STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7001613	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **04/05/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESS HEALTH	**1700 - 75TH STREET** **DOWNERS GROVE, IL 60516**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 000}	Initial Comments On January 28, 2016, the physical plant portion of a Licensure Survey was conducted at the above facility. The surveyors were accompanied during the survey walk-through by the following provider representatives: The Chief of Operations (COO) The Assistant Administrator (AA) The facility was observed to be the sole tenant in a one story building of (apparent) Type V (000) construction. The building was observed to be neither fully covered by an automatic sprinkler system nor fully covered by an automatic smoke detection system. The facility was surveyed as an existing ambulatory health care occupancy under the 2000 Edition of the NFPA 101 Life Safety Code, including Chapter 21, and as an existing Ambulatory Surgical Treatment Center under 77 Illinois Administrative Code 205, as amended by Section 205.710. Unless otherwise noted, those code sections listed herein that do not include a reference to a specific NFPA code and year of issue (such as NFPA 70 1999) are taken from the 2000 Edition of the NFPA 101 Life Safety Code. Unless otherwise noted, all deficiencies cited herein were found through observation during the survey walk-through, staff interview, or document review. The requirements of 77 Illinois Administrative Code 205 are NOT MET as evidenced by the deficiencies cited under the following L-Tags.	{L 000}		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7001613	A. BUILDING: 01 - MAIN BUILDING B. WING _____	R 04/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESS HEALTH	1700 - 75TH STREET DOWNERS GROVE, IL 60516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 000}	Continued From page 1 On February 22, 2018, follow-up on-site was conducted. The requirements of 77 Illinois Administrative Code 205 are NOT MET as evidenced by the deficiencies cited under the following L-Tags. On March 5, 2018, certification package was reviewed and found acceptable in response to our on-site survey conducted on February 22, 2018. The requirements of 77 Illinois Administrative Code 205 are NOW MET.	{L 000}		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7001613	A. BUILDING: 01 - MAIN BUILDING B. WING _____	R 02/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESS HEALTH	1700 - 75TH STREET DOWNERS GROVE, IL 60516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 000}	Initial Comments On January 28, 2016, the physical plant portion of a Licensure Survey was conducted at the above facility. The surveyors were accompanied during the survey walk-through by the following provider representatives: The Chief of Operations (COO) The Assistant Administrator (AA) The facility was observed to be the sole tenant in a one story building of (apparent) Type V (000) construction. The building was observed to be neither fully covered by an automatic sprinkler system nor fully covered by an automatic smoke detection system. The facility was surveyed as an existing ambulatory health care occupancy under the 2000 Edition of the NFPA 101 Life Safety Code, including Chapter 21, and as an existing Ambulatory Surgical Treatment Center under 77 Illinois Administrative Code 205, as amended by Section 205.710. Unless otherwise noted, those code sections listed herein that do not include a reference to a specific NFPA code and year of issue (such as NFPA 70 1999) are taken from the 2000 Edition of the NFPA 101 Life Safety Code. Unless otherwise noted, all deficiencies cited herein were found through observation during the survey walk-through, staff interview, or document review. The requirements of 77 Illinois Administrative Code 205 are NOT MET as evidenced by the deficiencies cited under the following L-Tags.	{L 000}		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7001613	A. BUILDING 01 - MAIN BUILDING B. WING _____	R 02/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESS HEALTH	1700 - 75TH STREET DOWNERS GROVE, IL 60516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 000}	Continued From page 1 On February 22, 2018, follow-up on-site was conducted. The requirements of 77 Illinois Administrative Code 205 are NOT MET as evidenced by the deficiencies cited under the following L-Tags.	{L 000}		
{L 115}	20.3.7.2/21.3.7.2 SMOKE COMPARTMENTATION Ambulatory health care facilities are divided into at least two smoke compartments with smoke barriers having at least a one-hour fire resistance rating. Doors in smoke barriers be at least 1 3/4 inch solid core and are equipped with closing devices (latch not required). Vision panels are provided and are of fixed wired glass limited to 1,296 sq. in. per panel. (21.3.7.2) (see codes sections for exceptions for size, smoke detection and sprinkler protection) This Regulation is not met as evidenced by: Based on observation during the survey walk-through and document review, smoke barriers are not constructed and maintained as required. Findings include: A. On January 28, 2016 at 9:30 AM, while accompanied by the COO and the AA, the surveyors observed that the smoke barrier wall identified on facility life safety plans could not be determined as being complete to the underside of the roof deck above, as required by 21.3.7.2 and 8.3.2, because there is no access to the attic space through the layer of drywall attached to the underside of the roof trusses.	{L 115}	ASCs that are < 5,000 sq. ft. do not require a subdivided smoke compartment if they are protected with an approved smoke detection system. Our facility is 3,178 sq. ft. and has an approved smoke detection system. Therefore, all smoke compartment deficiencies have been resolved (A, B, C, D). In February 2016 we installed an approved smoke detection system. Attached, please find correspondence from your department and the installer "Affiliated".	3/9/18

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MAR 12 2018
LIFE SAFETY & CONSTRUCTION

7(1)(b) Chief of Operations

3/9/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7001613	A. BUILDING 01 - MAIN BUILDING B. WING	R 02/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESS HEALTH	1700 - 75TH STREET DOWNERS GROVE, IL 60516

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{L 115}	Continued From page 2 B. On January 28, 2016 at 9:35 AM, while accompanied by the COO and the AA, the surveyors observed that at least two ducts which penetrate the smoke barrier wall identified on facility life safety plans lack smoke dampers required by 21.3.7.3 and 8.3.5.1. The two ducts observed were in the wall between the Staff Lounge and the Laboratory. C. On January 28, 2016 at 9:55 AM, while accompanied by the COO and the AA, the surveyors observed multiple pipe or other penetrations, through the smoke barrier wall identified on facility life safety plans, which are not sealed against the passage of smoke as required by 8.3.6.1. Locations observed include: 1. 9:55 AM, Cashier's Office, 1 penetration. 2. 10:05 AM, Copy Room, 3 penetrations. D. On January 28, 2016, while accompanied by the COO and the AA, the surveyors observed pass-through windows, in the smoke barrier wall identified on the facility life safety plans, which are not fixed fire window assemblies as required by 21.3.7.4 and 8.2.3.2.2. Locations observed include: 1. 9:55 AM, Cashier's Office. 2. 10:05 AM, PoC Room.	{L 115}		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7001613	30195	8/13/18

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Access Health	1700 75th St., Downers Grove, IL 60516

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
000	A post certification visit (PCV) was conducted on 8/13/18, to determine compliance with TITLE 77: PUBLIC HEALTH CHAPTER I: DEPARTMENT OF PUBLIC HEALTH SUBCHAPTER b: HOSPITAL AND AMBULATORY CARE FACILITIES PART 205 AMBULATORY SURGICAL TREATMENT CENTER LICENSING REQUIREMENTS SECTION 205.710 PREGNANCY TERMINATION SPECIALTY CENTERS, 205.410 b) 1-3., cited during the licensure survey on 05/25/2018. The Facility was back in compliance based on the following: 1. On 8/13/18 at approximately 9:00 AM, the sterilization logs for sterilizer #1 and sterilizer #2 were reviewed from 6/4/18 through 8/11/18. The logs indicated that a Biological Spore Test was completed weekly as required. The logs also indicated that a chemical indicator was present in every load as required. The instruments in each load were documented on the logs as they appeared on the instrument inventory list. 2. On 8/13/18 at approximately 9:15 AM, the In-Service Training Record for New Sterilization Procedures and New Patient Form (dated 5/25/18) was reviewed and included completion of the in-service by all staff that perform sterilization at the Facility. 3. The sterile processing and storage room was observed on 8/13/18 at 10:30 AM. Every pack was labeled with the load number, the sterilizer number, the date, and the operator's initials.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE TITLE DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7001613	30195	8/13/18

