

EXHIBIT 151

(Rev. 67, Issued: 10-18-10, Effective: 10-18-10, Implementation: 10-18-10)

MODEL LETTER **REQUESTING** A PLAN OF CORRECTION FOLLOWING AN INITIAL CRITICAL ACCESS HOSPITAL (CAH) SURVEY

Name/Title of Responsible Individual
Name of Hospital
Street Address
City, State, Zip Code

Dear _____:

Enclosed you will find the Form CMS-2567 "Statement of Deficiencies and Plan of Correction." This form enumerates deficiencies found during the initial Medicare certification survey completed at your facility on (date).

Your plan of correction must be returned to this office signed and dated, with an anticipated completion date for each corrective action, within ten (10) days of receipt of this letter.

The Plan of Correction must contain the following:

- What measures will be put into place or what systematic changes will be made to ensure the deficient practice does not recur, including the anticipated implementation date (a reasonable time-frame is allowed); and
- How the corrective action will be monitored to ensure compliance: what quality assurance indicators will be put into place and who will be responsible to oversee their monitoring.

The State agency will review the plan to determine if it is acceptable. If acceptable and the State determines that a revisit is not necessary, the State will recommend certification as a CAH to the CMS regional office (CMS- RO). If a revisit is deemed necessary, and the State determines by the revisit survey that the facility is in compliance, the State will recommend certification as a CAH. The CMS-RO will determine the effective date of CAH certification.

A complete copy of the Form CMS-2567 is subject to public disclosure. All responses must be shown on this form. Attachments may be submitted as supporting documentation. Please be specific as to how the deficient practice will be corrected. Failure to do so will result in the plan being returned for revision, creating a delay in the approval of your plan of correction.

Sincerely,

State Agency Representative

Enclosure: Form CMS-2567

cc:

Fiscal Intermediary/Medicare Administrative Contractor
Regional Administrator
State Department of Health