STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315201	A. BUILDING ______ B. WING ______	C 03/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE REHABILITATION AND HEALTHCARE CENTER	255 EAST MAIN ST MOORESTOWN, NJ 08057

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: NJ151989, NJ150562, NJ150415, and NJ152328 Census: 140 Sample Size: 9 The facility is not in compliance with the requirments of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 557 SS=E	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and policy review, it was determined that the facility failed to maintain dignity for residents in the congregate dining area for 1 of 3 meals observed by leaving plates on the plate warmer domes and serving trays and by failing to remove the fluids from plastic cups or removing the foil lids. The residents' hands were not washed prior to 1 of 3 meals observed. The facility also failed to sit while feeding Resident #3 during 1 of 3 meals observed. Findings included:	F 557	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by Provider of the truth or facts alleged or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed because the provisions of Federal and State laws require it. F557 Respect, Dignity/Right to have Personal Property 1. Residents identified had their hands washed prior to the following meal, fluid from their cups offered in standard cups with a straw, and plates removed from	4/15/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/15/2022

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 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.

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F 557	Continued From page 1 1. During a lunch observation on 03/10/2022 starting at 12:50 PM in the locked [Executive Order 26, 4.b] unit, all 26 residents' plates were left in the plate warmer and left on the serving tray. Nineteen of the 26 residents were observed using the 4-ounce plastic juice cup with the foil pulled back to drink their juice. No straws were offered to nineteen residents and staff did not offer to pour the fluids into a standard glass or cup. An interview was held with Certified Nursing Assistant (CNA) #1 on 03/10/2022 at 1:15 PM. He reported he had worked at the facility for two months. The CNA stated straws were available, but most residents did not like to use straws. He stated dietary usually sent cups on the trays to pour the juice into, but today they had not. He stated he agreed it was not homelike to leave the plates on the plate warmers and on the serving trays, but it was easier and less messy to do so. CNA #2 was interviewed on 03/11/2022 at 12:14 PM. The CNA stated cups usually came on the meal trays and the CNAs were able to pour the juice out of the plastic cups with foil lids. The CNA reported that on 03/10/2022 the dietary department did not send the cups with the plates. CNA #3 was interviewed on 03/12/2022 at 10:25 AM. She stated usually cups were on meal trays when the trays were delivered from the kitchen. She added the reason residents drank from the plastic juice cups on Thursday was because the kitchen did not send the cups and towelettes up on the trays. The Dietary Manager (DM) and the Administrator were interviewed on 03/12/2022 at 10:31 AM. The DM stated that typically cups were not sent on the	F 557	plate warmers and domes. Resident requiring feeding assistance were helped by staff seated next to them at eye level. There were no negative outcomes noted. In-service education on dignity during meal service was provided to nurses, CNAs and activities staff. 2. All residents have the potential to be affected by the concerns identified. An audit of all resident's meal service as it relates to dignity was initiated, and no concerns noted. 3. The Director of Nursing has educated all clinical and activities staff on dignity during meal service. 4. The Registered Dietician or Food Service Director has completed audits for meal service daily for one week, weekly for 4 weeks and then monthly for 3 months. Results of the audits will be reported to the monthly Quality Assurance Performance Improvement committee for review. The Quality Assurance Performance Improvement committee will determine the need for further and continued action.	

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F 557	Continued From page 2 meal trays since cups were available in each unit for use. The Administrator added cups were available on each unit and he preferred staff pour the juices out of the plastic containers with the foil lids and into a standard glass since that was a more dignified way of presenting the juices to residents. The Administrator stated he thought the residents' dining experience should be the same as in a restaurant. He stated serving the residents' meals on the dome base and on the serving tray was not appropriate and could be considered a dignity issue. The Registered Dietician was interviewed at 10:59 AM on 03/12/2022 and stated she agreed the plates should be taken off the tray and out of the dome bases and fluids served in cups to give residents the sense of home. The Director of Nursing (DON) was interviewed on 03/12/2022 at 11:32 AM. The DON stated she personally did not have an issue with juices sipped out of plastic cups with the foil rolled back but did have issues with plates staying on the dome bottoms and the serving trays. 2. An observation was made on 03/12/2022 at 9:35 AM of Registered Nurse (RN) #1 feeding Resident [redacted]. The RN was standing on the right side of the bed feeding the resident. Due to the RN standing, the RN was not eye level with the resident and was much higher than the resident. During an interview with the RN at this time she stated she was not aware she was required to sit while feeding a resident. The RN stated she had never heard that standing while feeding a resident was a dignity issue. CNA #3 was interviewed on 03/12/2022 at 10:00	F 557		

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F 557	Continued From page 3	F 557		

AM and stated she had been trained in CNA school to always sit when feeding a resident but was not sure why.

The Director of Nursing (DON) was interviewed on 03/12/2022 at 11:32 AM. She stated staff were not supposed to stand when feeding residents because it was a dignity issue. She stated RN #1 knew better.

The facility's "Dining Services" policy, dated August 2021, indicated "All meals will be served at the proper temperature and with appropriate presentation ...All residents will be provided with the opportunity and encouraged to perform hand hygiene prior to meals."

3. During a lunch observation on 03/10/2022 starting at 12:50 PM in the locked [Executive Order 26, 4.b] unit, all 26 residents ate without being offered to have their hands washed. Prior to the lunch meal, all residents were observed seated in the common area and then brought to the dining area for lunch. At no time were residents offered hand hygiene prior to or during the meal.

An interview was held with CNA #1 on 03/10/2022 at 1:15 PM. The CNA stated while he had washed the assigned residents' hands during morning care, he had not washed the residents' hands prior to eating, stating hand sanitizer and moist towelettes were not available in the [Executive Order 26, 4.b] unit. He added that while there was a sink in the dining area it would be too much activity and trouble to get all the residents to the sink to wash their hands.

CNA #2 was interviewed on 03/11/2022 at 12:14 PM. She acknowledged that on 03/10/2022 the

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F 557	Continued From page 4 residents' hands were not washed prior to the lunch meal. The CNA stated usually dietary provided towelettes on the meal trays, but yesterday they had not. CNA #3 was interviewed on 03/12/2022 at 10:25 AM. She stated on Thursday (03/10/2022) during the lunch meal the residents had not had their hands washed. She added the kitchen had not provided the towels on the meal tray used to wash hands. The Dietary Manager (DM) and Administrator were interviewed on 03/12/2022 at 10:31 AM. They stated the dietary department always included the towelettes on meal trays so the CNAs could wash the residents' hands. The DM stated should the towelettes be forgotten for some reason, each unit had towelettes on the unit. The DM denied not sending the towelettes on Thursday (03/10/2022). The Administrator stated he had received no reports of not having supplies to wash the residents' hands. The DON was interviewed on 03/12/2022 at 11:32 AM and stated she expected residents to have the opportunity to wash their hands before meals. New Jersey Administrative Code § 8:39-4.1(a)12	F 557		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or	F 609		4/15/22

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F 609	Continued From page 5 mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ152328 Based on interviews and document review, it was determined that the facility failed to report an allegation of sexual abuse to the state agency within the specified two hours for 1 of 2 allegations of sexual abuse reviewed. The allegation of abuse involved Resident [Executive Order] and Resident [Executive Order] Findings included: A review of the resident's face sheet indicated the facility admitted Resident [Executive Order] with diagnoses that Executive Order 26, 4.b.	F 609	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by Provider of the truth or facts alleged or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed because the provisions of Federal and State laws require it. F609 Report of Alleged Violations 1. Residents [Executive Order] and [Executive Order] identified had their allegations reported to the appropriate agencies and were not adversely affected by the failure to report the allegation of abuse within the 2 hours required. In-service education on timely	

