AND SPECIF ONG	RIVAR Rd. CALLY PROVIDER'S FLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.530 (e) Operative Care A registered nurs	Operative Care A registered nurse, qualified by training and	Policy changes were made and implemented effective July 14, 2011, a Registered Nurse with competencies and experience in the field of surgery	7/14/2011
experience present in t the circulat operative p technique.	experience in operating room nursing, shall be present in the operating room and function as the circulating nurse during all invasive or operative procedures requiring aseptic technique.		
This requir	This requirement was not met as evidenced by:		
Based on re and staff in of 2 (B#1 a the Facility circulating	Based on review of Facility Job Descriptions and staff interview it was determined that for 2 of 2 (E#1 and 2) Registered Nurses available, the Facility failed to ensure the presence of a circulating RN during an invasive and		concurrent up to 3 months and will be revisited annually.
operative procedure. Findings include:	rocedure. Iclude:	 A. Sabeter RN which in turn will be reported to the Medical Staff Committee Meeting on a monthly basis 	
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08/04/2011 THU 14:37 FAX FULLERTON MEDICAL CENTER

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NAME AND ADDRESS OF FACILITY Northern Illinois Women's Center, 1400 Broadway, Ste 201, Rockford, IL 61104

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Section 205.530 (c) Operative Care A registered nurse, qualified by training and experience in operating room nursing, shall be present in the operating room and function as a circulating nurse during all invasive or operative procedures" 205.530 (e) 1. On Wednesday June 22 ^{cd} , NIWC re-hired Licensed Registered Nurse (See: E #3 personnel file reviewed on 6/6/11@ 10:15 AM, the 2 of 2 Registered Nurse, qualified by training and experience in operating room nursing, was present in the operating room and functioned as a circulating nurse during all operative procedures. Montwork I. On 6/6/11 at 10:15 AM, the 2 of 2 terminated RN's personnel files (E #3 & 4) were reviewed. There was no Registered Nurse currently employed. 205.530 (e) 1. On Wednesday June 22 ^{cd} , NIWC re-hired Licensed Registered Nurse (See: E #3 personnel file reviewed on 6/6/11@ 10:15 AM, the 2 of 2 terminated RN's personnel files (E #3 & 4) were reviewed. There was no Registered Nurse currently employed. 205.530 (e) 1. On Wednesday June 22 ^{cd} , NIWC re-hired Utcensed Registered Nurse (See: E #3 personnel files reviewed on 6/6/11@ 10:15 AM, the 2 of 2 terminated RN's personnel files (E #3 & 4) were reviewed. There was no Registered Nurse currently employed.	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 205.530 (c)	A registered nurse, qualified by training and experience in operating room nursing, shall be present in the operating room and function as a circulating nurse during all invasive or operative procedures" This requirement was not met as evidenced by: Based on review of Facility staff personnel files and staff interview, it was determined that for 2 of 2 Registered Nurses (E #3 & 4) previously employed by the Facility, the Facility failed to ensure a Registered Nurse, qualified by training and experience in operating room nursing, was present in the operating room and functioned as a circulating nurse during all operative procedures. Findings include: 1. On 6/6/11 at 10:15 AM, the 2 of 2 terminated RN's personnel files (E #3 & 4) were reviewed. There was no-	credentials (See Exhibit A, pg 3) and found her qualified for the Director of Nursing Position. 2. RN has Operating Room experience. (Exhibit G) She will be re-oriented by the doctor, clinic director (approx 2 to 3 wks.) Her performance will be re-evaluated by medical & clinical directors in 3 mos. & documented. Yearly evaluations	Orion-tation 1:22-to 6-15-11

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NAME AND ADDRESS: Michigan Avenue Center for Health, Ltd.

	WHAT IS WRONG	DATE TO BE COMPLETED	
205.540 (c)	Postoperative Care: Patients in whom a complication is known or suspected to have occurred during or after the performance of a surgical procedure, shall be informed of such condition and arrangements made for treatment of the complication. In the event of admission to an inpatient facility a summary of care given in the ambulatory surgical treatment center concerning the suspected complication shall accompany the patient.	Sic Next raige	
	This requirement was not met as evidenced by:		
	Based on review of Facility policy, clinical records, and staff interview, it was determined that, in 2 of 7 (Pt #3 and #4) clinical records reviewed of patients transferred to an inpatient facility, the Facility failed to ensure required documentation accompanied the patient.		
	Findings include:		
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DATE OF SURVEY	DATE OF SURVEY 6/23/11 BY 15168 (Surveyor)	(Provider's Représentative)	26 ((-1/)/1

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NAME AND ADDRESS OF FACILITY: Aanchor Health Center, 1186 Roosevelt Rd., Glen Ellyn, IL 60137

Sanitary Facility The sterilization of materials shall be done by autoclaving the		
materials in accordance with the recommendations of the manufacturer of the autoclave. The effectiveness of the autoclave shall be verified and documented at least weekly with a biological spore assay containing B. Stearothermophilus.	See Next Page	
This requirement was not met as evidenced by:		
A. Based on review of Facility policy, Manufacturer's Guidelines, Biological Spore Testing Log, and staff interview, it was determined that for 3 of 9 weeks in March and April 2011 (4 th week in March and 4 th & 5 th week in April), the Facility failed to ensure biological spore testing was verified and documented each week.		
Findings include:		
 On 5/4/11 at 10:30 AM, the Facility policy titled, "Autoclave Spore Check" was reviewed. The policy required, "The steam autoclave will be bacteriologically monitored on a weekly basis using Bacillus Sterotheomophilus spore ampoules. Follow direction of the manufacturer as given in the package." 		
 On 5/4/11 at 10:40 AM, the 3M Attest 1262 Biological Indicator Guidelines were reviewed. The guidelines required, "12. Incubate processed and control biological indicators for 48 hours" 		
	 shall be verified and documented at least weekly with a biological spore assay containing B. Stearothermophilus. This requirement was not met as evidenced by: A. Based on review of Facility policy, Manufacturer's Guidelines, Biological Spore Testing Log, and staff interview, it was determined that for 3 of 9 weeks in March and April 2011 (4th week in March and 4th & 5th week in April), the Facility failed to ensure biological spore testing was verified and documented each week. Findings include: On 5/4/11 at 10:30 AM, the Facility policy titled, "Autoclave Spore Check" was reviewed. The policy required, "The steam autoclave will be bacteriologically monitored on a weekly basis using Bacillus Sterotheomophilus spore ampoules. Follow direction of the manufacturer as given in the package." On 5/4/11 at 10:40 AM, the 3M Attest 1262 Biological Indicator Guidelines were reviewed. The guidelines required, "12. Incubate processed and control biological 	 shall be verified and documented at least weekly with a biological spore assay containing B. Stearothermophilus. This requirement was not met as evidenced by: A. Based on review of Facility policy, Manufacturer's Guidelines, Biological Spore Testing Log, and staff interview, it was determined that for 3 of 9 weeks in March and April 2011 (4⁴⁰ week in March and 4th & 5th week in April), the Facility failed to ensure biological spore testing was verified and documented each week. Findings include: On 5/4/11 at 10:30 AM, the Facility policy titled, "Autoclave Spore Check" was reviewed. The policy required, "The steam antoclave will be bacteriologically monitored on a weekly basis using Bacillus Sterotheomophilus spore angoules. Follow direction of the manufacturer as given in the package." On 5/4/11 at 10:40 AM, the 3M Attest 1262 Biological Indicator Guidelines were reviewed. The guidelines required, "12. Incubate processed and control biological

