



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
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BUREAU OF FACILITY STANDARDS  
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September 15, 2016

Thair Pond, Administrator  
Tomorrow's Hope - Meridian  
1655 Fairview Avenue, Suite 100  
Boise, ID 83702

RE: Tomorrow's Hope - Meridian, Provider #13G033

Dear Mr. Pond:

This is to advise you of the findings of the Medicaid/Licensure survey of Tomorrow's Hope - Meridian, which was conducted on September 9, 2016.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;
5. The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

6. Include dates when corrective action(s) will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions, which require construction, competitive bidding or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **September 28, 2016**, and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

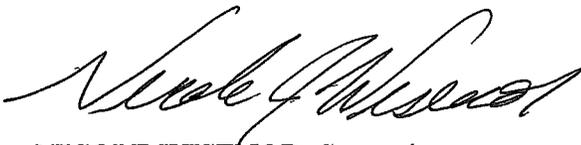
[www.icfmr.dhw.idaho.gov](http://www.icfmr.dhw.idaho.gov)

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by September 28, 2016. If a request for informal dispute resolution is received after September 28, 2016, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Dennis Kelly, RN or Nicole Wisenor, Co-Supervisors, Non-Long Term Care at (208) 334-6626, option 4.

Sincerely,



NICOLE WISENOR, Supervisor  
Non-Long Term Care

NW/pmt  
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/15/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G033</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/09/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>TOMORROW'S HOPE - MERIDIAN</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1821 GREENHEAD MERIDIAN, ID 83642</b>
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W 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the recertification survey conducted from 9/6/16 to 9/9/16.</p> <p>The survey was conducted by:</p> <p>Jim Troutfetter, QIDP, Team Lead Trish O'Hara, RN</p> <p>Common abbreviations used in this report are:</p> <p>AED - Anti-epileptic Drug CBC - Complete Blood Count CMP - Comprehensive Metabolic Panel IPP - Individual Program Plan LPN - Licensed Practical Nurse MAR - Medication Administration Record</p>	W 000		
W 111	<p><b>483.410(c)(1) CLIENT RECORDS</b></p> <p>The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain a record keeping system that contained accurate information for 2 of 4 individuals (Individuals #2 and #6) whose medical records were reviewed. This resulted in the potential for medication administration errors. The findings include:</p> <p>1. Individual #2's 11/20/15 IPP stated he was a 25 year old male whose diagnoses included profound mental retardation and Down's</p>	W 111		

*RECEIVED*  
*SEP 28 2016*  
*FACILITY STANDARDS*

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>AD</i>	(X6) DATE <i>9/28/16</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 111	Continued From page 1 Syndrome.  His record contained a Physician's Order for hydrocortisone (a steroid drug) two 5 mg tablets in the morning and one 5 mg tablet in the afternoon.  However, his MAR contained an entry, dated 9/5/16, that documented he was to receive two 5 mg tablets in the morning and two 5 mg tablets in the afternoon.  During an interview on 9/8/16 at 11:00 a.m., the LPN confirmed the discrepancy.  The facility failed to ensure Individual #2's MAR contained accurate information.  2. Individual #6's record documented a 33 year old male whose diagnoses included severe intellectual disability.  His MAR, dated 8/2016, documented he had received calcium/vitamin D supplement, 600/400 mg.  However, his Physician's Orders, dated 8/2016, did not list the calcium/vitamin D supplement.  During an interview on 9/8/16 at 11:00 a.m., the LPN stated the calcium/vitamin D was still an active order and that the pharmacy failed to list it on the the physician's orders.  The facility failed to ensure Individual #6's physician's orders contained accurate information.	W 111	individual #1 & #6 med sheet's have been fixed to match to ensure correct Dr order's with correct documentation on MAR  LPN Responsible BY 10/11/16  - all individuals Dr order's & MAR's will be reviewed to ensure they match and they are accurate. LPN Responsible BY 10/11/16  - Accountability sheet updated to ensure bubble pack and med sheets match LPN to review account PD responsible Sheet at least done monthly BY 10/11/16  - Books will be reviewed at least quarterly with a Book Review Completed to ensure Dr order's and med sheet match PD Responsible BY 10/11/16		
W 325	483.460(a)(3)(iii) PHYSICIAN SERVICES	W 325			

BY 10/11/16  
  
- quarterly Book Review form update to ensure check the Dr. order's to med sheet  
PD Responsible  
BY 10/11/16

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W 325	Continued From page 2  The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a routine screening laboratory examinations were provided to 1 of 3 individuals (Individual #1) whose laboratory records were reviewed. This resulted in the potential for medical concerns to go undetected. The findings include:  1. Individual #1's 3/17/16 IPP stated she was a 35 year old female whose diagnoses included moderate intellectual disability.  Her record contained a Physician's Order Sheet and Progress Notes, dated 4/26/16, which documented she was to receive a CBC and a CMP within the following three months.  However, no documentation could be found related to Individual #1 receiving a CBC or CMP within the three month period.  During an interview on 9/8/16 at 9:30 a.m., the LPN and Training Coordinator confirmed she was scheduled for laboratory work on 9/15/16.  The facility failed to ensure Individual #1 received laboratory work as ordered.	W 325	<p>→ Individual #1 Lab work was completed LPN responsible BY 10/11/16</p> <p>→ All Books to be reviewed to ensure all individuals have a current labs LPN responsible BY 10/11/16</p> <p>→ LPN trained to ensure all labs are up to date and followed through with action list PD responsible BY 10/11/16 → All Books will be reviewed at least quarterly with labs being checked to ensure they are current. All items <del>are</del> needed will be added to action list by PD PD responsible BY 10/11/16</p>	
W 326	483.460(a)(3)(iii) PHYSICIAN SERVICES	W 326	- LPN to bring documentation of items on action list being	

fix and in place to the monthly QA meeting  
LPN responsible  
BY 10/11/16

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W 326	<p>Continued From page 3</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes special studies when needed.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure individuals were provided with general and preventative medical care for 1 of 3 individuals (Individual #2) whose medical records were reviewed. This resulted in individuals not receiving bone density studies, as recommended in accordance with their medication use. The findings include:</p> <p>1. Individual #2's 11/20/15 IPP stated he was a 25 year old male whose diagnoses included profound intellectual disability and Down's Syndrome. His Physician's Orders, dated 8/2016, documented he received Lamictal (an anticonvulsant drug) 100 mg twice a day.</p> <p>An article, published by the American Epilepsy Society in March 2009, stated AED therapy was associated with metabolic bone disease and a high risk for fractures, with a reduction in bone mineral density reported in 20% - 75% of individuals taking AEDs. The article further recommended assessment of bone mineral density 3-5 years after initiation of AED therapy.</p> <p>However, documentation of a bone mineral density assessment was not present in Individual #2's records.</p> <p>During an interview on 9/8/16 at 1:00 p.m., the LPN confirmed Individual #2 had not received a baseline bone density study.</p>	W 326	<p>→ Individual #2 had a dexa Scan completed. LPN responsible by 9/26/16</p> <p>→ all individual's books records to be reviewed to ensure if they are on AED therapy they have had a bone mineral density assessment completed LPN responsible by 10/1/16</p> <p>→ add Bone density to immunization sheet and Nursing Summary to ensure the Bone density test are up to date PD responsible by 10/1/16</p> <p>→ When completing monthly Nursing Summary LPN to make sure Bone density dates, if needed are listed on Summary &amp; immunization sheet.</p>	
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sheet.  
LPN responsible by 9-29-16

PD to Review Records at least Quarterly will check immunization sheets and Nursing Summaries to ensure all bone density assessments are up to date

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W 326	Continued From page 4	W 326			
W 345	<p>In a follow up interview on 9/13/16 at 12:50 p.m., the Training Coordinator stated Individual #2 had been receiving anticonvulsant medication since he was admitted to the facility on 5/3/99.</p> <p>The facility failed to ensure Individual #2 received a bone density study as recommended.</p> <p>483.460(d)(3) NURSING STAFF</p> <p>The facility must utilize registered nurses as appropriate and required by State law to perform the health services specified in this section.</p> <p>This STANDARD is not met as evidenced by: Based on review of Board of Nursing Rules and Regulations, record review and staff interviews, it was determined the facility failed to ensure the registered nurse was utilized as per this standard and as required by state law. This directly impacted 3 of 3 individuals (Individuals #1 - #3) whose medical records were reviewed, and had the potential to impact all individuals (Individuals #1 - #6) residing at the facility. This resulted in the potential for individuals to experience negative impacts to their health. The findings include:</p> <p>1. The Idaho Board of Nursing Rules and Regulations (IDAPA 23.01.01) state, at IDAPA 23.01.01.401, that "In addition to providing hands-on nursing care, licensed professional nurses work and serve in a broad range of capacities including, but not limited to, regulation, delegation, management, administration, teaching, and case management. Licensed professional nurses, also referred to as registered</p>	W 345			

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W 345	Continued From page 5 nurses or as 'RNs,' are expected to exercise competency in judgment, decision making, implementation of nursing interventions, delegation of functions or responsibilities, and administration of medications and treatments prescribed by legally authorized persons."  IDAPA 23.01.01.401.02(a) states the functions of the RN include "Assesses the health status of individuals and groups" and IDAPA 23.01.01.401.02(b) states the RN "Utilizes data obtained by assessment to identify and document nursing diagnoses..."  IDAPA 23.01.01.460 states "Licensed practical nurses function in dependent roles. Licensed practical nurses, also referred to as LPNs, provide nursing care at the delegation of a licensed professional nurse..."  IDAPA 23.01.01.460.02(a) states the function of the LPN include "Contributes to the assessment of health status by collecting, reporting and recording objective and subjective data."  Individual #1 - #3's records were reviewed. The records documented quarterly assessment data which was collected by the facility's LPN. However, RN review of the data, necessary for the assessments to be completed in accordance with state law, was not done in a timely manner, as follows:  a. Individual #1's 3/17/16 IPP stated she was a 35 year old female whose diagnoses included moderate intellectual disability.  - For the fourth quarter of 2015, the LPN's assessment data was gathered on 10/14/15. The	W 345	→ the RN has been into Review and sign all Nursing Exams RN Responsible BY 10/11/16  → all Books will be reviewed monthly by LPN when they complete their Nursing Summary, to ensure the RN had been in to review the Nursing exam LPN Responsible by 10/11/16  → Nursing Summary updated to include date of Nursing exam and if signed & reviewed by RN. PD Responsible by 10/11/16  → Nursing Contract updated for RN to come in at least every other month or as needed. Sooner if needed Adm Responsible BY 10/11/16		

→ PD to review records at least Quarterly to ensure nursing exams have been completed and reviewed by RN and will add in exams needed to be reviewed by RN to action list  
PD Responsible by 10/11/16

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W 345	<p>Continued From page 6</p> <p>RN documented she reviewed the assessment data on 3/22/16 (160 days after the assessment data was garnered).</p> <p>- For the first quarter of 2016, the LPN's assessment data was gathered on 1/18/16. The RN documented she reviewed the assessment data on 3/22/16 (64 days after the assessment data was garnered).</p> <p>- For the second quarter of 2016, the LPN's assessment data was gathered on 4/18/16. The RN documented she reviewed the assessment data on 6/3/16 (59 days after the assessment data was garnered).</p> <p>- For the third quarter of 2016, the LPN's assessment data was gathered on 7/21/16. The RN documented she reviewed the assessment data on 9/7/16 (48 days after the assessment data was garnered).</p> <p>b. Individual #2's 11/20/15 IPP stated he was a 25 year old male whose diagnoses included profound intellectual disability and Down's Syndrome.</p> <p>- For the fourth quarter of 2015, the LPN's assessment data was gathered on 12/17/15. The RN documented she reviewed the assessment data on 3/22/16 (96 days after the assessment data was garnered).</p> <p>- For the second quarter of 2016, the LPN's assessment data was gathered on 6/20/16. The RN documented she reviewed the assessment data on 9/7/16 (79 days after the assessment data was garnered).</p>	W 345		

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W 345	<p>Continued From page 7</p> <p>- For the third quarter of 2016, the LPN's assessment data was gathered on 9/25/16. The RN documented she reviewed the assessment data on 3/22/16 (179 days after the assessment data was garnered).</p> <p>c. Individual #3's 2/5/16 IPP stated he was a 25 year old male whose diagnoses included profound mental retardation.</p> <p>- For the fourth quarter of 2015, the LPN's assessment data was gathered on 12/11/15. The RN documented she reviewed the assessment data on 6/3/16 (175 days after the assessment data was garnered).</p> <p>- For the first quarter of 2016, the LPN's assessment data was gathered on 2/1/16. The RN documented she reviewed the assessment data on 3/22/16 (50 days after the assessment data was garnered).</p> <p>- For the second quarter of 2016, the LPN's assessment data was gathered on 5/1/16. The RN documented she reviewed the assessment data on 6/3/16 (33 days after the assessment data was garnered).</p> <p>- For the third quarter of 2016, the LPN's assessment data was gathered on 8/3/16. The RN documented she reviewed the assessment data on 9/7/16 (35 days after the assessment data was garnered).</p> <p>During a phone interview on 9/9/16 at approximately 9:00 a.m., the RN stated she was not aware there was a time limitation related to when assessment data was gathered and when she was required to review it.</p>	W 345		