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F 609	Continued From page 6 Executive Order 26, 4.b. A review of the quarterly Minimum Data Set (MDS), dated Executive Order 26, 4.b., revealed Resident Execu scored Executive Order 26, 4.b. on the Brief Interview for Mental Status indicating Resident Execu was Executive Order 26, 4.b. The MDS indicated Resident Execu exhibited physical behaviors directed toward others one to three days during the assessment period. Resident Execut required limited assistance for transfers and limited assistance for ambulation, and supervision for locomotion on the unit. A review of the face sheet for Resident Execu indicated the facility admitted the resident with diagnoses that Executive Order 26, 4.b. A review of Resident Execut's quarterly MDS, dated Executive Order 26, 4.b., indicated Resident Execu Executive Order 26, 4.b. on the BIMS which indicated Executive Order 26, 4.b. Executive Order 26, 4.b.. Resident Execu required extensive to total dependance for all activities of daily living except the resident required supervision for eating. A review of a state reportable event, presented by the facility and dated Executive Order 26, 4.b.), indicated on Executive Order 26, 4.b.) Resident Execu was witnessed Executive Order 26, 4.b. another	F 609	reporting of allegations of abuse was immediately provided to staff. 2. All residents have the potential to be affected by the concerns. All previous allegations for the prior 90 days were audited and were in compliance. 3. The Director of Nursing and Administrator have educated all staff on abuse, neglect and misappropriation of property and timeliness of reporting. 4. The Administrator will audit all reportables for timeliness of reporting. Results of the audits will be reported to the monthly Quality Assurance Performance Improvement committee for review. The Quality Assurance Performance Improvement committee will determine the need for further and continued action	

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

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F 609	Continued From page 7 resident, Resident [Executive Order 26, 4.b.] The report indicated the nurse separated the residents and Resident [Executive Order 26, 4.b.] was placed on [Executive Order 26, 4.b.]. The report also indicated Resident [Executive Order 26, 4.b.] was placed in a different unit on [Executive Order 26, 4.b.]. The Administrator, who had submitted the documentation to the state agency, documented neither resident had any [Executive Order 26, 4.b.] from the event and the residents' activities of daily living had not been impacted. The Administrator marked on the report that the event was not significant. In the investigation packet, the Administrator indicated he had spoken with the nurse that had seen the incident on 12/20/2021 (two days after the incident) to obtain a statement about the incident that occurred on 12/18/2021. There were no other resident interviews in the investigation and a resident-to-resident abuse in-service was given to the one nursing employee that had not immediately reported the incident to the Administrator. There was no evidence there was a 24-hour report. An interview was held with Licensed Practical Nurse (LPN) #2 on 03/11/2022 at 9:43 AM. The LPN stated Resident [Executive Order 26, 4.b.] was on 15-minute checks to make sure staff knew where the resident was located. She stated moving the resident's room was also part of the plan of care after the incident with Resident [Executive Order 26, 4.b.]. The Administrator was interviewed on 03/11/2022 at 1:47 PM. The Administrator stated they submitted the initial report for the 12/18/2021 event via telephone call from home but had not documented the call. The Administrator called the state department of health during the interview and spoke with a representative (DOH #1) on speaker phone. The state representative stated	F 609		

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F 609	Continued From page 8 she had checked the log and there was nothing documented that would confirm the Administrator had notified the state agency about the 12/18/2021 alleged abuse between Resident [Execu] and Resident [Executive] On 03/11/2022 at 4:09 PM an email was received from DOH #2 that indicated documentation could not be found that supported the facility having reported the 12/18/2021 incident. The Administrator was interviewed on 03/12/2202 at 8:43 AM. The Administrator stated he was not made aware of the 12/18/2021 incident between Resident [Execu] and Resident [Execu] until 12/19/2021 at which time he called the state agency. The undated facility's policy titled, "Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating," indicated, "2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility ...2. "Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury". New Jersey Administrative Code § 8:39-5.1(a)	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged	F 610		4/15/22

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F 610	Continued From page 9 violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ152328 Based on observations, resident and staff interviews, review of medical records, and document review, it was determined that the facility failed to thoroughly investigate an allegation of sexual abuse for 1 of 2 allegations of sexual abuse reviewed. The allegation of abuse involved Resident [redacted] toward Resident [redacted]. Findings included: A review of the resident's face sheet indicated the facility admitted Resident [redacted] with diagnoses that Executive Order 26, 4.b. [redacted]	F 610	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by Provider of the truth or facts alleged or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed because the provisions of Federal and State laws require it. F610 Investigate/Prevent/Correct Alleged Violation 1. Residents [redacted] and [redacted] identified were not adversely affected by incomplete allegation investigations. 2. All residents have the potential to be affected by the concerns. All previous allegations for the prior 90 days were audited and included complete investigations. 3. The Regional Director of Clinical Services educated the Administrator and Director of Nursing on thorough investigations of abuse, neglect and misappropriation of property. 4. The Regional Director of Clinical	

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F 610	Continued From page 10 A review of the quarterly Minimum Data Set (MDS), dated [Executive Order 26, 4.b.] revealed Resident [Execu] scored [Executive Order 26, 4.b.] on the Brief Interview for Mental Status indicating Resident [Execu] was [Executive Order 26, 4.b.]. The MDS indicated Resident [Execu] exhibited physical behaviors directed toward others one to three days during the assessment period. Resident [Executi] required limited assistance for transfers and limited assistance for ambulation, and supervision for locomotion on the unit. A review of the care plan for Resident [Executive] revised on 12/18/2021, indicated Resident [Execu] was found with their hand in the brief of another resident. The goal was Resident [Execu] would have no episodes of inappropriate sexual advances and the residents on the unit wound be safe and sexual advances toward other residents will not be made. Interventions to achieve the goal included anticipating and meeting Resident [Executive] needs, assisting the resident to develop more appropriate methods of coping and interacting, every 15-minute checks and transferring to a private room, psychology, and psychiatric consultations. A review of the face sheet for Resident [Execu] indicated the facility admitted the resident with diagnoses that included [Executive Order 26, 4.b.] A review of Resident [Execu]'s quarterly MDS, dated 11/10/2021, indicated Resident [Execu] scored [Executive] on the [Executive Ord] which indicated [Executive Order 26, 4.b.] [Executive Order 26, 4.b.]. Resident [Execu] required extensive to total dependance for all activities of daily living	F 610	Services will review all reportable event investigations are complete. Results of the audits will be reported to the monthly Quality Assurance Performance Improvement committee for review. The Quality Assurance Performance Improvement committee will determine the need for further and continued action	

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F 610	Continued From page 11 except the resident required supervision for eating. A review of Resident Executive care plan with an initiation date of Executive Order 26, 4.b. indicated the resident had been inappropriately touched by another resident. The goal of having no ill effects and feel safe from inappropriate touching was to be achieved by a Executive Order 26, 4.b. A review of a state reportable event, presented by the facility and dated Executive Order 26, 4.b. Executive Order 26, 4.b., indicated on Executive Order 26, 4.b. Executive Order 26, 4.b.) Resident Execu was Executive Order 26, 4.b. another resident, Resident Executive The report indicated the nurse Executive Order 26, 4.b. and Resident Execu was Executive Order 26, 4.b.. The report also indicated Resident Execu was Executive Order 26, 4.b. The Administrator, who had submitted the documentation to the state agency, documented neither resident had any Executive Order 26, 4.b. from the event and the residents' activities of daily living had not been impacted. The Administrator marked on the report that the event was not significant. In the investigation packet, the Administrator indicated he had spoken with the nurse that had seen the incident on Executive Order 26, 4.b. (Executive Order 26, 4.b. to obtain a statement about the incident that occurred on Executive Order 26, 4.b. There were no other resident interviews in the investigation. A statement from Resident Execu dated Executive Order 26, 4.b. was included in the report submitted to the state. Resident Executive Order 26, 4.b. A statement from Resident Executive Order 26, 4 was also included. Resident Executive Order 2 There were no other interviews from other	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315201	A. BUILDING ______ B. WING ______	C 03/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE REHABILITATION AND HEALTHCARE CENTER	**255 EAST MAIN ST MOORESTOWN, NJ 08057**