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NAME AND ADDRESS ACU Health Center 736 North York Road, Hinsdale, Illinois 60521

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LIST RULE VIOLATED	EXTERSIMMALAR OF REQUIREMENT AND SPECIFICALLY FROYDRYS FLAN OF CORRECTION AND WEAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.420 (a)	Sanitary Facility	The nurse supervisor has	6/30/11
Cont.	The policy included, "cieaning of the operating suite will occur at the end of every surgery day."	discussed this situation with the staff. Medical Assistants	
	2.On 5/23/11 at approximately 2:00PM, OR #1 was inspected. OR #1 contained tape on an IV pole and	have been trained and assigned to clean equipment	
	dust on the snotion macanne where there was an opened suction catheter. The last surgical day was on 5/21/11.	at the end of the surgical day prior to terminal cleaning.	
	 On \$/23/11 at approximately 2:15PM, OR #2 was inspected. OR #2 contained tape on an IV pole and brown stains on the suction machine. The last surcited (atv was on \$/14/11. 	The nurse supervisor will be responsible for monitoring compliance on a daily basis.	
	 The above findings were confirmed by the Assistant Administrator during an interview on 5/23/11 at approximately 2:45PM 		

(Provider's Representative)

By 07105 (Surveyor)

Date of survey 5//24/11_

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NAME AND ADDRESS ACU 736 North York Road Hinsdale, Illinois 60521

VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY PROVIDER'S PLAN OF CORRECTION AND WHAT IS VARONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.420 (a)	Samitary Facility The ambulatory surgical treatment center shail insure maintenance of a sanitary facility	See Next Page	
	This requirement is not met as evidenced by:		
	Based on Facility policy review, observation and staff interview, it was determined that for 2 of 2 operating rooms (OR# 1 and 2) observed, the Facility failed to ensure a sanitary environment.		
	Findings include:		
	 On 5/23/11 at approximately 2:30PM , Facility policy titled.¹ Terminal Cleaning of the Operating Suite.¹ was reviewed. 		
DATE OF SURVEY 5/23/11	S/23/11 07105	(Provider's Representative)	ntative)

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

COMPLETION DATE 12/11/2013 (Provider's Representative) **D**HOSPITAL occurred two years ago. We can only PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED (patient #1, #2 and #3). The provider The same anesthesiologist provided of the pre-anesthetic evaluation and the anesthesia induction time. This speculate that one or a combination discrepancies of the documentation provider has not worked for us for one year and could not recall what Regarding items #2, #3 and #4 anesthesia to all three patients has been questioned about the of the following occurred. **D HOSPICE** maintained for each patient and all entries in the ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WILT IS WRONG it was determined for 4 of 6 patients (Pt. #1, #2, #3 and #4) who underwent a surgical procedure surgical procedure is performed and when care, services are given. The record shall include the Based on document review and staff interview, on 12/02/11, the facility failed to ensure a pre-This requirement is not met as evidenced by: anesthesia evaluation was conducted prior to clinical record shall be made at the time the D HMO treatment, medications, or other medical Accurate and complete records shall be (Surveyor) following : anesthesia record. administration of anesthesia. D HHA BY Clinical Records Findîngs include: NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY D ASTC NAME AND ADDRESS DATE OF SURVEY 205.610 h) DF FACILITY LAST RULE VIOLATED Р .

12-05-13;01:18PM;

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Page 2 of 10

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IAME AND ADDRESS	4751 West Toughy Ave Lincolnwood, IL 60712 ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.420 (a)	 Sanitary Facility The ambulatory surgical treatment center shall insure maintenance of a sanitary facility with all equipment in good working order. This requirement is not met as evidenced by: A. Based on observation and staff interview, it was determined that for 4 of 4 rooms inspected (OR#1, exam room #1, recovery room and laboratory), the facility failed to ensure a sanitary environment and maintained supplies to prevent potential contamination. Findings include: *OR 9/6/11 at approximately 9:15AM, the facility was toured and the following was observed: *OR #1 (last used on 9/3/11) contained rust on the base of the surgical table, suction machine and stool. The baseboard near the hand washing sink was damaged.		
ATE OF SURVEY _9/7/11	BY_07105 (Surveyor)	(Provider's Represe	ntative)

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Gmail - Fwd: 8/21/2014 FOIA Request



9/25/2014

Fwd: 8/21/2014 FOIA Request

Linxwiler, Darlene <Darlene.Linxwiler@illinois.gov> To: Tue, Sep 23, 2014 at 3:57 PM

The following FOIA requests are a "no records" response. The documents or information requested are not yet available or no records are available to produce. The FOIA's are as such:

FOIA 1504910156 -- 2013 IL Abortion Stat Reports (not available at this time)

FOIA 1504910169 - health notices sent to patients/public following sanitary violations for abortion clinics (no records to provide)

FOIA 1503010087 – documentation defining the title/categories used in each column of the 2012 IL Abortion Stat Report (no records to provide)

I still have one outstanding response concerning health and sanitary inspection reports for ASTC's. I will provide this response as soon as I am presented with the response from program. (FOIA 1504910158)

You may request a review of these responses by contacting the Office of the Public Access Counselor (PAC) at:

Public Access Counselor

Office of the Attorney General 500 So. Second Street

Springfield, IL 62706

FAX: 217-782-1396

EMAIL: publicaccess@atg.state.il.us

You also have the right to file for injunctive or declaratory relief in the circuit court for Sangamon County or the county where you live (5 ICLS 140/11). If you choose to file a Request for Review with the PAC, you must do so within 60 calendar days of the date of this letter (5 ILCS 140/9.5(a)). Please note that you must include

https://mail.google.com/mail/u/0/?ui=2&ik=0257544790&view=pt&q=darlene.linxwiler%40illinois.gov&qs=true&search=query&msg=148a44e812a4e763&siml=14... 1/2

9/25/2014

Gmail - Fwd: 8/21/2014 FOIA Request

a copy of your original request letter and this letter when filing a request for review.

Thank you.

From:

Darlene Linxwiler

Freedom of Information Officer

Sent: Monday, September 22, 2014 4:20 PM

EASTC I HHA I HMO I HOSPICE I HOSPITAL

NAME AND ADDRESS Northern Illinois Women's Center. 1400 Broadway, Rockford, IL 61104 OF FACILITY

LIST RULE VIOLATED	ENTER SUMMARY OF REQUIREMENT AND SPECIFICALLY WHAT IS WRONG	PROVIDER'S PLAN OF CORRECTION AND DATE TO BE COMPLETED	COMPLETION DATE
205.420 (C) (2) Cont.	 Findings include: 1. The autoclave log for July 2010 to June 6, 2011, was reviewed on 6/7/11 between11:30 and 12:30 PM. The log contained documentation of biological testing of the 2 autoclave machines for the following dates: 7/7/10 (passed), 11/3/10 (failed), 11/17/11 (negative), 3/16/11 (failed), and 4/6/11 (passed). 2. An interview with the Administrator on 6/6/11 at approximately 2:00 PM The Administrator stated that biological testing is performed quarterly. 	A daily autoclave log is kept for each autoclave and is stored in the autoclave book for inspection. (Exhibit E pg 1) Clinic (C) administrator created a Maintenance Log for Autoclave to ensure passing spore tests on both autoclaves. Clinic director will monitor proper maint/cleaning done according to autoclave manual. In the event that a Service Call is required for maintenance, a copy of the service done and signature of serviceperson will be attached to maintenance log. Clinic Administrator will sign off on all cleaning/service done. (Exhibit F) CC committee initiated these policies and Clinic director will monitor them weekly to ensure poc remains in effect.	6.13-11
DATE OF SURVEY6	6/8/11 BY19840 (Surveyor)		<u>6.</u> 28.11 entative)

