**Agency Name**

**STREET ADDRESS, CITY, ZIP**:

**Provider Number**

**FEDERAL PLAN OF CORRECTION**

 **Exit Date**

 **PROVIDER’S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE**

 **CROSS ‐ REFERRENCED TO THE APPROPRIATE DEFICIENCY)**

**The Administrator signing and dating the first page of the CMS-2567 is indicating their approval of the plan of correction being submitted on this form.**

 **Tag**

 **Number**

**(X5)**

**COMPLETION**

**DATE**

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