Name of Foster Parents (s): Lermadelia Tagumasi Date of Inspection: 01/27/22

**Department of Health**

**Developmental Disabilities Division**

**Adult Foster Home Corrective Action Report**

☐ No deficiencies. Home inspection after COVID-19 emergency.

| SECTION | PLAN CORRECTION (To be completed by the caregiver) | Completion Date |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |