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for the total operation of the outpatient abortion facility. 1. The governing body shall consist of at least one individual who will assume full responsibility. 2. The outpatient abortion facility shall maintain documentation on the licensed premises identifying the following information for each member of the governing body: a. Name; b. contact information; c. address; and d. terms of membership. 3. The governing body shall develop and H/Health Standards Section PARTICIPATION Base EXHIBIT: Polity Cests to tentation of tentation of tentation, Certification, Policy Number 2412 Our policy marginal Patient Care, has been edited, and is in the process of being reviewed by the Medical Director. All old, new, edited and revised policies will be signed-off by the Medical Director and Administrator. In the process of being reviewed by the Medical Director and Administrator. In the process of being reviewed by the Medical Director and Administrator. In the process of being reviewed by the Medical Director and Administrator. In the process of being reviewed by the Medical Director and Administrator. In the process of being reviewed by the Medical Director and Administrator. In the process of being reviewed by the Medical Director and Administrator. In the process of being reviewed by the Medical Director and Administrator. In the process of being reviewed by the Medical Director and Administrator. In the process of being reviewed by the Medical Director and Administrator. In the process of being reviewed by the Medical Director and Administrator. In the process of being reviewed by the Medical Director and Administrator. In the process of being reviewed by the Medical Director and Administrator. In the process of being reviewed by the Medical Director and Administrator. In the process of being reviewed by the Medical Director and Administrator. In the process of being reviewed by the Medical Director and Administrator. In the process of		B. The outpatient a				
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b. contact information; c. address; and d. terms of membership. 3. The governing body shall develop and H/Health Standards Section OPERATORY DISCORDER OF PROVIDE O			erning body:	<u>t</u>	1	318
d. terms of membership. 3. The governing body shall develop and hithealth Standards Section THAT TO THE STANDARD OF PROVIDED			information;			
H/Health Standards Section CRATTER DIRECTORS OF PROVIDENCE SERVICES SIGNATURE (X6) DATE (X6) DATE (X6) DATE (X7) DATE (X7) DATE (X8) DATE (X8) DATE (X8) DATE (X8) DATE					will be signed-off by t	ne Medical Director
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Udmustrate (1-17-(6) 6899 S4GB14 If continuation sheet 1 o	HH/Health	Standards Section	SECUCIÓN DE DEDOCO ENTATIVE O RIC	אואדוופכ		
S4GB14 If continuation sheet 1 o					- _	LIB 11 8
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STATEMEN'	AND DUAN OF CORRECTION		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		BO0004541	B. WING		R 09/12/2016
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	movilees on elienties	<u> </u>	naces out	STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUPPLIER			SHING STREET	
WOMEN'	S HEALTH CARE CE	NTERING	EANS, LA		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
{\$ 000}	Initial Comments		{\$ 000}	S 169	
	2rd Follow Lin to P	elicensing Survey , in	!	A new policy has been wi	itten
	conjunction with (n	elicensing survey , in ew) Complaint # LA00043389. ere cited related to the		requiring the "Report of Induced	·
	complaint.			Termination of Pregnancy" to be	· ************************************
	Abbreviations			Completed online in the LEERS sy	stem
		istrator or of Nursing		within thirty (30) days of the dat	e of the
	ITOP induce	ed Termination of Pregnancy		termination procedure.	
	(Reports) LEERS Lou	isiana Electronic Event	Ì	After the ITOP is entered	into the LEERS
	Registration Syste			system, the physician must log in and use a	
	MA Medical As	esistant Fire Marshall		private four-digit pin to certify th	
	U/S Ultrasound			Once the record is certifi	ed, the LEERS
S 107	4421 A-B Governia	ng Body	S 107	system will give it the registratio forward it to LDH.	n number and
	A. The outpatient	abortion facility shall be in	İ	One copy is printed for t	
		I applicable federal, state, and		record. The record is e-signed by	
	local statutes, laws ordinances.	s, rules, regulations, and		so a stamped signature is no long	ger required.
		abortion facility shall have a			
	governing body tha	at assumes full responsibility		See Exhibit: Policy Leers Docum	entation/
	for the total operates facility.	ion of the outpatient abortion		Certification. Policy Number 241	
		ling body shall consist of at			:
		ıl who will assume full			ļ:
	responsibility.	ent abortion facility shall	•	Our policy manual <u>Patie</u>	nt Care.
	maintain documen	tation on the licensed premises following information for each		has been edited, and is in the p	ocess of
	member of the go			being reviewed by the Medical [Director.
	a. Name;	information;		All old, new, edited and revised	policies
	c. addres	s; and		will be signed-off by the Medica	Director
		of membership. ing body shall develop and		and Administrator.	
DHH/Health	Standards Section	a orion dotolop and	1		1

