State of Michigan
Department of Licensing and Regulatory Affairs
Bureau of Survey and Certification
Long Term Care Division

**Facility Desk Review Attestation**

REQUEST TO ACCEPT EVIDENCE OF DEFICIENCY CORRECTION IN LIEU OF A REVISIT

Facility Name: _____ CMS Provider Number: 23-_____

Event ID #: _____ Survey Date: _____

The above facility was cited for noncompliance with the following Centers for Medicare and Medicaid Services (CMS) Long Term Care Regulations on the survey date indicated above:

Tag: _____ Scope/Severity: _____ Tag: _____ Scope/Severity: _____

Tag: _____ Scope/Severity: _____ Tag: _____ Scope/Severity: _____

Tag: _____ Scope/Severity: _____ Tag: _____ Scope/Severity: _____

Tag: _____ Scope/Severity: _____ Tag: _____ Scope/Severity: _____

Tag: _____ Scope/Severity: _____ Tag: _____ Scope/Severity: _____

All deficiencies (tags above) must be at a Scope/Severity level F (without a finding of substandard quality of care) or below to be eligible for a desk review. Under CMS regulation and the Michigan Public Health Code (MCL333.22113), the Bureau may opt to accept evidence of correction to confirm substantial compliance in lieu of an onsite revisit of these deficiencies. Final determination if a desk review is warranted is at the discretion of the bureau.

The facility agrees to provide evidence to document correction of the deficiencies listed. By signature below and submission of attached evidence, the facility alleges the correction of the above deficiencies and the presence of ongoing quality assurance to ensure that continuing compliance with these regulations will be maintained.

It is understood that the bureau reserves the right to determine if the evidence submitted verifies compliance, and still may visit the facility at any time to verify correction of these deficiencies. It is further understood that enforcement remedies applicable to these deficiencies may be immediately imposed if the bureau determines that the facility has not corrected these deficiencies.

Name of Administrator (Please Print):_____

Administrator's Signature: _____ Date: _____

**INTERNAL USE ONLY**

This evidence has been determined to be: ☐ Acceptable ☐ Not acceptable evidence of compliance.

The effective date of compliance is: _____.

Manager Signature: _____ Date: _____