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Access Health	1700 75th St., Downers Grove, IL 60516

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
000	4. On 8/13/18 at approximately 9:45 AM, the clinical records were reviewed for 10 patients who underwent surgery at the Facility between 6/1/18 and 8/11/18. The 10 records included every sterile instrument used on the patient, along with the date of sterilization, sterilizer number, and load number. 5. On 8/13/18 at approximately 10:15 AM, the sterilizer cycle tapes were reviewed for sterilizer #1 and sterilizer #2. The cycle tapes included the sterilizer operator's initials daily (indicating review of the tapes daily), and the Facility Manager's initials weekly (indicating review of the tapes weekly). 6. The Quality Assurance/Quality Improvement Quarterly Meeting Minutes, dated 7/26/18, were reviewed on 8/13/18 at approximately 10:30 AM and included the review of the quarterly Infection Control Surveillance Report (completed by the Chief of Operations/Infection Control Officer (E #1) on 7/6/18). 7. On 8/13/18 at approximately 10:35 AM, an interview was conducted with the Chief of Operations/Infection Control Officer (E #1). E #1 stated that all of the Facility's staff who perform sterilization were in-serviced on the new sterilization policies and procedures. E #1 stated that E #1 had conducted a review of the sterilization logs on 7/6/18, and the logs were completed as required.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7001613	30195	8/13/18

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Access Health	1700 75th St., Downers Grove, IL 60516

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A001				

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE

EXHIBIT A

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7001613	30195	5/24/18

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Access Health	1700 75th St., Downers Grove, IL 60516

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
000	A licensure survey was conducted on 5/21/18 through 5/24/18. An Immediate Jeopardy (IJ) began on 5/22/18 due to the Facility's failure to ensure a chemical indicator was included in each sterilized pack to ensure successful sterilization; failure to ensure biological indicator tests were performed weekly; failure to maintain sterilizer logs which included the load number, contents, chemical indicator, and operator identification; and failure to ensure surveillance of the sterilization process, and was identified on 5/23/18, at TITLE 77: PUBLIC HEALTH CHAPTER I: DEPARTMENT OF PUBLIC HEALTH SUBCHAPTER b: HOSPITAL AND AMBULATORY CARE FACILITIES PART 205 AMBULATORY SURGICAL TREATMENT CENTER LICENSING REQUIREMENTS SECTION 205.710 PREGNANCY TERMINATION SPECIALTY CENTERS, 205.410 b) 1-3. The IJ was announced on 5/23/18 at 9:00 AM to the Chief of Operations (E #5) and the Assistant Administrator (E #1). The IJ was removed by the survey exit date of 5/24/18 based on observation, document review, and interview as follows: 1. The sterile processing and storage room was observed on 5/24/18 at 4:30 PM. Every surgical instrument had been re-sterilized, and every pack was labeled with the load number, the sterilizer number, the date, and the operator's initials. 2. The "Autoclave Sterilization In-Service Training Record" (dated 5/24/18) was reviewed on 5/24/18 and included that 5 of the employees responsible for performing sterile processing had completed the training. 3. The Staff Schedule for 5/25/18-6/1/18 was reviewed on 5/24/18 at 10:45 AM. One of the employees who had been trained in sterilization on 5/24/18 was on the schedule every day to perform sterilization.		See Page 10	

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE 7(1)(b) [redacted]

TITLE Chief of Operations

DATE 6/25/18

If continuation sheet Page 1 of 13

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7001613	30195	5/24/18

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Access Health	1700 75th St., Downers Grove, IL 60516

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
000	000 (cont'd) 4. On 5/24/18 at approximately 11:00 AM, an interview was conducted with the Chief of Operations/Infection Control Officer (E #5). E #5 stated that E #5 will be present at the Facility to train all of the remaining employees and oversee the sterilization until all staff are trained. 5. The "Sterilization Policy" was revised on 5/23/18 and included, "...Place chemical indicator strip in pouch... All autoclaved items must have the following documentation: a. Date b. Contents of package c. Autoclave #, d. Cycle #...Surveillance Schedule for Sterilization: Daily: performed by POC [point of care] staff: I. Review cycle tapes and initial. II. Inspect for presence of chemical indicators/ indicator tape. III. Inspect packets for integrity. IV. Autoclave log to be completed...Weekly: performed by POC staff: ...III. Documentation of test results on Biological Spore Testing Log... Quarterly Infection control Survey by Infection Control Coordinator: I. Monitor all sterilization activities and documents. II. Review autoclave log and tapes... IV. Prepare report for Quarterly Consulting Committee..." 6. The "Operative Notes" form in the patient's record had been revised to include a space to document each sterile instrument used on the patient. 7. The Sterilization Log Form (effective 5/23/18) was reviewed on 5/24/18 and required documentation of the sterilizer number; load number; load contents; the use of a chemical indicator; comments; weekly biological spore test; and the operator's initials.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE 6/25

7(1)(b)

EXHIBIT A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
7001613	30195	5/24/18

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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T026	205.410 b) 1-3 b) The facility shall have written policies and procedures and shall maintain documentation governing the care, use, decontamination, sterilization, storage and disposal of all materials to ensure that an adequate supply of sterile equipment, instruments and supplies is available for each procedure. Written policies and procedures shall include documentation that the facility has considered, selected and implemented nationally recognized guidelines, including the Centers for Disease Control and Prevention publication, "Guidelines for Disinfection and Sterilization in Healthcare Facilities" or "Guide to Infection Prevention In Outpatient Settings"; or the Association of perlOperative Registered Nurses (AORN) publication "Perioperative Standards and Recommended Practices for Inpatient and Ambulatory Centers". The policies, procedures and documentation shall include and address: 1) Staff orientation and in-service training to understand and implement facility policies and procedures for infection control, and to adhere to manufacturer's instructions for receiving, decontaminating, cleaning, preparing, sterilizing and high-level disinfection, handling, storage and quality control of equipment, supplies and instruments; 2) Preventive maintenance of all central supply service equipment pursuant to manufacturer's instructions or infection control guidelines; and 3) The Infection Control Program (Section 205.550), which shall be under the direction of a designated qualified health care professional with training in infection control. This Regulation is not met as evidence by: A. Based on document review, observation, and interview, it was determined that for 6 of 48 dilators (surgical instruments) and 6 of 6 hose connectors (surgical instruments), the Facility failed to ensure chemical indicators (sensitive chemicals to assess critical variables [e.g., time, temperature, or steam saturation] during a sterilization cycle) were included in the sterilization pouch/pack/wrap, potentially affecting the safety of the 50 - 60 patients undergoing surgical procedures at the Facility every month.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE TITLE DATE 6/25 7(1)(b)

EXHIBIT A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
7001613	30195	5/24/18

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Access Health	1700 75th St., Downers Grove, IL 60516

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
T026	205.410 b) 1-3 (cont'd) Findings include: 1. On 5/22/18 at 2:30 PM, the Facility's policy titled, "Sterilization Policy" (reviewed on 1/15/18), was reviewed and required, "Steam Autoclave.. Wrapped Instrument Procedure... Lay instruments on to center of wrap in this order... Indicator strip..." 2. On 5/23/18 at 10:35 AM, the Facility's policy titled, "Infection Control and Tissue Review Program" (reviewed on 1/15/18), was reviewed and required, "II. Purpose... 2. Develop a system for surveillance (detecting by interview, recording, reporting and evaluation)... V. Methods of Surveillance: Daily... 4. Sterilization: a. Autoclaves: Review of cycle tapes, chemical indicators, indicator tape used..." 3. On 5/22/18 at approximately 2:00 PM, an observational tour of the sterile storage room was conducted. During the tour, 48 transparent sterile packs containing dilators (instrument used to open the cervix) were observed. (These packs were selected because they were packed in transparent wrap and did not need to be opened to observe the presence of the chemical indicators.) 6 of the 48 packs observed had no chemical indicators present in the packs to indicate successful sterilization (sensitive chemicals to assess critical variables [e.g., time, temperature, or steam saturation] during a sterilization cycle). A chemical indicator should be present in every sterile pack per policy and the manufacturer's guidelines. (A chemical indicator is a paper strip that is visible through the transparent, sterile wrap.) The packs were dated as being sterilized on: 7/16/15 (2 packs), 3/28/18, 5/21/18 (2 packs) and one undated pack.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE 6/25 7(1)(b)

EXHIBIT A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
7001613	30195	5/24/18

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Access Health	1700 75th St., Downers Grove, IL 60516

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T026	205.410 b) 1-3 (cont'd) 4. On the counter in the sterile processing and supply room were 6 of 6 hose connector pouches, all lacking chemical indicators. Sterilization dates included: 5/19/18 (2 pouches), 5/21/18 (3 pouches), and one undated pouch. 5. On 5/22/18 at 10:00 AM, an interview was conducted with the Chief of Operations (E #5). E #5 stated that all sterilized pouches/ packs should have a chemical indicator in the pouch. 6. On 5/23/18 at 9:00 AM, another interview was conducted with E #5. E #5 stated that all surgical procedures scheduled for 5/24/18 (next surgical date) would be canceled, and every instrument in the Facility would be re-sterilized to ensure the presence of a chemical indicator in each pack. E #5 stated that all staff will be retrained on sterilization, and the contents of each load and the presence of a chemical indicator will be documented on a log sheet. E #5 stated that E #5 would oversee the re-sterilization of all of the instruments.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE 6/25/ 7(1)(b)

EXHIBIT A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
7001613	30195	5/24/18

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	205.410 b) 1-3 b) (continued)			
T026	B. Based on document review and interview, it was determined that for 2 of the last 7 months (December 2017 and February 2018), the Facility failed to ensure biological indicator tests were performed weekly, potentially affecting the safety of the 50 - 60 patients undergoing surgical procedures at the Facility every month. Findings include: 1. On 5/22/18 at 3:00 PM, the Facility's policy titled, "Autoclave Quality Control" (reviewed on 1/15/18), was reviewed. The policy required, "Principle: The biological indicator ampules are autoclaved [sterilized] at least once a week with a regular sterilization cycle..." 2. On 5/23/18 at 10:35 AM, the Facility's policy titled, "Infection Control and Tissue Review Program" (reviewed 1/15/18), was reviewed. The policy required, "II. Purpose... 2. Develop a system for surveillance (detecting by interview, recording, reporting and evaluation)... V. Methods of Surveillance: Weekly: 1. Autoclaves - Biological Indicator." 3. On 5/21/18 at 10:00 AM, the Biological Indicator Testing Logs from November 2017 through May 2018 were reviewed. There was no documentation of a weekly biological indicator for the entire month of December 2017 and for the last 3 weeks in February 2018. 4. On 5/22/18 at 10:00 AM, an interview was conducted with the Chief of Operations (E #5). E #5 stated that biological tests are supposed to be completed each week for each sterilizer. E #5 stated that all staff will be retrained on sterilization.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE 6/2[redacted]

7(1)(b)

EXHIBIT A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
7001613	30195	5/24/18

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Access Health	1700 75th St., Downers Grove, IL 60516

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T026	205.410 b) 1-3 (cont'd) C. Based on document review and interview, it was determined that the Facility failed to ensure surgical instrument sterilizer load logs were maintained, potentially affecting the safety of the 50 - 60 patients undergoing surgical procedures at the Facility every month. Findings include: 1. On 5/23/18 at 9:00 AM, the 2013 Association for the Advancement of Medical Instrumentation (ANSI/AAMI) ST79 Comprehensive Guide to Steam Sterilization and Sterile Assurance in Health Care Facilities was reviewed. The Guide required, "10.3.2. Sterilizer records: For each sterilization cycle, the following information should be recorded and maintained: 1) the lot number, b) the specific contents of the load...c) the exposure time and temperature, if not provided on the sterilizer recording chart, d) the name or initials of the operator..." 2. On 5/21/18 at 10:00 AM, the Facility sterilizer logs were requested from the Assistant Administrator (E #1). E #1 stated that there were no sterilizer logs which included the load number, contents of the load, or operator's identification. E #1 asked the surveyor how the Facility could track sterilized loads. E #1 was referred to the ANSI/AAMI Guidelines. 3. On 5/23/18 at approximately 9:00 AM, an interview was conducted with the Chief of Operations/Infection Control Officer (E #5). E #5 stated that the Facility follows the ANSI/AAMI Guidelines. E #5 stated that all surgical procedures scheduled for 5/24/18 (next surgical date) would be canceled, and every instrument in the Facility would be re-sterilized. E #5 stated that all staff will be retrained on sterilization, and the contents of each load and the presence of a chemical indicator will be documented on a log sheet. E #5 stated that E #5 would oversee the re-sterilization of all of the instruments.			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE | TITLE | DATE 5/25

7(1)(b)

EXHIBIT A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
7001613	30195	5/24/18

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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T026	205.410 b) 1-3 (cont'd) D. Based on document review and interview, it was determined that the Infection Control Officer (E #5) failed to ensure surveillance of sterilization was conducted per policy. Findings include: 1. On 5/23/18 at 10:35 AM, the Facility's policy titled, "Infection Control and Tissue Review Program" (reviewed 1/15/18), was reviewed and required, "II. Purpose... 2. Develop a system for surveillance (detecting by interview, recording, reporting and evaluation)... V. Methods of Surveillance: Daily: Sterilization: Autoclaves: Review of cycle tapes, chemical indicators, indicator tapes used... Weekly: 1. Autoclaves - Biological Indicator... Sterilization policy shall be followed by all personnel..." 2. The Facility's Quarterly Quality Assessment/Quality Improvement Meeting Minutes (which includes the Infection Control Meeting Minutes) from 01/2017-05/2018 were reviewed on 5/22/18 and lacked any surveillance reports regarding sterilization. 3. On 5/22/18 at approximately 9:00 am, sterilization logs (including cycle tapes, chemical indicator use, load content, and biological indicators) were requested from the Assistant Administrator (E #1). E #1 presented the surveyor with boxes of sterilizer cycle tapes and biological indicator logs. E #1 stated that the contents of each load are not documented, and no log of the presence of a chemical indicator in each pack is maintained at the Facility.			

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T026	205.410 b) 1-3 (cont'd) 4. On 5/23/18 at approximately 9:00 am, an interview was conducted with the Chief of Operations/Infection Control Officer (E #5). E #5 stated that E #5 reviews the sterilization logs quarterly. E #5 stated that the last review was in January 2018. E #5 stated that E #5 did not identify any issues with sterilization at that time, and there was no documentation of the completion of this review. E #5 stated that the quarterly review by E #5 consisted of a visual inspection of the sterile processing and storage room. E #5 stated that all surgical procedures scheduled for 5/24/18 (next surgical date) would be canceled, and every instrument in the Facility would be re-sterilized to ensure the presence of a chemical indicator in each pack. E #5 stated that all staff will be retrained on sterilization, and the contents of each load and the presence of a chemical indicator will be documented on a log sheet. E #5 stated that E #5 would oversee the re-sterilization of all of the instruments. E. Based on document review and interview, it was determined that for 2 of 2 staff (E #1 and E #5) sterilizing instruments, documenting sterilization on the logs, and reviewing the logs for completion, the Facility failed to ensure that sterilization was documented correctly to identify the instruments included in each load on the logs. Findings include: 1. On 5/23/18 at approximately 2:00 PM, the "Autoclave Log" (effective 5/23/18), was reviewed and included spaces on the log which required the recording of the autoclave number; date; cycle number; contents of the load; presence of a chemical indicator; autoclave tapes; comments; and the initials of the sterilization operator. 2. On 5/24/18 at approximately 4:30 PM, the Autoclave Logs from 5/23/18 - 5/24/18 were reviewed. The logs lacked documentation of the specific instruments which were included in the contents of each load. Documentation included, "Dilators x 4, Currettes x 7..." However, the documentation lacked the sizes of the instruments to identify which instruments were in each load (There are 14 different size dilators and			

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T026	205.410 b) 1-3 (cont'd) 8 different size currettes). Some instruments were documented by different names rather than the names of the instruments on the Instrument Inventory List. Therefore, it could not be determined which items were sterilized in each load. 3. On 5/24/18 at approximately 5:00 PM, an interview was conducted with the Chief of Operations (E #5). E #5, who had been present at the Facility to oversee the sterilization of every surgical instrument on 5/23/18 and 5/24/18, reviewed the Autoclave Logs and could not identify the instruments documented in each load. E #5 stated that the staff would have to be trained on documenting the instruments on the logs as they appear on the Instrument Inventory List so that every instrument would be documented using the correct name and size for each instrument.	T026	The POC for all sterilization issues was completed the week of the inspection 5/25/18. 1. Sterilization Log for both autoclaves has been audited and completed. 2. All instruments in the facility are on the Instrument Inventory Log have been properly sterilized and verified by the Infection Control Coordinator by comparison to the Autoclave Log. 3. An existing "Aseptic Technique" Policy has been modified to include the documentation to identify what sterile instrument was used on the patient. 4. The "Operative Notes" form in the patient's record has been revised and now has space to record the details of each sterile item used on a patient. Managers, and Assistant Managers have been trained on all the new policies. All medical staff have been trained by the Infection Control Coordinator regarding the new protocols. The Infection Control Coordinator has been monitoring the sterilization department weekly. The Infection Control Coordinator will prepare a surveillance report for the next Quarterly Consulting Committee to be scheduled in July 2018.	5/25/18

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T028	205.410 d) d) The facility shall have written procedures to assure the safety in storage and use of all narcotics and medications in accordance with State and federal law. This Regulation is not met as evidence by: Based on document review, observation and interview, it was determined for 1 of 1 anesthesia medication tray, the Facility failed to ensure medications were secured at all times. This potentially affected the 3 patients in the clinic on 5/21/18. Findings include: 1. The Facility's policy titled, "Medication Control & Accountability" (reviewed 1/15/18)" was reviewed on 5/23/18 and required, "Drugs shall be accessible only to responsible personnel designated by the facility ... Narcotics and all controlled substances are stored in a locked area or compartment." 2. An observational tour of the recovery room (RR) was conducted on 5/21/18 from 9:55 AM to 11:00 AM. The anesthesiologist entered the RR at approximately 10:20 AM with a small medication tray containing vials of: Labetalol (for blood pressure), Atropine (decrease mucous secretions before surgery), Flumazenil (treat drowsiness caused by sedatives), and Dopram (treats breathing problems after surgery). The bin also contained syringes with needles attached. The anesthesiologist placed the bin on a desk at the entrance/exit to the RR. These medications remained unattended for approximately 45 minutes, until the nurse placed them in the locked medication cart. 3. During an interview on 5/23/18 at 9:40 AM, the Assistant Administrator (E#1) stated, "The medications should be locked or kept in the possession of the anesthesiologist at all times."	T028	Per our policy all Narcotics and Controlled Substances are stored in a double locked Narcotic Cabinet. The tray of medications that were left unattended were not Narcotics or Controlled Substances. These other medications are locked up in the Medication Cart at the end of the day. After interviewing the staff and the anesthesiologist, they informed me that the tray was left out because the surveyors were busy examining the medication prep area and that the staff could not get to the medication cart in a timely matter. Nevertheless, a memo has been released addressing the fact that all medications need to be locked up immediately after use, and that they never to be left unattended (See Enclosure). The Nurse Supervisor and Manager of the center will monitor the proper return of the medication to the appropriate locking drawer at the end of the surgery on a daily basis.	6/25/18

