DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
_____
_____

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____
B. WING _____

(X3) DATE SURVEY COMPLETED

NAME OF FACILITY

STREET ADDRESS, CITY, STATE, ZIP CODE

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. *(See reverse for further instructions.)* Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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INSTRUCTIONS FOR COMPLETION OF THE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (CMS-2567)

I. **PURPOSE**

This document contains a listing of deficiencies cited by the surveying State Agency (SA) or Regional Office (RO) as requiring correction. The Summary Statement of Deficiencies is based on the surveyors' professional knowledge and interpretation of Medicare and/or Medicaid or Clinical Laboratory Improvement Amendments requirements.

II. **FORM COMPLETION**

Name and Address of Facility – Indicate the name and address of the facility identified on the official certification record. When surveying multiple sites under one identification number, identify the site where a deficiency exists in the text of the deficiency under the Summary Statement of Deficiencies column.

Prefix Identification Tag – Each cited deficiency and corrective action should be preceded by the prefix identification tag (as shown to the left of the regulation in the State Operations Manual or survey report form). For example, a deficiency in Patient Test Management (493.1107) would be preceded by the appropriate D-Tag in the 3000 series. A deficiency cited in the Life Safety Code provision 2-1 (construction) would be preceded by K8. Place this appropriate identification tag in the column labeled ID Prefix Tag.

III. **Summary Statement of Deficiencies –** Each cited deficiency should be followed by full identifying information, e.g., 493.1107(a). Each Life Safety Code deficiency should be followed by the referenced citation from the Life Safety Code and the provision number shown on the survey report form.

IV. **Plan of Correction –** In the column Plan of Correction, the statements should reflect the facility's plan for corrective action and the anticipated time of correction (an explicit date must be shown). If the action has been completed when the form is returned, the plan should indicate the date completed. The date indicated for completion of the corrective action must be appropriate to the level of the deficiency(ies).

V. **Waivers –** Waivers of other than Life Safety Code deficiencies in hospitals are by regulations specifically restricted to the RN waiver as provided in section 1861(e)(5) of the Social Security Act. The long term care regulations provide for waiver of the regulations for nursing, patient room size and number of beds per room. The regulations provide for variance of the number of beds per room for intermediate care facilities for the mentally retarded. Any other deficiency must be covered by an acceptable plan of correction. The waiver principle cannot be invoked in any other area than specified by regulation.

VI. **Waiver Asterisk(*) –** The footnote pertaining to the marking by asterisk of recommended waivers presumes an understanding that the use of waivers is specifically restricted to the regulatory items. In any event, when the asterisk is used after a deficiency statement, the CMS Regional Office should indicate in the right hand column opposite the deficiency whether or not the recommended waiver has been accepted.

VII. **Signature –** This form should be signed and dated by the provider or supplier representative or the laboratory director. The original, with the facility's proposed corrective action, must be returned to the appropriate surveying agency (SA or RO) within 10 days of receipt. Please maintain a copy for your records.

According to the Paperwork Reduction Act of 1995, no persons are required to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information is 0938-0391. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

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