CHECKLIST FOR SURVEY PACKET (certified facilities)

Send to central office within 40 days of the survey exit

FACILITY NAME:	
ADDRESS:	
CMS CERT. NUMBER: 26	**FACILITY NUMBER:**
SURVEY EVENT ID:	**EXIT DATE:**
TEAM LEADER:	

☐	Application for Medicare and Medicaid - CMS 671
☐	Resident Census - CMS 672
☐	Letter to Facility: To Confirm Survey
☐	Confirmation of Mailing and Receipt Information or Electronic Verification
☐	Letter to Facility: Acceptance or Rejection of Plan of Correction
☐	Letter from Facility: To Request IDR, *if applicable*
☐	Final Statement of Deficiencies and Accepted Plan of Correction – Federal Health Care Survey (F-Tags) CMS 2567
☐	State Tags SOD/POC (referred to F tags) CMS 2567
☐	Life Safety SOD/POC (K Tags) CMS 2567
☐	State Tags SOD/POC (referred to K tags) CMS 2567
☐	LSC Book and Fire Safety Crucial Data Form – FSES if applicable

Reviewed by Regional Manager/Designee: _____ Date _____