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F 610	Continued From page 12 residents residing on the same unit as Resident Executive The care plan for Resident Execu, initiated on 12/19/2021, indicated Resident Execu had been inappropriately touched by another resident. The goal of not having any ill effects and the goal of the resident feeling safe was to be accomplished through Executive Order 26, 4.b. and Executive Order 26, 4.b. consults and a Executive Order 26, 4.b. was to be completed. Review of the medical record for Resident Executive Order 26, 4.b. saw the resident on Executive Order 26, 4.b. and found no change in the resident's condition and documented the resident was unable to recall anything that occurred. Review of the Executive Order 26, 4.b. for Resident Execu revealed a Executive Order 26, 4.b. had not been completed until Executive Order 26, 4.b.. An observation on 03/11/2022 at 9:10 AM, Resident Execu was sitting on the edge of the bed eating breakfast. At 9:30 AM and interview was held with Resident Executive Resident Execu stated they did not remember any incidents that occurred with another resident but confirmed the facility had spoken to him about respecting other residents' boundaries and spaces. An interview was held with Licensed Practical Nurse (LPN) #2 on 03/11/2022 at 9:43 AM. The LPN stated Resident Execu was on 15-minute checks to make sure staff knew where the resident was located. She stated that along with moving the resident's room was part of the plan of care after the incident with Resident Execu. The Director of Nursing (DON) and the Administrator were interviewed on 03/11/2022 at	F 610		

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F 610	Continued From page 13	F 610		

3:09 PM. The DON stated only Resident [Executive Order 26, 4.b.] was placed on [Executive Order 26, 4.b.] and then every [Executive Order 26, 4.b.]. The Administrator stated he did not think lack of timely reporting from the staff was a systemic/global issue and more of a specific nurse issue, adding that was why the decision was made only to educate the nurse that failed to report the resident-to-resident abuse that occurred on 12/18/2021. The Administrator stated no other residents on Resident [Executive Order 26, 4.b.]'s unit had been interviewed. He added that "hindsight being 20/20, it would have been prudent to speak with other residents" on the unit to see if Resident [Executive Order 26, 4.b.] had inappropriately touched any other residents.

The Administrator was interviewed on 03/12/2022 at 8:43 AM. He stated the expectation was for staff to protect the resident after an allegation of [Executive Order 26, 4.b.] and remove the [Executive Order 26, 4.b.] from the room (resident or staff). He stated the resident abuser would be placed on [Executive Order 26, 4.b.], [Executive Order 26, 4.b.] services would be arranged to evaluate the [Executive Order 26, 4.b.]l impact of the event, nursing would be expected to complete [Executive Order 26, 4.b.] and document the assessment in the resident's medical record and complete an incident report. The Administrator stated when a care plan was initiated, he expected the plan to be followed. The Administrator reviewed the medical record for Resident [Executive Order 26, 4.b.] and acknowledged the date of the [Executive Order 26, 4.b.] and reviewed the care plan for Resident [Executive Order 26, 4.b.] and acknowledged the care plan for the abuse had not been followed.

The undated facility policy titled, "Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating," indicated, Investigating Allegations: 1. All allegations are thoroughly investigated. The administrator initiates investigations ...7. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315201	A. BUILDING ______ B. WING ______	C 03/12/2022

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F 610	Continued From page 14 individual conducting the investigation as a minimum: ...h. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident." New Jersey Administrative Code § 8:39-5.1(a)	F 610		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315201	A. Building B. Wing	4/18/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE REHABILITATION AND HEALTHCARE CENTER	255 EAST MAIN ST MOORESTOWN, NJ 08057

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0557 Reg. # 483.10(e)(2) LSC	Correction Completed 04/15/2022	ID Prefix F0609 Reg. # 483.12(c)(1)(4) LSC	Correction Completed 04/15/2022	ID Prefix F0610 Reg. # 483.12(c)(2)-(4) LSC	Correction Completed 04/15/2022
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
3/12/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO