

Nursing Care Quality Assurance Commission

P.O. Box 47864

Olympia, WA 98504-786  
360-236-4703

Nursing Program Plan of Correction

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| --- | --- | --- | --- | --- | --- | --- |
| Name of Program: | | | Name and Title of Person Completing Plan: | | | |
| Signature of Program Director: | | | | | Date: Click here to enter a date. | |
| WAC Deficiency | Identify Contributing Factors  Conduct an assessment of the factors leading to the deficiency | Identify the plan of action to correct the problem(s)   1. Identify specific interventions that will be implemented to address the identified problem(s); and 2. How and when this will be reevaluated. | | Identify how the program will ensure on-going compliance with the changes.  Include specific examples | Name the person or persons responsible to implement the action plan | Date of Implementation |
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