plier representative's signature

TITLE

(X8) DATE

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If continuation sheet 1 of 8

Health Standards Section						
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
YUD LDAN	OF CORRECTION	DENTI TOATION NOMBER.	A. BUILDING:			
		BO0004641	B. WING		R 09/12/2016	
NAME OF E	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY.	STATE, ZIP CODE		
		2701 GEN		SHING STREET		
WOMEN.	S HEALTH CARE CE	NTER INC NEW ORL	EANS, LA	70115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE	
S 107	Continued From pa	ge 1	S 107			
	adopt bylaws which responsibilities 4. The governi meet annually and	ng body shall, at minimum, maintain minutes of such enting the discharge of its				
	Based on observation terview the Gover facility was in comprequirements for the State Fire Mars was evidenced by a facility at one time of the SFM Inspection occupancy limit at a Findings: In an observation of a total of 23 person Further observation work in the facility. Review of the lates Marshal, Code Enforcement of English and FS2D revealed, under "or footage of 2400 square Review of patient to the second of the	90/9/16 at 8:50 a.m. revealed as waiting in waiting rooms. In revealed 8 staff members at at the Office of the State Fire proceeding and Building Safety lated 12/01/15, provided by DON as most current, ecupancy", "26", with a square		Upon learning from the Surveyors we were not in comp with the Fire Marshall's occupant (as per our previous Inspection we asked the Fire Marshall for a inspection. The previous Administrate of the fifty (50). The Fire Marshall stated, based of ingress/egress options and the laposition of chairs in the facility, we easily have an occupancy of several states of the Marshall states.	liance acy rates Report), new strator n occupancy on our ayout and we could nty (70).	
		l procedure/recovery room		See attached Fire Marshall Inspect	ліўн керогт	

DHH/Health Standards Section STATE FORM

PRINTED: 10/21/2016 FORM APPROVED

Health Standards Section							
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, .	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		BO0004641	B. WING		09/12	2/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
	S HEALTH CARE CE	NTER INC 2701 GEN		HING STREET			
	OURANA DV CTA				ON .	42/52	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
S 107	Continued From pa	ge 2	S 107				
	total of 35 patients	of sign-in sheets revealed a signed in for the day. s: counseling, follow-up, and					
	reported that the cli 40 patients a day, a are in different plac counseling/education After a review of the verified that 29 produced FS2DON verified the procedures are sch mornings by 9:00 a to expect to be ther	19/16 at 10:20 a.m. FS2DON nic will schedule no more than and that at any given time they es, such as counseling, group on, procedures, U/S, labs, etc. or recovery room log, the DON cedures were done that day nat all patients having surgical reduled to be at the clinic in the .m. or 9:30 a.m., and are told re for most of the day. 2/16 at 2:20 p.m. FS1ADM,					
	after review of the occupancy stated 2 been told by the prebuilding occupancy Administrator verific 26 persons in the bentered the building FS1ADM verified the patients signed in function that besides the pawere 8 staff working would bring the total surgical patients we present for the integree their busiest dated.	SFM report, verified the 6 She reported that she had evious administrator the					
S 169	4425 - E-F Patient Requirements	Med Records/Reporting	S 169	∆-			
	E. Other Reports.	The outpatient abortion facility					