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W 345	Continued From page 8	W 345	→ individual # 2 has an appointment scheduled for dental.	
W 352	<p>483.460(f)(2) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE</p> <p>Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure individuals received an annual dental examination for 2 of 3 individuals (Individual #2 and #3) whose dental records were reviewed. This resulted in the potential for individuals' dental needs to go undetected. The findings include:</p> <p>1. Individual #2's 11/20/15 IPP stated he was a 25 year old male whose diagnoses included profound mental retardation and Down's Syndrome.</p> <p>Individual #2's record was reviewed and documented his last dental appointment was on 8/9/14. However, no documentation of a more recent dental appointment could be found.</p> <p>During an interview on 9/7/16 at 2:00 p.m., the LPN confirmed Individual #2's last dental appointment was in 8/2014 and that he had an appointment on 10/7/16.</p> <p>2. Individual #3's 2/5/16 IPP stated he was a 25</p>	W 352	<p>individual # 3 has an appointment scheduled for dental</p> <p>LPN responsible by 10/1/16</p> <p>→ All Books Reviewed to ensure all dental services are up to date.</p> <p>LPN responsible by 10/1/16</p> <p>→ LPN trained on following up on dental exams to ensure the reports are in book and the exam is completed as recommended</p> <p>Sup: LPN responsible by 10/1/16</p> <p>→ Program Director to Review Records at least quarterly to ensure all dental exams have been completed and if not they</p>	

will be added to action list  
PD responsible BY 10/1/16

→ LPN to Bring documentation of items on action list to monthly QA to ensure they have been completed

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W 352	Continued From page 9 year old male whose diagnoses included profound mental retardation.  Individual #3's record was reviewed and documented his last dental appointment was on 12/4/14. However, no documentation of a more recent dental appointment could be found.  During an interview on 9/7/16 at approximately 2:00 p.m., the Training Coordinator stated Individual #3's last dental appointment was in 12/2014.	W 352		
W 356	The facility failed to ensure Individuals #2 and #3 received an annual dental examination. <b>483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT</b>  The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure comprehensive dental services were provided for 1 of 3 individuals (Individual #1) whose medical records were reviewed. This resulted in an individual's dental needs being un-addressed. The findings include:  1. Individual #1's 3/17/16 IPP stated she was a 35 year old female whose diagnoses included moderate intellectual disability.	W 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G033</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/09/2016</b>	
NAME OF PROVIDER OR SUPPLIER  <b>TOMORROW'S HOPE - MERIDIAN</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1821 GREENHEAD MERIDIAN, ID 83642</b>		
(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) COMPLETION DATE
W 356	<p>Continued From page 10</p> <p>Her record contained a Doctor's Orders And Progress Notes, dated 1/20/16, that documented "PT [patient] has one area of decay that needs addressed ..."</p> <p>However, her record did not contain documentation that she had been to the dentist to have the area of decay addressed.</p> <p>During an interview on 9/7/16 at 2:00 p.m., the LPN stated Individual #1 had not been to the dentist to have the area of decay fixed and that she had an appointment scheduled on either 12/1/16 or 12/2/16.</p> <p>The facility failed to ensure Individual #1 received recommended dental care in a timely fashion.</p>	W 356	<p>* individual #1 has an appointment on follow up dental work LPN responsible BY 10/1/16</p> <p>* all individuals records for dental will be reviewed to ensure all follow up care have been completed or scheduled. LPN responsible BY 10/1/16</p> <p>* LPN to record on nursing summary if follow up dental appointments are needed when the complete monthly nursing summary LPN responsible BY 10/1/16</p> <p>* PD to review records at least quarterly to ensure all dental procedures have been</p>	

followed up on and if needed add to action list  
PD responsible BY 10/1/16  
\* LPN to bring documentation to monthly QA meeting of follow up or items from action list has been completed LPN responsible BY 10/1/16

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G033</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/09/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>TOMORROW'S HOPE - MERIDIAN</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1821 GREENHEAD MERIDIAN, ID 83642</b>		
(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
M 000	16.03.11 Initial Comments  The following deficiencies were cited during the state licensure survey conducted from 9/6/16 to 9/9/16.  The surveyors conducting your survey were:  Jim Troutfetter, QIDP, Team Lead Trish O'Hara, RN	M 000	<p><b>RECEIVED</b></p> <p><b>SEP 28 2016</b></p> <p><b>FACILITY STANDARDS</b></p> <p><i>refer to W111</i></p> <p><i>refer to W325</i></p> <p><i>W 326 W345 W 352</i></p> <p><i>W 356</i></p>	
MM080	16.03.11100 Governing Body and Management  The requirements of Sections 100 through 199 of these rules are modifications or additions to the requirements in 42 CFR 483.410 - 483.410(e), Condition of Participation: Governing Body and Management incorporated in Section 004 of these rules.  This Rule is not met as evidenced by: Refer to W111.	MM080		
MM166	16.03.11600 Health Care Services  The requirements of Sections 600 through 699 of these rules are for modifications and additions to the requirements in 42 CFR 483.460 - 483.460(n) (2), Condition of Participation: Health Care Services incorporated in Section 004 of these rules.  This Rule is not met as evidenced by: Refer to W325, W326, W345, W352, and W356.	MM166		

Bureau of Facility Standards

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

TITLE

(X6) DATE

*Submitable AD 9-28-16*