**Agency Name**

**STREET ADDRESS, CITY, ZIP**:

**Provider Number**

**STATE 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 STATE FORM is indicating their approval of the plan of correction being submitted on this form.**

**Tag**

**Number**

**(X5)**

**COMPLETION**

**DATE**

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