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From: Senger, Karen <karen.senger@illinois.gov Date: Tue, Dec 20, 2011 at 9:16 PM</karen.senger@illinois.gov 	>
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This is response to your email and the additional in	formation on past FOIA requests
or interpret specific questions related to the survey	to the surveillance nurses. The Department does not address findings. The Department conducted licensure surveys at both e current deficient practices identified on the date of the survey months if necessary.
The National Health Care facility- The Department monitor the facilities compliance.	has accepted the plan of corrections and will continue to
Northern Illinois Women's Center is still in legal pro	Cess.
In relation to your follow-up questions regarding the FOIA, the Department did not have an acceptable I	e POC for American Women's Des Plaines at the time of the POC to release. See attached POC
https://mail.google.com/mail/u/0/?ui=2&ik=0257544790&view=pt&q=	kqs=true&search=query&th=148f5404d4571227⪝=148f5404d4571227& 1/3
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CMP Fullerton Kimball ASTC- the Department re onsite visits to ensure compliance from the surv will continue to monitor compliance.	eleases only acceptable POCs the Department made several ey and is still awaiting a written acceptable Plan of correction and
	I/19/96 was not found in the microfilm and the Department is only no copy of the POC on file for the 4/19/96 survey.
Karen Senger, RN, B.S.N. Supervisor of Central Office Operations Division of Health Care Facilities and Programs 525 West Jefferson Street, 4th Floor Springfield, IL 62761	

Phone: 217-782-0381 Fax: 217-782-0382 email: karen.senger @illinois.gov

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State abortion records full of gaps

Thousands of procedures not reported to health department

June 16, 2011|By Megan Twohey, Tribune reporter

Health care providers are failing to detail abortion complications to the state as required by law, one of many gaps in a surveillance system viewed as crucial to protecting patients, a Tribune review has found.

The state's system for tracking abortions is so broken that regulators also may be missing more than 7,000 of the procedures per year.

The Illinois Department of Public Health must collect details about every abortion performed in the state, including whether the patient is injured or dies.

The mandatory reporting is essential for tracking trends in public health and can provide a window into quality of care. While abortion has proven to be a very safe procedure, heightened rates of complications or clusters of deaths could signal problems with particular providers.

"If people are looking at reports and seeing excessive complications, that might warrant another look or another inspection," said Vicki Saporta, president of the National Abortion Federation, an association of providers.

But there are significant holes in state monitoring of a procedure that affects tens of thousands of Illinois women each year. Nationally, current rates suggest that nearly 1 in 3 women will have an abortion, according to research published in the medical journal Obstetrics & Gynecology.

The Tribune found:

•State regulators have documented between 7,000 and 17,000 fewer abortions a year than a national research group found in Illinois.

•This reporting is the only tool Illinois authorities have to monitor some abortion providers, yet regulators may be allowing doctors and clinics to operate off the books. Regulators collect reports from 26 providers, but the abortion rights research group has identified 37 providers doing business in the state.

•Also unknown to officials are the types of abortion-related problems experienced by women. Nearly 4,000 reports of abortion complications involving Illinois residents in 2009 were missing the required description. •Health care providers who intentionally fail to submit accurate and complete reports are committing a criminal act, and a failure to report abortion complications is grounds for revoking their licenses, but the Department of Public Health has never sought disciplinary action against a provider.

Kelly Jakubek, an agency spokeswoman, said in a written response that it was the responsibility of abortion doctors to ensure they comply with the mandatory reporting requirement.

Regulators don't respond to the reports in any way, she said, because they view the information as serving statistical purposes only.

"It's outrageous," declared Maurice Stevenson, whose wife died in 2002 from infection following an abortion at a Planned Parenthood clinic in Chicago. "These procedures, complications and deaths should be public record."

Critics contend that accurate government accounting is essential, especially with a politically charged issue such as abortion in which both sides push information to further their agendas.

A review of malpractice cases revealed other abortion-related complications in Illinois — with no way of knowing whether they were reported to the state.

For example, in 2002, after an area woman's uterus was torn in an abortion she began hemorrhaging, went into cardiac shock and was hospitalized for three weeks. Several years later, a mother of three experienced seizure symptoms and slipped into a coma following her abortion at a city clinic. And in 2009, a teenage girl suffered respiratory and cardiac arrest and died immediately following her abortion in a northern suburb, according to court records.

The state Legislature included mandatory reporting in the 1975 Illinois Abortion Law, a compilation of guidelines enacted after the U.S. Supreme Court decision in Roe v. Wade.

Abortion providers succeeded in stripping away many of the law's other requirements, but a 1993 legal settlement between providers and the state retained mandatory reporting "to better protect the health of women undergoing these procedures."

Why does the information matter?

The confidential reports are "very important from both a demographic and public health viewpoint," according to the federal Centers for Disease Control and Prevention, which surveys abortion data collected by the states.

In addition to illuminating trends in unplanned pregnancies and documenting access to abortion, the reports have helped to reveal that certain procedures carry higher risks of complications and that dangers increase exponentially as the pregnancy progresses.

In Illinois, reporting also provides an opportunity to monitor all doctors who perform abortions. Not all abortion providers are licensed as such. The Department of Public Health has licensed 14 providers as ambulatory surgical treatment or pregnancy termination specialty centers.

(Page 2 of 2)

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But licensing is different in other settings where abortions are performed, including at clinics where surgeries account for less than 50 percent of their business and at private physicians offices.

It is unclear which providers are making reports.

The New York-based Guttmacher Institute, an abortion rights research organization, conducts its own accounting across the country. Its information is widely viewed as more accurate than what is collected by state regulators because the organization makes extensive efforts to identify abortion doctors and follow up with them.

It was Guttmacher that located 37 providers in Illinois in 2008, and it is Guttmacher that has consistently counted thousands more abortions per year than the number recorded by state regulators.

A Tribune examination of the reporting data collected by the state revealed missing information.

Providers often did not specify, as required, whether a complication was a tear of the uterus or another specific problem.

In certain medical malpractice cases reviewed by the Tribune, women said they were never informed by their provider that the abortion was unsuccessful and later underwent challenging pregnancies, painful deliveries and other complications.

Others suffered anesthesia-related problems, hemorrhaging and infections, according to the suits.

The federal government also identified gaps in Illinois' abortion surveillance system, saying that more than 15 percent of reports in 2007 did not specify how far along pregnancies were and what type of procedure was used.

Jakubek said the numbers of abortion providers documented by Illinois regulators and Guttmacher are different because they use different counting methods. The research

organization's tally includes hospitals, clinics and physicians' offices. Jakubek said the 26 providers identified by state regulators "only includes facilities," but declined to elaborate on her definition of facility.

The problem of underreporting isn't limited to abortion, said John Lumpkin, who left the Department of Public Health in 2003 after serving as director for 12 years. But the agency lacks the funds to address it, he said.

"Whether it's flu, food poisoning or pregnancy termination, we knew there was underreporting going on," said Lumpkin, who now directs the Robert Wood Johnson Foundation's Health Care Group. "The health department doesn't have the resources to follow up with every doctor's office that is reporting food poisoning or flu, nor did it have resources to follow up with every provider of pregnancy termination."

Stanley Henshaw, a Guttmacher researcher, has explored abortion reporting problems and "lax enforcement" across the country.

Some providers feared that reports would fall into the hands of anti-abortion protesters or competitors, even though breaches of confidentiality are rare.

Today, Henshaw theorizes it is the shoddiest operators who are not reporting the abortions they perform. Either they refuse to comply or are so off the radar they are unaware of the requirement.

"I think it's only a problem with the worst providers," said Henshaw, who has recommended audits of state abortion reports, a process that would involve verifying who all the providers are.

As safe as abortion is, dangerous providers do exist, made evident by the murder charges filed this year against a Philadelphia abortion doctor whom prosecutors accused of operating a "house of horrors."

Some providers identified by the Tribune refused to discuss reporting.

Others, such as Planned Parenthood and Family Planning Associates, said they were diligent about complying and concerned if others were not.

"It is useful public health information. ... We'd hope all providers would comply," said Carole Brite, president of Planned Parenthood of Illinois.

At the same time, Planned Parenthood could not confirm for the Tribune whether it had reported the 2002 death of Stevenson's wife, only that it had reported the 2008 death of another patient. The organization said it had no reason to believe the 2002 death was not reported but that the records were in storage.

And Family Planning Associates said it could not confirm whether it had reported three deaths, in 1998, 1999 and 2000.

A woman who identified herself as a manager of the Women's Aid Clinic of Lincolnwood would not comment on a 2009 death.

The Tribune identified these deaths as part of its review of malpractice suits.

Providers are required to report all abortion-related deaths to the state, not just those in which the death was directly caused by abortion or those involving wrongdoing on the part of health care workers.

In states with more complete reporting, officials have taken active steps to identify providers and follow up with them.

In Minnesota, doctors are informed of the reporting requirement when they are licensed. And state officials send annual reminders to every physician and press those who submit incomplete forms, said Carol Hajicek of the Minnesota Department of Health, which sends a lengthy report on abortion data to the Legislature each year.

"We think we're getting them all," Hajicek said.

mtwohey@tribune.com



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Holiday feast Thanksgiving issue

full of food, facts Parade

Norman Rockwell His personality an

paintings; a series ChicagoStyle



state's wolk-in cli

dead after abortions

By Pamela Zekman

and Pamela Warrick

Stereo

Fever

A special section

- Copyright, 1978, The Chicago Sun-Times
- At least 12 women have died following legal abortions in
- At least 12 women have new tonowing regar according in Ellinois walk-in abortion ethnics. Although state health officials knew of not a single clinic death just a week ago, The Sun-Times and Better Govern-ment Assn. have learned of a dozen women who suffered fa-tal infections or bled to death after undergoing abortion pro-coduces in extenzeoutland clinics; cedures in state-regulated clinics:

• Evelyn Dudley, 38, of Benton Harbor, Mich. She died of a hemorrhage on March 16, 1973, after an abortion at the now-defunct Friendship Medical Center, 850 W. 103rd St.

• Julia Rogers, 20, of Gary, Ind. She died March 28, 1973, also from a hemorrhage, a week after her Friendship abortion.

• Dorothy Muzarow, a registered nurse who, federal sources say, apparently underwent two incomplete abortions at the Women's Aid clinic in Lincolnwood. She died of a hemorrhage on Aug. 23, 1974.

• Linda Fondeen, who died Jan. 20, 1974, of a massive in-ternal infection after an abortion at Pre-Birth Inc. The clinic has since gone out of business.

• Dorothy Brown, who bled to death on Aug. 16, 1974, after an abortion at the Friendship clinic.

Another woman, known to federal health authorities only as Ms. Floyd, who died March 28, 1975, three days after her abortion at the Associated Concern clinic. The clinic was

energy and the second second



'Twelve women suffered fatal infections or bled to death after undergoing abortion procedures in state-regulated clinics.'

closed down July 1 of that year by the Illinois Department of Public Health.

· Sandra Lynn Chmiel, a 35-year-old mother of four from the suburbs, who died of massive bleeding from a punctured uterus on June 3, 1975, just hours after her abortion at Bio-genetics Ltd., 520 N. Michigan. According to testimony at a coroner's inquest, Chmiel was over 12 weeks pregnant when a Biogenetics doctor agreed to perform her abortion for \$600. The clinic has insisted its doctor only "repaired" the damage the woman did by trying to abort herself, but the clinic settled the case for \$75,000 a few weeks ago.

 Another woman identified by federal sources died in 1975 of a blood clot five days after an abortion in a Spring-field clinic. Federal health officers believe the death was "probably not preventable.

· Yet another woman known to federal authorities died of

Turn to Page 25



SANDRA LYNN CHMIEL 35-year-old mother of four died of massive bleeding June 3, 1975, after her abortion at Biogenetics Ltd. She is shown with two of her children.



Mom has abortion, and another child

By Pamela Zekman and Pamela Warrick

Capyright, 1978, The Chicago Sun-Times

Many women survive the consequences of inaccurate laboratory reports. In Agnes Glasper's case, the fetus survived as well. That, in itself, nearly killed both mother

and baby. Glasper had an abortion at a new-defunct Chicago clinic on Nov. 28, 1975. A laborato-ry reported the abortion was successful. Sev-en and a half months later, Glasper gave birth.

birth. In what is believed to be the first "wrong-ful birth" case ever filed in this state, Glasper is seeking \$100,000 from the clinic, the laboratory and the doctor who per-formed her "abortion."

Glasper, 30, already had two children and was studying to be a nurse when she found out she was pregnant. It was all she could do to feed two children and herself on the \$260

to feed two emidren and nersell on the \$200 check she got each month from the Illinois Department of Public Aid. To understate the situation, hers was an unwanted pregnancy. "I felt awful about be-ing pregnant again. I didn't want any more kids and I could not financially handle an-ther " artic Cherger other," said Glasper.

SHE WENT TO the Illinois Reproductive Health Center at 209 N. Michigan for an abortion. She and about 75 other women had abortions there that day.

She didn't care about waiting seven hours for her abortion and she didn't care that

"I just felt also tron and she built a straight-back chair to sit in after the abortion. "I just felt happy that it was over with," she said. "I was so relieved. I did not want another child." The tissue removed from her womb was cost to the acouderburgt Concern Medical

sent to the now-defunct General Medical Laboratories Ltd. for analysis. A report signed by a lab pathologist said "products of conception" were found in Glasper's aborted tissue, indicating the abortion apparently was successful.

But that report, claims Glasper's attorney,



pressed. I thought about killing the baby--in fact, I al-

Merwin Auslander, was based on "carelessly and negligently performed" pathological pathological tests.

WHEN SHE STILL had not menstruated two months after the abortion, Glasper went to her family doctor to find out why. He told her she was still pregnant-by then, about four months pregnant.

That was much "too pregnant" for an-other clinic abortion, and all the hospitals she called for help turned her down. She didn't have the money to fly to New York for an abortion. "f couldn't believe this was really happen-

ing. I don't think I believed it until I started showing....For the next five months, I thought I was carrying a deformed baby."

The doctor, Glasper assumed, surely must have damaged the baby during the attempted abortion. "I couldn't sieep at night. I thought a to about killing myself." On July 10, 1976, Glasper gave birth to a boolthut in sound of the Decrement the Tiff.

healthy, six-pound girl. She named her Tiffanγ.

CLASPER THOUGHT seriously about abandoning the baby at the hospital, but, afraid it might be neglected, she took the in-

fant home. "I was so depressed," Glasper said, "I thought about killing the baby—in fact, I almost did.

"The baby cried a lot and one night, very late, she was crying again and I found my-self standing over her crib holding a pillow over her head. I was standing there, I don't



IT TOOK time and intense psychiatric care, but Agnes Glasper has learned to love her

daughter, Tiffany, a daughter she thaught she had obarted during a visit to a now-defunct abortion clinc in 1975. She is suing the operators of the clinic—in what is believed to be the first "wrongful birth" case in Illinois.

know how long, when I came to my senses." By then, Glasper was a very sick woman. Tilfany's birth had made her psychotic, Glasper's psychiatrist said. She suffered de-

Glasper's psychiatrist said. She suffered de-lusions. Her mind created crazy explanations for how this child had survived an abortion. "I thought the baby had come from the devil, that is was evil. One time it was rain-ing out real hard. I got scared. I got it in my head somehow that if I sprinkled her with rain water it might... like purify her I car-ried her out in the rain in my nightclothes and I got some water and sprinkled it on the

NOW, THANKS TO intensive psychial care, Glasper no longer has those feelin about her baby. Now, she says, "I li her...my doctor helped me do that." But for her and her child's suffering, Al-

lander is seeking \$100,000 from the ope tors of the clinic and laboratory who caus Tiffany's "wrongful birth."

Auslander says he is treading on new leg ground in this case. Never before, he sa has a suit been filed in Illinois chargin "wrongful birth." But Auslander took ti case, he said, because "a lot of damage h been done to this woman."



Continued from Page 24

a rare inflamation of the heart in 1975, three days after an abortion at a Champaign clinic.

• Diane Smith, whose death Sept. 11, 1976, is still under investigation by federal offi-cials. She apparently told doctors at the hos-pital where she died she had just undergone an abortion at a Chicago area clinic.

• A woman state public health authorities are still trying to identify who died in 1977 of a perforated uterus following an abortion in a Cervite City (III) objection

of a perforated uterus following an abortion in a Granite City (III). clinic. In addition to these, is the death of Sherry Emry. She died Jan. 2, 1978, of a ruptured ectopic pregnancy which, an Indiana coroner ruled, resulted from an incomplete abortion at the Water Tower Reproductive Center Ltd., 840 N. Michigan.

AS A RESULT OF INFORMATION turned over to the Cook County state's attorney of-fice by The Sun-Times and Better Government Assn., State's Atty. Bernard Carey has reopened the investigation of Emry's death.

reopened the investigation of Emry's death. And members of her family have filed a \$5 million lawsuit against the Water Tower clinic for medical malpractice. The Water Tower clinic is owned by Dr. Arnold Bickham, named in The Sun-Times as one of the cly's biggest abortion profiteers. He was working at the Friendship clinic

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AT LEAST one Michigan Avenue obortion mill, Water Tower Reproductive Center, doesn't empty after each patient's abortion battles containing aborted tissue, meaning there can be no accurate laboratory test to determine whether the fetus was removed.

a second a second s

when at least three Friendship patients died. is not known whether Bickham, who sells the cheapest abortions in Chicago, per-sonally performed Emry's abortion. But, had it not been for the corners he cuts in health care at his clinic, Sherry Emry

might be alive today. A five-month investigation of the city's

abortion trade by The Sun-Times and Better Government Assn. discovered women may pay dearly for Bickham's discounts.

AT HIS WATER TOWER Reproductive Center Ltd., 840 N. Michigan, our undercov-er investigator documented how Bickham saves money on laboratory fees by tossing the tissue out when the law says it must be sent to pathologists for analysis.

That economy alone could be saving Bick-

I hat economy atone could be saving Bick-ham as much as \$50,000 a year. It may have cost Sherry Emry her life. Working inside the Water Tower clinic seven months after Emry's death, BGA in-vestigator Mindy Trossman did not see any aborted tissue sent to pathologists.

If pathologists find no fetal parts, or other signs of pregnancy in the tissue sample, the doctor must conclude one of three things: The patient was not pregnant in the first

and has undergone an unnecessary place. operation. . The abortion was incomplete and fetal

Seventh in a series

parts are beginning to rot in the patient wamh

· The patient is suffering a life-threatenin ectopic pregnancy. An ectopic pregnancy, which occurs whe

the embryo emplants itself in the Fallopia tubes instead of the womb, can be fatal undetected. As the embryo grows, it burst the tube and fills the woman's abdomina

area with blood. Victims of such abnormal pregnancies ca quickly bleed to death.

Our investigator got her first hint the there were no pathological reports bein done for patients of the Water Tower clini when, working as a medical assistant, sh was told by her supervisor to empty operal ing-room bottles full of "products of concer tion" form gauged patients.

ing-room obties the or "products of concer-tion" from several patients. The supervisor explained: "If we had to empty the bottles after eac patient, we'd only be able to do 20 [abor tions] a day."

AS IT IS, THE CLINIC does two to three times that many abortions in a day. Tross man saw one aide wrap up a mass of bloody

Chicago Sun-Times special reprint

12 die after legal abortions at walk-in clinics

Continued from Page 25_

aborted tissue and throw it in the trash can.

"Bickham wants us to take the bottles to the washroom to dump it, but you get too busy to do that," said the alde. "I just throw it in the garbage."

Just unrow is in the garbage." The aide later was reprimanded by the supervisor. "It starts to smell if you leave it in the garbage in the steriliza-tion room," she said. "Throw it down the toilet. "Bickham says we pay \$10,000 a month rent here so the toilets should be able to handle it. If they get clogged, the building should take care of it."

e

It was to Bickham's Water Tower clinic that Sherry Emry went for her abortion According to Lake County (Indiana) Corquer Albert Wil-

lardo Jr., Emry died of a ruptured ectopic pregnancy result-ing from her incomplete abortion at the Water Tower clinic.

The story of her deal was pieced together by The Sun-Times and BGA and the findings were turned over to Cook County State's Attorney Bernard Carey's office. As a result of the information, Carey opened an investigation into Descho dealers. Emry's death. She was only 26 years old when she died. A strong individual, said the coroner, the way she endured

the pain of those last days. She always was a strong person, said her mother. And in-dependent. She ran her own business—a leather-crafts shop in Hammond, Ind.

In riammond, no. Separated from her husband, Sherry was making it alone. For the first time in five years, her business was in the black. Her divorce was nearly final; 1978 would be her year. But in the last weeks of 1977, Sherry found out she was pregnant.

She thought she knew what she had to do. Abortion, she

She indught she knew what she had to do. Adortion, she confided to a friend, was her only option. She picked up a copy of the Chicago Reader and scanned the ads. It didn't take long for her to settle on an abortion clinic. Water Tower Reproductive—it had one of the biggest

ads on the page. With the Water Tower name and the Michigan Av. ad-dress, it sounded classy. Certainly, it would be safe. Still, she was scared.

On the morning of Dec. 28, Sherry Emry went to the Wa-ter Tower clinic and had what seemed to be a routine abor-tion—at least, it was what doctors would call "uneventful." She was back at a friend's Chicago apartment in time to catch the noon news.

Three days later, the pain started. The clinic had given her Its standard sheet of instructions for postoperative care. Yes, it said, expect some cramps.

it said, expect some cramps. It's OK, she told her friends. Just cramps; maybe a touch of flu. It was New Year's Eve but she went to bed early. By Jan. 2, Sherry couldn't get out of bed. Friends took turns sitting with her, trying to persuade her to see a doctor. No, she said, it was probably just flu. She'd feel better. But she slept fittully. Sweating one minute, shivering the next. Her knees ached, her stomach ached, every part of her hurt. And she was so pale-deathly pale, one might say. On that second day of 1978, Sherry died, probably during the afternoon because when they found Sherry In her bed after dark, the body was already cold and stiff.

٠ Sherry Emry's life, was in the words of the Indiana coro-ner, "salvageable." She should still be alive today, he says. But because of an incomplete abortion at the Water Tower clinic, ruled Willardo, she is dead. Had Emry's doctor at the Water Tower clinic carefully ex-amined her and had he received a reliable iab report on the tissue removed during her abortion, "the chance is very slim" that Emry's ectopic condition would have been missed, said Willardo.

said Willardo. To find out how a healthy woman like Sherry Emry could

10 Ind out how a healthy woman like Sherry Enry could die of an ectopic pregnancy just days after seeing a doctor, the Indiana coroner subpenaed the clinic's records on Emry. Bickham ignored the subpenas and is now fighting new subpenas for those and other patient records issued by the Cook County state's attorney. What the Indiana coroner wants to know is whether Bick-

A note to our readers

Reliable abortion counseling should be obtainable from family physicians. Other organizations that are prepared to respond to women's health questions are:

· Planned Parenthood Assn., 55 E. Jackson, 322-4240. · Health Evaluation Referral Service, 2757 N. Semi-

nary, 248-0166.

The Women's Switchboard of the Midwest Women's Center, 800-972-5404.

should be alive today.

Sherry Emry's life, the coroner said, was 'salvageable.' She

THREE DAYS before undergoing an incomplete obortion of Woter Tower Reproductive Center Ltd., Sherry Emry was at home in Hommond opening Christmos presents. Five days after the operation, she died, according to the Loke County (Ind.) coroner, of a ruptured ectopic pregnancy. Her mother, Cleo Higgason, asked: "Why didn't they know before? Why did I have to lose a daughter?



ham's clinic discovered Emry's life-threatening condition, and if not, why not.

gason. "I just can't believe all these things I have been read-ing in The Sun-Times can go on and on and no one knows about it.

"Why didn't they know before? Why did I have to lose a daughter?"

According to our investigations, the Chicago Loop Medi-clinic at 316 N. Michigan and the Biogenetics Ltd. clinic at 520 N. Michigan usually don't trash tissue samples from their abortion

But we found that the Loop Mediclinic handles specimens so carelessly that the reports it gets back may be meaning-

And neither the Mediclinic nor Biogenetics can be depended upon to share the findings of pathological reports with its patients, even when the reports may call for emergency medical attention.

In addition, the laboratory the clinics use—La Salle Scien-tific Laboratories Ltd., 914 W. Diversey—may be issuing dangerously unreliable reports, according to expert pathologists consulted during our investigation

WHILE WORKING undercover filing pathology reports at the Loop Mediclinic, BGA investigator Julia Rockier discov-ered two La Salle laboratory reports with opposite findings for the same Mediclinic abortion patient: One says fetal parts were found in the tissue sample, indi-cating that the patient was definitely pregnant. The other says no signs of pregnancy were detected: the patient was either not pregnant or the doctor left the fetus inside. Daniel Miltman, owner of La Salle Laboratories, said if clinics don't properly label the containers as products of the same abortion, the Jah.may mistakenly issue two endorts:

same abortion, the lab may mistakenly issue two reports:

And those reports could give opposite results becaus container may have all the evidence of pregnancy whi other may contain only blood. But, according to the clinic file on the public aid pa-with the conflicting reports, tissue from her abortion ; even got to the lab. Scrawled at the bottom of the fil "Scoreme calidocality through survey by Linds".

even got to the lab. Scrawled at the bottom of the fi "Specimen accidentally thrown away by Linda." Any number of La Salle laboratory reports on Medi-and Biogenetics patients claimed pathologists had ident with the naked eye conclusive signs of pregnancy. "A microscopic exam is essential," said Dr. Paul B. Sza Chicago's dean of pathology and director of Cook Co Hospital's pathology division. "Even with a microscop happens over and over again that we cannot see [the signs of pregnancy]." Dr. Willard Cates Jr., who oversees abortion surveille for the National Center for Disease Control in Atlanta, lieves pathological reports are so important that no cl should allow a patien to leave the premises without cf

lieves pathological reports are so important that no el should allow a patient to leave the premises without ("You can't let a woman walk out of an abortion cl without an immediate review of the specimen," Cates s Without that lab analysis, he said, "You can't be cert that the woman was pregnant, or that you got all the ft remains, or whether she had an ectopic pregnancy." In a survey of almost 200 patients at the Mediclinic, B investigator Rockler found that, with few exceptions, put aid patients got microscopic exams. Cash patients did n The laboratory bills Medicaid separately for tests on w fare patients. Millman said Illinois Department of Public *e* requires microscopic exams. Last year, La Saile billed Medicaid for \$735,000 worth work. By July of this year, the laboratory already had bill

Last year, ha sane often metatata to provide meta-work. By July of this year, the laboratory already had bill Medicaid another \$597,000. That makes La Salle one of ti top three laboratories on the state's Medicaid payment lig

THE LAB'S USE of preprinted reports also disturbe The LAWS USE of preprinted reports also insturio Szanto, who inspects hospitals for the College of America Pathology. On such forms, the findings of tissue analysis at preprinted and blanks are left only for pathologists to fill i dimensions of blood clots removed. But Rockler found dozens of La Salle reports on which pathologist, Dr. Arnold Mass, had not even filled in th

blanks.

blanks. " Millman said Mass had only substituted for a vacationing pathologist and had not followed lab policy. "That's our fault," Millman conceded after reviewing some of the reports. "The work [analysis] was definitely done, it just wasn't done as professionally as it should have

Millman said the lab does accurate tests and does not issue phony, reports.

THAT IS disputed by James Trainor, former head of the Illinois Department of Public Aid. After leaving his state of-fice Trainor accepted an offer to become a director of La Salle Labs, but lasted only four days because he felt the lab was not operating properly.

But even on occasions when clinics do get "reasonable re-But even on occasions when clinics do get "reasonable re-sults" from the lad, doctors at both Biogenetics and the Loop Mediclinic may ignore them. In July, for instance, the Loop Mediclinic received a report from the laboratory indicating an abortion on a 25-year-old rape victim was either incomplete or unnecessary. The pathologist reported finding no signs of pregnancy in the tissue removed during the abortion but the patient said the clinic never told her this.

In August, "my own doctor told me I was still pregnant. He said I was three months pregnant. I couldn't believe it," the woman said. "He told me to go back to the clinic that did the abortion."

She returned to the Loop Mediclinic, where she said the doctor who had performed her abortion told her that the pathology report indicated that the first abortion was complete.

But a copy of the pathology report seen by our investigator showed the doctor had not removed the products of con-ception. But the clinic doctor went on to explain to his con-fused patient that once in a while "we get a missed abortion ?

'The doctor said I was the one in a thousand," the patient recalled. .

Our medical experts said they would not tolerate such de-lays. A pathological report that shows no evidence of preghays. A pathological report that shows ho evidence of preg-nancy must be treated as a medical emergency, our experts say. The patient must be tracked down. As Dr. Wendy Recant, director of surgical pathology at Michael Reese, put it: "This patient must be watched be cause in all likelihood she has an ectopic pregnancy. "It would be the grossest kind of malpractice to miss one evidence and the desence and the total state the total state and t

ectopic pregnancy and one woman went home and bled to death. . . ." Sherry Emry did.

NEXT: Padding profits with tax dollars, with the scut

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Women take chances with 'tryout' doctors

By Pamela Zekman and Pamela Warrick

Copyright, 1978, The Chicogo Sun-Times When a woman goes to an abortion clinic. she entrusts her body to strangers-doctors she knows nothing about, doctors she has never met.

never met. On Michigan Av., women entrust their bo-dies to doctors who may be mere mechanics on the abortion assembly line. They may be moonlighting residents, gen-eral practitioners with little or no training in women's medicine, or even unicensed physi-cians While slick clinic brochures promise on the head cartified a heteroteins approach only board-certified obstetrician-gynecolo-gists, few have earned even that accreditation

These doctors rarely tell patients their names. To many, patients are not people.

