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 documenting the correction of all listed deficiencies on or after the alleged compliance date. By signing below and submitting this evidence, the facility confirms that these deficiencies have been corrected, the facility is currently in compliance and ongoing quality assurance is occurring 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: _____