

## EXHIBIT 162

### MODEL LETTER REQUEST FOR A PLAN OF CORRECTION FOLLOWING AN INITIAL SURVEY FOR SWING-BED APPROVAL IN A HOSPITAL

**(Date)**

Name/Title of Hospital Administrator, CEO, or Responsible Individual  
Name of Hospital  
Street Address  
City, State, ZIP Code

Dear **(Hospital Administrator, CEO, or Responsible Individual)**

You will find enclosed the Form CMS-2567, "Statement of Deficiencies and Plan of Correction," which enumerates deficiencies found as a result of the initial Medicare certification survey completed at your facility on **(date)**.

Although a reasonable period of time may be allowed for actual correction of these deficiencies, 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 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 hospital with swing-bed approval to the CMS regional office. The effective date of certification will be the date that the approved plan of correction was received. If a revisit is necessary, and the State determines by the re-survey that the facility is in compliance, the effective date will be the last day of the survey.

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. **NOTE: "CORRECTED" is not an acceptable reply.** Please be specific as to how the deficient practice will be or has been 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.

Your plan of correction must contain the following:

- What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur; and

**(Name)**

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**(Date)**

- How will the corrective action(s) be monitored to ensure compliance (e.g., what quality indicators will be put into place and who will be responsible to oversee the monitoring).

Sincerely yours,

**(State Agency)**

Enclosures: Form CMS-2567