



**Missouri Department of Health and Senior Services**

P.O. Box 570, Jefferson City, MO 65102-0570 Phone: 573-751-6400 FAX: 573-751-6010  
RELAY MISSOURI for Hearing and Speech Impaired and Voice dial: 711



**Paula F. Nickelson**  
Director

**Michael L. Parson**  
Governor

**ADC - ACCEPTABLE PLAN OF CORRECTION**

Date

Recipient's Name

ADC Name

ADC Address

Dear Recipient:

This is to acknowledge receipt of your plan of correction on Date it was received and to advise you that the plan has been reviewed and is considered acceptable as submitted.

If at the time of the inspection or complaint investigation, violations existed which have a direct or immediate impact to the health, safety or welfare of a participant, but which did not create imminent danger, a re-inspection will be conducted within sixty (60) days of the original inspection completed on Date of Exit to determine whether the deficiencies have been corrected. For all other deficiencies, correction of the violations will be verified during the next on-site visit.

If you have any questions, please contact me at Address and/or Telephone Number.

Sincerely,

Program Manager's Name, Program Manager  
Section for Long-Term Care Regulation

Program Manager's Initials/initials of person typing the letter

**PROMOTING HEALTH AND SAFETY**

The Missouri Department of Health and Senior Services' vision is optimal health and safety for all Missourians, in all communities, for life.



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**ADC-INSEPCION, NO DEFICIENCIES**

Date

Recipient's Name

ADC Name

ADC Address

Dear Recipient:

This is to confirm the recent inspection of ADC Name completed on Date of Exit. This inspection was conducted for the purpose of determining compliance with the requirements for licensure as an Adult Day Care Center.

Based upon our findings during this visit, your program is in compliance with all licensure laws, rules and regulations.

Thank you for the time and courtesy extended by you and your staff during the inspection. If you have any questions, please feel free to contact inspector's name at inspector's phone number.

Sincerely,

Program Manager's Name, Program Manager  
Section for Long-Term Care Regulation

Program Manager's Initials/initials of person typing the letter

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**ADC – PLAN OF CORRECTION NOT RECEIVED**

Date

Recipient's Name

ADC Name

ADC Address

Dear Recipient:

Name of ADC was inspected on Date of Exit by the Missouri Department of Health and Senior Services. The purpose of this inspection was to determine if regulations were being met as required for licensure of an Adult Day Care Center.

The inspections revealed some deficiencies that were discussed with Name of the on-site Director/designee during the exit conference. The statement of deficiency letter was mailed to the ADC Director/designee on date mailed.

This letter is to advise you that the plan of corrections for ADC Name have not been received. As stated in the original letter, you are required to submit your plan of correction to this office within ten (10) working days of the receipt for review and approval.

Please immediately forward your plan of correction to this office. If you have already forwarded your plan of correction to this office, or if the ADC Director/designee did not receive the original letter mailed on Date mailed, please contact Inspector's name and phone number.

Please mail the original statement of deficiencies with your signature and plan of correction to: Department of Health and Senior Services, Inspector's office address.

Sincerely,

Program Manager's Name, Program Manager  
Section for Long-Term Care Regulation

Program Manager's Initials/initials of person typing the letter

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**ADC – REJECTED PLAN OF CORRECTION**

Date

Recipient's Name

ADC Name

ADC Address

Dear Recipient:

This is to acknowledge receipt of your plan of correction in this office on **Date received** and to advise you that the plan has been reviewed and it has been determined that the plan is not acceptable as submitted. It will be necessary for you to complete and forward an amended plan of correction in order that the inspection process may be completed.

The following represents deficiencies that require an amended plan of correction as well as the reason(s) the plan of correction has been rejected:

Type Text

Enclosed is your statement of deficiencies. Use the space provided to the right of each deficiency to type your plan of correction and the expected date of completion. A plan of correction must be entered for each item clearly identifying HOW, WHAT, WHEN, WHERE it was or will be corrected. The plan should also include provisions instituted to prevent reoccurrence.

As stated in your letter of **Date of letter**, your plan of correction must contain the following:

- What corrective action(s) will be accomplished for those participants found to have been affected by the deficient practice;
- How you will identify other participants having the potential to be affected by the same deficient practice;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;

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- How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness, and
- Your plan of correction must include dates by which corrective action will be completed.
- **Your Plan of Correction MUST NOT INCLUDE THE NAME OF PARTICIPANTS. In addition your Plan of Correction should not include other participant specific information such as medical records.**

Sign, date, and return the statement of deficiencies with the plan of correction to this office **immediately**. Please make a copy of the completed forms for your records. Upon our receipt of your plan of correction, you will be notified in writing if it has been accepted or rejected.

If you have any questions, please contact me at **Address and/or Telephone Number**.

Sincerely,

**Program Manager's Name**, Program Manager  
Section for Long-Term Care Regulation

**Program Manager's Initials/initials of person typing the letter**



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Director

**Michael L. Parson**  
Governor

**ADC – REVISIT LETTER**

Date

Recipient's Name

ADC Name

ADC Address

Dear Recipient:

This is to confirm the revisit of ADC Name on Date of revisit.

This revisit was to determine if deficiencies noted during the inspection completed on Date of Exit had been corrected.

At this time, all deficiencies noted on that inspection have been corrected. The results of this inspection will be forwarded to Central Office for appropriate action.

If you have any questions, please contact me at Address and/or Telephone Number.

Sincerely,

Program Manager's Name, Program Manager  
Section for Long-Term Care Regulation

Program Manager's Initials/initials of person typing the letter

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Governor

**ADC – STATEMENT OF DEFICIENCIES LETTER**

**Date**

**Recipient's Name**

**ADC Name**

**ADC Address**

This is to confirm the recent inspection of **ADC Name** completed on **Date of Exit**. This inspection was conducted for the purpose of determining compliance with the requirements for licensure as an Adult Day Care Center.

The inspection revealed deficiencies that were discussed with you during this exit conference. These are listed on the enclosed statement of deficiencies with their corresponding regulation number and deficiency classification. Please use the space to the right of each deficiency to enter your plan of correction and the expected date of completion. A plan of correction must be entered for each item clearly identifying HOW, WHAT, WHEN, WHERE it was or will be corrected. The plan should also include provisions instituted to prevent reoccurrence.

**Your plan of correction must contain the following:**

- What corrective action(s) will be accomplished for those participants found to have been affected by the deficient practice;
- How you will identify other participants having the potential to be affected by the same deficient practice;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness; and
- Your plan of correction must include dates by which corrective action will be completed.
- **Your Plan of Correction MUST NOT INCLUDE THE NAME OF PARTICIPANTS. In addition your Plan of Correction should not include other participant specific information such as medical records.**

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Sign, date and return the statement of deficiencies with the plan of correction to this office within ten (10) working days of the receipt. Please make a copy of the completed forms for your records. The Section for Long-Term Care Regulation (SLCR) will notify you in writing if it has been accepted or rejected.

If at the time of the **inspection or complaint investigation**, violations existed which have a direct or immediate impact to the health, safety or welfare of a participant, but which did not create imminent danger, a re-inspection will be conducted within sixty (60) days of the original inspection completed on **Date of Exit** to determine whether the deficiencies have been corrected. For all other deficiencies, correction of the violations will be verified during the next on-site visit.

In accordance with Section 192.2270, RSMo, you have one (1) opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request (separate from the plan of correction), along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies to:

Manager's Name	Steven Vest
Manager's Title	MO Department of Health & Senior Services Regional
SLCR Quality Review Unit	Office
Address 1	920 Wildwood Drive, P.O. Box 570
Address 2	Jefferson City, MO 65102 City, MO Zip Code
	<a href="mailto:Steven.Vest@health.mo.gov">Steven.Vest@health.mo.gov</a>

Please include a copy of the statement of deficiencies being disputed with your correspondence to the SLCR Survey and Compliance Unit.

This request must be sent during the same ten (10) working days you have for submitting a plan of correction for the cited deficiencies. The informal dispute resolution may be conducted by telephone, in writing or in a face-to-face meeting. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

You must keep copies of all inspection reports, statement of deficiencies and plans of correction available at your center for public inspection. These findings are also available in our office in accordance with the Public Disclosure Act.

Thank you and your staff for the time and courtesy extended to SLCR staff during the inspection. If you have any questions, please contact **(the name of the inspector at the inspector's phone number)**. Please mail the original statement of deficiencies with your signature and plan of correction to (inspector's office address).

Sincerely,

Program Manager's Name, Program Manager  
Section for Long-Term Care Regulation

Program Manager's Initials/initials of person typing the letter

Enclosure

SAMPLE