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T056	205.540 a) a) All patients' postoperative conditions shall be observed and assessed in the facility for a period of time sufficient to ensure that the patient is awake, physiologically stable, manifests no immediate postoperative complications, and is ready to return to home or to a similar environment. Overnight stays are not permissible. Before discharge from the facility, each patient shall be evaluated by a qualified practitioner for proper anesthesia recovery. No patient shall be required to leave the facility in less than one hour following the procedure or procedures. Each post-surgical patient's overall condition shall be assessed and documented in the medical record by a qualified practitioner, showing that the patient is ready for discharge or in need of further treatment or monitoring. This Regulation is not met as evidence by: Based on document review, observation and interview, it was determined that for 3 of 3 (Pts. #1, #2 and #3) patients observed, the Facility failed to ensure that each patient was evaluated by a nurse prior to discharge. Findings include: 1. The Facility's policy titled, "Post - Operative Standing Orders Approved Discharge Criteria" (reviewed 1/15/18) was reviewed on 5/21/18 and required, "When the criteria is met, the Recovery Room Nurse may discharge the patient. Any inconsistencies with the above criteria or any concerns that the nurse may have will be brought to the attention of the physician." 2. An observational tour of the recovery room (RR) was conducted on 5/21/18 from 9:55 AM to 11:00 AM. Two staff members were in the room waiting for patients to arrive (E#2 – Health Education Counselor and E#3 – Medical Assistant). During the observation, 3 patients came to the RR after a pregnancy termination procedure.	T056	A memo has been released re-educating staff that all patients must be evaluated by a nurse prior to discharge. Medical assistants have been reminded that a nurse must assess the patient to see if the patient meets the discharge criteria (See Enclosure). The Nurse Supervisor will monitor the discharge of patients.	6/25/18

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T056	205.540 a) (cont'd) 3. Pt. #1 arrived in the RR at 9:58 AM. Pt. #1 was a 23 year old female admitted on 5/21/18 for pregnancy termination. Pt. #1 was transported by wheelchair to a chair in the RR. Pt. #1 was very sleepy and was unable to keep her eyes open. Pt. #1 required the assistance of 3 staff members to stand. Pt. #1 had an intravenous line (IV) that was opened all the way (allowing fluids to be administered quickly). After sitting in the chair, Pt. #1 was placed on oxygen per nasal canula (tube in the nose). Vital signs were taken upon arrival and every 10 minutes for two additional times. The IV was discontinued (half bag remaining) and Pt. #1 walked to the bathroom, dressed herself and was discharged at 10:30 AM. Pt. #1 was in the recovery room for 32 minutes. Pt. #1 was not evaluated by a nurse prior to discharge. 4. Pt. #2 arrived in the RR at 10:17 AM. Pt. #2 was a 28 year old female, admitted on 5/21/18 for pregnancy termination. Pt. #2 was nauseated and requested a pan to vomit. The IV was discontinued and Pt. #2 walked to the bathroom, dressed herself and was discharged at 11:06 AM. When getting ready to leave the RR, Pt. #2 requested a basin because she was still nauseated. Pt. #2 was given a basin and E#3 walked Pt. #2 out of the facility. Pt. #2 was in the recovery room for 49 minutes. Pt. #2 was not evaluated by a nurse prior to discharge. 5. Pt. #3 arrived in the RR at 10:37 AM. Pt. #3 was a 36 year old female admitted on 5/21/18 for pregnancy termination. Vital signs were taken upon arrival and every 10 minutes for two additional times. The IV was discontinued and Pt. #3 walked to the bathroom, dressed herself and was discharged at 11:22 AM. Pt. #3 was in the recovery room for 45 minutes. Pt. #3 was not evaluated by a nurse prior to discharge. 6. During an interview on 5/23/18 at 9:40 AM, the Assistant Administrator (E#1) stated, "We encourage patients to stay for about an hour and depend on our Medical Assistants to evaluate the patients and inform the nurse of any abnormal findings. If everything is normal, the patients are discharged without seeing a nurse."			

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7(1)(b) [redacted]