**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**

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |