Name of Foster Parents(s): Gladys Menor Date of Inspection: 1/6/22

## **Department of Health**

## **Developmental Disabilities Division**

## **Adult Foster Home Corrective Action Report**

 $\ \square$  No deficiencies, Home inspection after COVID-19 emergency

| SECTION | PLAN CORRECTION                    | Completion Date |
|---------|------------------------------------|-----------------|
|         | (To be completed by the caregiver) | completion but  |
|         | (constant and an experience)       |                 |
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