**Plan of Improvement for (Provider Name):**

Date of Survey or Complaint Citation report:

***4-001.06(B)(i-v) Plan of Improvement.*** *If the Department determines that a provider is in non-compliance with the provider requirements outlined in the Medicaid provider agreement or applicable law or regulation, a plan of improvement will be required from the provider.* *Within 20 days\* of receipt of the Department’s written results, the provider must submit an acceptable plan of improvement to address areas found to be out of compliance. The plan of improvement must:*

*Be specific in identifying a planned action on how the areas found to be out of compliance have been or will be corrected, for the individual cases included in the review and system wide within the provider organization;*

1. *Be specific in identifying a planned action on how the area found to be out of compliance have been or will be corrected for the individual*

 *cases included in the review and system wide within the provider organization;*

1. *Include an expected date for completion of the plan of improvement that is timely, taking into consideration the nature of the violation;*
2. *Identify a means to prevent a recurrence;*

 *(iv) Identify who is responsible for implementing the plan of improvement and ensuring all areas are corrected and maintained; and*

 *(v) Be signed and dated by the director of the entity or designee.*

\*This will be considered to be 20 business days.

Do not include individual or staff names in the plan. All references to individuals or staff must correspond with the numbered sample key included with the citation report. Complete a separate section of the worksheet for each citation grouping in the report you were issued. Add additional sections as needed based on the citations you are addressing in this POI. Contact your certification lead for any questions about the process.

Once you are notified that the plan has been accepted, implementation progress reports including supporting documentation must be submitted to DHHS.CBSCert@Nebraska.gov according to timeframes specified in the citation document.

The POI template is available in format you can edit at

<https://dhhs.ne.gov/Licensure/Pages/DD-Certified-Provider-Certification-Review-Sample-Forms.aspx>

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| **Regulation Cited:** |
| **Statement of Deficiencies:** |
| **Requirements** (see 4-001.06(B)(i-v) for complete requirements) | **Provider plan:** *Be specific in identifying a planned action on how the areas found to be out of compliance have been or will be corrected, for the individual cases included in the review and system wide within the provider organization;*  | **Date of Completion or Projected Completion & Title of Person Responsible for Completion** | **Surveyor review and approval (surveyor use only)**  |
| Planned action on how deficiencies will be corrected for the individual: |  |  |  |
| Planned action on how deficiencies will be corrected system wide within the provider organization:  |  |  |  |
| Means to prevent recurrence |  |  |  |

(Copy and paste additional sets of the table as needed based on the number of citations you are addressing in this POI)

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| Planned action on how deficiencies will be corrected system wide within the provider organization:  |  |  |  |
| Means to prevent recurrence |  |  |  |