They are profits. During the five months The Sun-Times and Better Government Assn. investigated the city's abortion business, we heard from many of these doctors' victims—women who were awakened nights after their abortions. by chills and fever, uncontrolled bleeding and painfully debilitating cramps. Some had dead tissue left inside them.

Others had massive infections, perforated howels, or punctured uteri. Some ultimately underwent complete hysterectomies—the re-

underwent complete hysterectomics—the re-moval of all reproductive organs. Former patients have filed lawsuits against doctors in all four of the Michigan Av, abortion mills where dangerous medical practices were uncovered during the investigation. But many women still softer quietly action but namy women sum suffer query, afraid to even admit they've had abortions, let alone press public charges against the joctors who performed them. At least two women who received Magni-icent Mile abortions are dead.

At Biogenetics Ltd., 520 N. Michigan, docors new to the abortion business-often

Act for more inspections Thompson gives order; Page 14

Third in a series

nere residents from Cook County Hospital looking for extra income-are "tried out" on patients by clinic director Dr. Carlos Baldoceda.

Baldoceda, 33, who was educated in South America, was promoted to medical director of Biogenetics this summer. Though he is licensed to practice medicine, even he has not received board certification for his specialty, gynecology.

Those who audition well for Baldoceda practice their techniques by operating solo on unsuspecting patients.

But a 28-year-old nursing student who received an abortion from one of Biogenetics' (ryouts this fall said it was clear to her that "the doctor had no idea what he was doing. I was het a guine nig." was just a guinea pig.'

HER ABORTION was part of Cook Coun-Here Albornion was part of Cook Coun-ly Hospital resident Jovenet DuBois' on-the-job training. "The director of the clinic was telling this guy, 'You're supposed to do that, you're supposed to do this. No, that's not the right instrument," is e said. "It must have been his first abortion," the

A must have been ins hist abortion," the patient concluded after DuBois' performance. At 36, the French-schooled DuBois is a third-year resident at the hospital. "He was picking up the wrong things, dropping the instruments," said DuBois' ner-vous patient. "I wonder what would happen



if he made a mistake. What would happen to the woman?"

Several weeks later, DuBois' "guinea pig" patient was still suffering cramps, passing blood clots and complaining of terrible pain. "THAT'S TERRIBLE," said Dr. John Fultz,

ADDIDT! STAT!

medical co-ordinator for the Illinois Department of Registration, when asked about the practice of residents auditioning on patients. "That's just like opening an office and deciding you're going to do surgery and then starting to do it. If you miss, you learn that's Turn to Page 12



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Both nations recall ton negotiators

Chicago Sun-Times special reprint

Patient recalls: 'I was just a guinea pig'

Continued from Page 12

waited five hours to see a doctor. She got Baldoceda. "He just took five minutes. He was very rude and did the abortion so fast, there was no time for the anesthetic to work." the woman recalled. "That's why I

think he left that afterbirth inside me." More than a week later she was still bleeding heavily and suffering from severe cramps. Baldoceda had to rescrape her uterus to remove the tissue he left behind. ۰

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Undercover investigators at both Biogenetics and the Water Tower Reproductive Cen-ter; 840 N. Michigan, also saw doctors per-forming abortions with precious little attention to their own cleanliness, or to their patients' health.

At Biogenetics, Young observed Baldoceda stop short, halfway out the clinic, to come back to do "just one more" abortion.

It was a busy day and the waiting room was still crowded with patients when Baldo-ceda changed his mind about going home.

He did not, however, change his clothes. "He just took off his coat and walked into a procedure room and started the abortion," Young said. "He didn't bother to take off his street clothes and put on his surgical scrubs."

AT WATER TOWER Reproductive, investigator Mindy Trossman watched clinic own-er Dr. Arnold Bickham, 41, leave on at least two occasions, with women still convalescing in the recovery room. Bickham's departure on those days left the

clinic without a physician. Had any of the women in recovery suffered serious compli-cations, Bickham's early departure could have been fatal.

Trossman also saw Bickham rush a patient out of the clinic before her abortion was finished

Ished. Although other doctors later found the woman had suffered a punctured vagina, Bickham sent her home bleeding, saving he would not do an abortion on her because she was 16 weeks pregnant. (By taw, clinics

was to weeks pregnant. By taw, clinics may perform abortions on women only up to 12 weeks pregnant.) Trossman saw the patient minutes after she was ordered off the operating table. She was sitting in a waiting-room chair, moaning and clutching her stomach.

A note to our readers

A five-month investigation by The Sun-Times and the Better Government Assn. has disclosed fraud and other abuses in some referral agencies and clinics providing abortion services in Chicago

These findings are documented in the accompanying stories and others to fol-low. The Sun-Times series also will re-port on clinics and hospitals where safe and compassionate medical care for

women is available. But this newspaper has decided that it cannot determine safe and sanitary conditions at all the abortion counseling ser-vices and clinics that advertised in our classified pages. Thus we are ceasing publication of such advertisements at this time.

Reliable abortion counseling should be obtainable from family physicians. Oth-er organizations that are prepared to re-spond to women's health questions are:

· Planned Parenthood Assn., 55 E. Jackson, 322-4240.

• Health Evaluation Referral Service, 2757 N. Seminary, 248-0166.

'He gave me no anesthesia, not even a local. I had tears



running down my cheeks. And then, he THE ABORTION yelled, "This lady is not pregnant!"

LATER, IN AN interview from her hospital bed, the patient, 19-year-old Anna Guinn of Hammond, Ind., gave this account of what happened:

Guinn said she was being examined by one of Bickham's doctors, Pawan K. Rattan, when she heard the suction machine go on. when she heard the suction machine go on. "Without giving me any anesthetic, he start-ed up the machine," said Guinn. "I started screaming because it was so painful." "The doctor said, 'Lean your head back and shut your mouth! Then, all of a sud-den," said Guinn, "he stopped. "He took the [instruments] out of me and said, 'Stay in this position.' Another doctor [Bickham] came in, stuck his hand up me and said, 'Too far along.' "What the hell are you talking about?" yelled Guinn. "It's already half done!" "Ma'am, we dián't even touch you," said Bickham.''All you had was a pelvic exam." Guinn said she asked Bickham to call an ambulance for her. "By this time, the cramps

'He just took five minutes. He was very rude and did the abortion so fast, there was no time for the anesthetic to work. That's why I think he left that afterbirth inside me.'

were unbearable. The whole examining table

was covered with blood," she said. But Bickham, according to Guinn, ignored her request. "He said, 'You don't need an ambulance... Get up and get dressed." EVEN WHEN Guinn's mother asked Bick-

EVEN WHEN Guint's motion asked block-ham about what happened in the operating room, Bickham would say only that Anna was too pregnant to get an abortion at his clinic. The mother said he never once hinted that her daughter might need emergency treatment.

So Guinn was driven back to Hammond But by early evening, she looked so pale and was in such pain that a friend took her to a hospital. That night, she underwent emer-gency surgery at Michael Reese Hospital to repair what doctors there diagnosed as a vaginal perforation and an incomplete abortion. Although Bickham had thrown Guinn out

of the clinic because, as he noted on her chart, she was "16 weeks pregnant," doctors at Reese determined Guinn was only six to

eight weeks pregnant. Bickham is one of the few board-certified doctors practicing in Michigan Av. abortion clinics. When he is in the clinic, he often rushes from patient to patient. Sometimes he rushes from abortion to abortion without washing his hands between patients or don-ning sterile gloves. "That is a terribly dangerous way to

spread infection from one patient to an-other," said Fultz, when asked about meth-ods such as Bickham's, "It is impossible [during an abortion] for his hands never to touch the patient."

The Biogenetics clinic boasts a staff of "all board-certified physicians" in its brochure. According to records of two medical associations, it has none.

But Biogenetics does have a woman not licensed to practice medicine who calls herself doctor.

Our investigator fielded a call from an an-



gry patient complaining about the "Dr." Shastia Khan-the "woman doctor" who gave her a \$20 postoperative exam. "She said I was fine," the patient complained,

said 1 Was tine," the patient complained, "but my own physician said I had all sorts of complications. I had missed tissue." While "Dr." Khan's duties generally are limited to performing postoperative exams and dispensing contraceptives, she also inserts intrauterine devices and prescribes drugs using another doctor's name. The clin-ic apparently bills Public Aid for her services to welfare patients under other doctors' names, according to some bills seen by investigators.

On at least one occasion, Khan had to ask our undercover aide for advice on what sort

of contractive a due for advice on What sort of contractive to give a woman experienc-ing complications from birth control pills. But the clinic gives Khan pads full of forms presigned by "Dr. P. Thaker" so she can write prescriptions for birth control pills and other medications.

"That's a dangerous and unprofessional practice," said Fultz, whose agency licenses doctors. Fultz said the Medical Practices Act forbids a physician, in this case Thaker, to lend his name to another person unlicensed to treat a patient.

Doctors signing patient charts for other doctors is also dangerous, unprofessional and illegal, medical experts say.

At the Water Tower Reproductive Center, patient charts are, almost without exception, signed by one doctor-Bickham, the clinic owner. While Bickham does his share of abortions at the busy clinic, other doctors perform many procedures there as well. According to Fultz, doctors signing re-cords for other doctors is "specifically pro-hibited in the Medical Practices Act."

At the Michigan Avenue Medical Center, 30 S. Michigan, Dr. Norberto Agustin also takes unprofessional liberties with patient charts charts

Aborting an abortion

Anna Guinn, 19, of Hammond, Ind., underwen emergency surgery for a perforated vaging, diagnased by dactors at Michael Reese Hospital as resulting fram an incomplete abortion. Earlier in the day, she had been sent home, bleeding and suffering cramps, from Water Tower Reproductive Center, 840 N. Michigan, where Dr. Arnold Bickham told her she was too preg-nont--16 weeks--for an abortion. (State law permits clinics to perform abortions only up ta 12 weeks.) Bickham made his assessment after having already storted the abartion, she said. However, Bickham told Guinn, "Ma'am, we didn't even touch you. All you had was a pelvic exam." Doctars at Michael Reese later determined she was six to eight weeks pregnant.



Rushing between abortions, Agustin occasionally doesn't even have time to wait for anesthetics to take effect, much less do his

Agustin, 41, went to medical school in Ma-nila. He is a general practitioner who at one time did abortions for \$15 each at Biogenetics.

AT MICHIGAN AVENUE Medical Center, an undercover investigator, working as a nurse's aide pointed out to Agustin that he had failed to note on a patient's chart any details of the abortion he'd performed hours before. Agustin sat down and called up the figures

from "memory"-including the size of the uterine cavity and amount of tissue removed. On two other occasions, investigator Ju-lianne Felkner saw Agustin write on patient

'Rushing between abortions, Agustin occasionally doesn't even have time to wait for anesthetics to take effect, much less do his record keeping.

charts that he had removed about 200 cc. of tissue and blood, when, in fact, he had re-moved three times that much.

But, according to Medicaid officials, Agus-tin's problems with record keeping are not limited to his abortion practice.

limited to his abortion practice. Before suspending Agustin from the Med-icaid program last year, state authorities found he had ordered as many as 21 differ-ent lab tests for patients whose charts in-cluded no diagnosis or evidence of any phys-ical examination. Public Aid investigators charged Agustin altered the records after the definencies. the deficiencies.

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NEXT: The aftermath of Dr. Hah.



FOIA Request

Linxwiler, Darlene <darlene.linxwiler@illir< th=""><th>nois.gov></th></darlene.linxwiler@illir<>	nois.gov>
То:	"DPH.FOIA" <dph.foia@illinois.gov></dph.foia@illinois.gov>

Tue, Aug 5, 2014 at 12:24 PM

The Department does not have a policy other than what is deemed mandatory by the statute below. The Department attempts to survey every five years.

(210 ILCS 5/9) (from Ch. 111 1/2, par. 157-8.9)

Sec. 9. Inspections and investigations. The Department shall make or cause to be made inspections and investigations it deems necessary. Information received by the Department through filed reports, inspection, or as otherwise authorized under this Act shall not be disclosed publicly in a manner to identify individual patients, except to another State agency for purposes of investigation of professional or business practices in a licensed ambulatory surgical treatment center. The other State agency shall not disclose the individual patient information publicly. Every facility licensed under this Act and any premises proposed to be conducted as a facility by an applicant for a license shall be open at all reasonable times to an inspection authorized in writing by the Director. No notice need be given to any person before any inspection. (Source: P.A. 88-490.)

Thank you.

Darlene

From: Sent: Thursday, July 31, 2014 4:32 PM

[Quoted text hidden]

[Quoted text hidden]





Fwd: FW: Franks constituent- FOIA request results

1 message

To:

Wed, Oct 1, 2014 at 4:27 PM

------ Forwarded message ------From: Jack Franks <jack@jackfranks.org> Date: Wed, Jun 29, 2011 at 9:47 AM Subject: FW: Franks constituent- FOIA request results To:

> Sent: Tuesday, June 28, 2011 3:08 PM To: Subject: RE: Franks constituent- FOIA request results Importance: High

Lori:

Here is the response from IDPH Office of Health Care Regulation related to	The
FOIA request were mailed on June 24, 2011.	

The Department licensing regulations do not mandate a frequency of licensure surveys nor is there funding to perform licensure surveys. Due to the media issues regarding the events in Philadelphia, the Department has began the survey process of conducting a health and building inspection of the 9 licensed pregnancy termination centers. We have completed 1 life safety and 3 nursing surveys. The results of these surveys have been forwarded to this past week based on her recent FOIA request. The remaining facilities have been completed and the Department is awaiting the plan of correction or they are scheduled to be completed by August 2011.

If you require additional information feel free to call.

Cleatia Illinois Department of Public Health Division Governmental Affairs **From:** Jack Franks [mailto:jack@jackfranks.org] **Sent:** Wednesday, April 20, 2011 3:05 PM **Subject:** Franks constituent- FOIA request results

Please let us know how to respond to this constituent, **Sector**. We ask that you please address her concerns about untimely or nonexistent inspections of clinics.

Thank you.

Lori Borhart

Chief of Staff for

Jack D. Franks

State Representative

63rd District

815 334-0063

jack@jackfranks.org

www.ilga.gov

From: Sent: Monday, April 11, 2011 10:55 AM To: jack@jackfranks.org Subject: My FOIA request results

Dear Jack-

This letter is not about abortion. It is about the safety of abortion clinics. In Philadelphia PA there was an abortion clinic that was raided by the DEA because it was also a prescription mill. It was later closed by the state, but only after much publicity of what the drug raid found. You can read the

http://philadelphia.cbslocal.com/2011/02/15/some-pennsylvania-state-...



Follow

had quit. Action is pending against eight others. Corbett called the situation "despicable," saying this was a case not of government running amok but rather



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