

**STATEMENT OF LICENSING DEFICIENCIES AND PLAN OF CORRECTION**

LIC-2567/07

**Name of Facility:**  
**Facility ID #:**  
**Administrator:**  
**Address:**  
**Phone Number:**

**City:**                      **Zip:**

**Surveyor:**  
**Facility Type:**  
**Date/s of Survey:**  
**Task/Work Order #:**  
**Type of Survey:**

DEFICIENCY	PLAN OF CORRECTION	COMPLETION DATE
<p>Return completed <i>Plan of Correction</i> to:                      DPHHS Division of Quality Assurance                      Licensure Bureau                      2401 Colonial Drive, 2<sup>nd</sup> Floor                      P.O. Box 202953                      Helena, Montana 59620-2953*</p>		

**RETAIN A COPY OF THIS COMPLETED REPORT FOR THE FACILITY'S RECORDS**

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**SIGNATURE** \_\_\_\_\_ **Title** \_\_\_\_\_ **Date** \_\_\_\_\_