DHH/Health Standards Section

S4GB14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING			,
		BO0004641	B. WING		09/1	₹ 2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
WOMEN'S REALTH CARE CENTERING			IERAL PERS .EANS, LA	SHING STREET 70115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S 169	shall maintain a dai receiving a surgical abortion. Patients m corresponding to th This daily patient roperiod of three year F. Reporting Requinguist 1. The outpatient abortion reporting requirement outpatient abortion reporting requirement to, the induced tenform and other doctored federal, state, a ordinances, and depregulations. 2. The outpatien in accordance with a the reporting of include but are not la rape; b. sexual batter c. incest; and	ly patient roster of all patients or chemically induced hay be identified e patient's medical record. ster shall be retained for a serements ent abortion facility shall eation to support that the facility is compliant with all ents, including, but not limited emination of pregnancy (ITOP) umentation as required by and local statutes, laws, coartment rules and ent abortion facility shall report all applicable state laws for crimes against a child that imited to:	S 169			
	failed to ensure all r met, as required by by having induced to reported documents (F#3, F#4, F#5, F#6 pregnancy reports re of 7 patient records Based on record rev failed to ensure doc support compliance	view and interview the facility eporting requirements were state statutes as evidenced ermination of pregnancy ed greater than 30 days for 4) of 4 induced termination of eviewed out of a total sample reviewed. view and interview the facility umentation was maintained to				

Health Standards Section

PRINTED: 11/22/2016 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		BO0004641	B. WING			R 12/2016
WOMEN'S HEALTH CARE CENTER INC 2701 GEN				STATE, ZIP CODE SHING STREET 70115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
S 169	by: 1) failure to provide reports certified (sig submitted (registere Records within 15 d procedure; 2) failure to provide reports certified and Vital Records with the st	documentation of ITOP Ined by physician) and ad) to the Office of Vital ays, as per their policy and documentation of ITOP I submitted to the Office of 30 days, as required by law; amped name of the certifying ce of the actual physician's	S 169			
	revealed, in part "A. for each abortion per completed by the attreport shall include: attending physician, be signed by the attrebulant to the Dej	0:1299.35.10 Reports, An individual abortion report erformed or induced shall be tending physicianThe(25) Signature of the C. All abortion reports shall ending physician and partment of Health and y days after the date of the				
	"Vital Records Abort presented on 09/12/as current, read in p August 29, 2011 the Termination of Pregithe LEERS (Louisiar Registration System provided by DHH (ht This form is to be coprocedure. Upon co	nancy" is completed online in				

DHH/Health Standards Section

Health Standards Section

Health Standards Section STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ BO0004641 09/12/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2701 GENERAL PERSHING STREET** WOMEN'S HEALTH CARE CENTER INC **NEW ORLEANS, LA 70115** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) S 169 Continued From page 5 S 169 "drop to paper" function. Further review revealed no procedure to provide evidence of the submission of the ITOP reports in the time required by facility policy and time required by state law. No procedure was noted that would ensure the physician signed the ITOP report. instead of using a stamp. Patient #F3 Review of #F3's Induced Termination of Pregnancy report revealed that her procedure was performed on 05/20/16. A hand written date (7/7/16) appeared in the box entitled "date registered." Under Physician Signature was a stamped name of FS4MD, but no signature. Date Certified (signed by Physician) was blank. Further review revealed no documented evidence that the report was submitted to the Louisiana Department of Health within 15 days, as per the facility policy and procedure or within thirty days. as required by law. Patient #F4 Review of #F4's Induced Termination of Pregnancy report revealed that her procedure was performed on 05/24/16. A hand written date (7/17/16) appeared in the box entitled "date registered." Under "Physician Signature" was a stamped name of FS5MD, but no signature. Date Certified (signed by Physician) was blank. Further review revealed no documented evidence that the report was submitted to the Louisiana Department of Health within 15 days, as per the facility policy and procedure or within thirty days. as required by law. Patient #F5 Review of #F5's Induced Termination of Pregnancy report revealed that her procedure

Health S	Standards Section	<u> </u>		•	1 01 (11)	, ii , ito veb
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION :	(X3) DATE COMP	SURVEY
	·	BO0004641	B. WING	10 mil 100		R 12/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
WOMEN	S HEALTH CARE CE	NIERING:	NERAL PERS LEANS, LA	SHING STREET 70115		
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S 169	Continued From pa	ge 6	S 169			
		05/20/16. The box entitled				
		as noted to be blank. Under re" was a stamped name of				
	FS4MD, but no sign	nature. Date Certified (signed				
		plank. Further review revealed dence that the report was				
	submitted to the Lo	uisiana Department of Health				
,		er the facility policy and thirty days, as required by				
	law.	unity days, as required by				
ļ				·		
	Pregnancy report re was performed on 0 (7/26/16) appeared registered." Under stamped name of F Certified (signed by review revealed no report was submitted Department of Heal	luced Termination of evealed that her procedure 06/01/16. A hand written date in the box entitled "date "Physician Signature" was a S4MD, but no signature. Date Physician) was blank. Further documented evidence that the dot to the Louisiana th within 15 days, as per the ocedure or within thirty days,	-			
	indicated that she is Induced Termination LEERS system. FS inputs the data into generated. FS3MA bottom of the report was printed. FS3MA enters this date in the FS3MA indicated that the way the LEERS	9/12/16 at 1:30 p.m., FS3MA responsible for entering the of Pregnancy into the 3MA indicated that once she the LEERS system a report is indicated that the date (at the) was the date that the form A indicated she (hand writes) he box titled "date registered." at she was not familiar with a system would provide the FS3MA reported she was not				

DHH/Health Standards Section

Health Standards Section						
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		BO0004641	B. WING		F 09/1	? 2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
WOMEN	'S HEALTH CARE CE	NIEKING:	NERAL PERS LEANS, LA	SHING STREET 70115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT! (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
S 169	Continued From pa	ge 7	S 169			
	certain that the prin submission.	ted date was the date of				
	indicated that she whad a policy which swas 15 days for the that she was not ce Induced Termination being submitted wit Department of Heal In an interview on o FS1ADM and FS2D had no documented Termination of Preg #F5 and #F6 had by and submitted within	r12/16 at 3:00 p.m., FS2DON was not aware that the clinic stated the submission date report. FS2DON indicated rtain how to determine if the nof Pregnancy reports were hin 30 days to Louisiana lth. on 09/12/16 at 3:05 p.m., oon indicated that the clinic devidence that the Induced mancy Report for #F3, #F4, ween signed by the physician on 15 days as required by the lin 30 days as required by law.				
		·				
			I			

DHH/Health Standards Section



State of Louisiana

Louisiana Department of Health Health Standards Section

IMPORTANT NOTICE- PLEASE READ CAREFULLY

DATE:

10/21/2016

TO:

ADMINISTRATOR OF Women's Health Care Center Inc.

FROM:

HEALTH STANDARDS SECTION

RE:

LICENSING SURVEY - FOLLOW-UP RESULTS

On 09/12/2016, a follow-up survey was conducted at your facility by the Department of Health and Hospitals, Health Standards Section, to determine if your facility was in compliance with licensing standards established by the State of Louisiana. This survey found deficiencies in your facility whereby corrections are required to assure compliance with licensing standards.

Enclosed for your completion and prompt response is the <u>STATE FORM</u> (STATEMENT OF DEFICIENCIES (SOD) AND PLAN OF CORRECTION (PoC)). A PoC for the deficiencies must be submitted within 10 working days after your receipt of the STATE FORM. In the column "Completion Date," enter a projected date of correction. An explicit date must be shown. This date may not exceed 60 days from the completion of the survey. Please refer to the enclosed memorandum, Required Components for the Plan of Correction, for guidance in developing your PoC. Failure to submit an acceptable PoC by the date indicated below may result in the imposition of specified remedies. The STATE FORM must be signed and dated by the administrator or other authorized official as indicated. The <u>SIGNIFICANT FINDINGS</u> form, if enclosed, does not require a PoC, but the facility is expected to sign, date, and return the form.

You have one opportunity to question citations of deficient practice through an Informal Dispute Resolution process. To be given such an opportunity you must send your written request, specifying the deficient practice(s) that you are disputing and why you are questioning these, to: DHH/Health Standards Section, Attention IDR Program Manager, P.O. Box 3767, Baton Rouge, LA 70821-3767. The request must be made within 10 calendar days of receipt of your STATE FORM. Again, this is an informal dispute resolution and it is not necessary for your attorney to be present, however, if you wish for your attorney to be included in the informal dispute resolution, please advise this office. Please refer to the enclosed memorandum, Informal Dispute Resolution Process, for further information.

Please provide this PoC by 11/7/2016. **Mail the completed original and properly signed/dated PoC to:** Health Standards Section, Attention Program Manager, P.O. Box 3767, Baton Rouge, Louisiana 70821-3767.

Enclosures

HSS-ALL-30a - THE REQUIRED COMPONENTS FOR A PLAN OF CORRECTION HSS-ALL-30b - INFORMAL DISPUTE RESOLUTION PROCESS

cc:

Health Standards Section, DHH



Rebekah E. Gee MD, MPH SECRETARY

State of Louisiana

Louisiana Department of Health Health Standards Section

IMPORTANT NOTICE- PLEASE READ CAREFULLY

DATE:

07/09/2018

TO:

ADMINISTRATOR OF Womens Health Care Center Inc

FROM:

HEALTH STANDARDS SECTION

RE.

COMPLAINT LICENSING SURVEY RESULTS

On 06/19/2018, a complaint survey was conducted at your facility by the Louisiana Department of Health, Health Standards Section. This survey found deficiencies in your facility whereby corrections are required to assure compliance with licensing standards.

Enclosed for your completion and prompt response is the <u>STATE FORM</u> (STATEMENT OF DEFICIENCIES (SOD) AND PLAN OF CORRECTION (PoC)). A PoC for the deficiencies must be submitted within 10 working days after your receipt of the STATE FORM. In the column "Completion Date," enter a projected date of correction. An explicit date must be shown. This date may not exceed 60 days from the completion of the survey. Please refer to the enclosed memorandum, <u>Required Components for the Plan of Correction</u>, for guidance in developing your PoC. Failure to submit an acceptable PoC by the date indicated below may result in the imposition of specified remedies. The STATE FORM must be signed and dated by the administrator or other authorized official as indicated. The <u>SIGNIFICANT FINDINGS</u> form, if enclosed, does not require a PoC, but the facility is expected to sign, date, and return the form.

You have one opportunity to question citations of deficient practice through an <u>Informal Dispute Resolution</u> process. To be given such an opportunity you must send your written request, specifying the deficient practice(s) that you are disputing and why you are questioning these, to: DHH/Health Standards Section, Attention IDR Program Manager, P.O. Box 3767, Baton Rouge, LA 70821-3767. You may also submit your written request via email to: <u>HSS.IDR-Sanction@la.gov</u>. The request must be made within 10 calendar days of receipt of your STATE FORM. Please refer to the enclosed memorandum. **Informal Dispute Resolution Process**, for further information.

Please provide this PoC by 07/22/2018. Email the PoC to Jennifer.Haines@la.gov or mail the completed original and properly signed/dated PoC to: Health Standards Section, Attention Program Manager, P.O. Box 3767, Baton Rouge, Louisiana 70821-3767.

Enclosures

HSS-ALL-30a - THE REQUIRED COMPONENTS FOR A PLAN OF CORRECTION HSS-ALL-30b - INFORMAL DISPUTE RESOLUTION PROCESS