acceptable
7/19/13

PRINTED: 06/18/2013
FORM APPROVED

Illinois Department of Public Health

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

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

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

RECEIVED-OHCR
JUL 12 2013
LIFE SAFETY & CONSTRUCTION

7(1)(b)

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

TITLE: Assoc Medical Director

(X6) DATE: 7/10/13

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

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

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

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

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

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

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

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

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(L 178)	Continued From page 9 not conducting the test for the full 30 minutes which may cause wet stacking in this unit. The contractor is not documenting the time it takes to transfer the load from normal power to emergency power.	(L 178)		

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

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

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

Implement RACE.

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

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

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

Evacuate the building./ Extiguish fire, if possible

To Activate Extinguishers:

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

Extinguisher locations:

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

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

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

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

☰ ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

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

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

2/25/14 DF

DATE OF SURVEY 10/07/13-10/8/13 BY 25926,25927,32822,31195 (Surveyors)

7(1)(b) [redacted]

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY 3/9/12 (Provider's Representative)

02/25/2014 13:06 6184519092 HOPE CLINIC PAGE 02/05

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH FACILITIES STANDARDS
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☒ ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

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

2/25/14 pr

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

NOTE: IF PLV, INDICATE DATE OF PRIOR SURVEY 3/9/12 Page 1 of 4

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Section 205.410 Equipment (Continued)	In the Recovery Room, a portable oxygen (O2) tank, used for emergencies, was checked for adequate oxygen. The O2 valve was turned to the open position and the O2 regulator indicated "Refill". 2. On 10/7/13, a review of Policy "Medical Emergency Protocol", revised 4/11, was conducted. Under "POLICY: 3b Oxygen tanks in .....Recovery Room have adequate amounts of oxygen" 3. On 10/7/13 at 11:20 AM and interview with E#1 was conducted. E#1 confirmed the O2 tank regulator indicated the tank needed replacing. E#1 stated "We check the oxygen tanks weekly. It was checked last week and will be checked again tomorrow before patients arrive."		

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

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

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

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

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

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

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

02/25/2014 13:06 6184519092 HOPE CLINIC PAGE 04/05

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DIVISION OF HEALTH FACILITIES STANDARDS
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

☒ ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

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

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

2/25/14 RV

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

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

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

☒ ASTC ☐ HHA ☐ HMO ☐ HOSPICE ☐ HOSPITAL

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

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

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

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

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

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

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

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

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

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

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

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

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