STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80a005	A. BUILDING: _____ B. WING _____	C 03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING AT MOUNTAIN RIDGE	680 MOUNTAIN BOULEVARD WATCHUNG, NJ 07069

(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) COMPLETE DATE
H 000	Initials Comments The facility is not in compliance with N.J.A.C. Title 8 Chapter 43E- General Licensure Procedures and Standards Applicable To All Licensed Facilities.	H 000		
H5790	8:43E-13.4(d) UNIVERSAL TRANSFER FORM:MANDATORY USE OF FORM A licensed healthcare facility or program shall retain a completed copy of the Universal Transfer Form sent with a patient when a patient is transferred as part of the patient's medical record. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00162369 Based on interview and record review it was determined that the facility failed to retain a completed Universal Transfer Form (UTF) for 1 of 4 residents reviewed who was transferred to the hospital for evaluation, Residents #2. The deficient practice was evidenced by the following: On 03/27/23 at 10:25 a.m., the surveyor review of Resident #2's medical record identified that the resident was transferred to the hospital on [redacted] due to NJ EX Order. 264b1. However, there was no documented evidence that a copy of the UTF was retained in the medical record when the	H5790		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/19/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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H5790	Continued From page 1 resident was transferred out to the hospital. At 12:13 p.m., the surveyor interviewed the Executive Director (ED) and inquired if there was a copy of the UTF for Resident #2 on [redacted] The ED stated that she was unable to locate a copy of the UTF for Resident #2. Further, the ED stated, "I guess they were in a hurry and were unable to make a copy." The surveyor reviewed the facilities policy and procedure titled, "New Jersey Universal Transfer Form Guideline revised 07/12" which revealed, "The completed form will be sent whenever a resident is transferred to any health care facility and a copy of the form shall be retained in the resident's medical record." Refer to 4.1(a)(2)	H5790		
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ00162369 CENSUS: 78 SAMPLE SIZE: 4 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure	A 000		

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A 000	Continued From page 2 that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights; This REQUIREMENT is not met as evidenced by: Complaint # NJ 00162369 Based on interview and record review it was determined that the facility failed to implement its policy and procedure on "Emergency Transfer of Residents to Acute Care Facility NJ" for 1 of 4 residents, Resident #2. The deficient practice was evidenced by the following: On 3/27/23 at 10:25 a.m., the surveyor reviewed Resident #2's closed medical record and	A 310		

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A 310	Continued From page 3	A 310		

according to the "Nurses Note" (NN) dated NJ EX Order 2 at 12:30 a.m., Resident #2 was located in his/her NJ EX in the NJ EX Order. 264b1 NJ EX Order. 264b1. Registered Nurse (RN) #1 indicated that she was "greeted" with the NJ EX Order. 264b1 and that the resident was NJ EX Order. 264b1 but responded to NJ EX Order. 264b1. In addition RN #1 documented that upon assessment the resident's NJ EX Order. 264b1) was low at NJ EX Order and the NJ EX Order. 264b1 was NJ EX percent room air. At 6:45 a.m., a Licensed Practical Nurse (LPN) #1 documented that at 6:30 a.m., Resident #2's BP was NJ EX Order 2.

On 3/27/23 at 12:50 p.m., and on 3/28/23 at 10 a.m., the surveyor interviewed RN #1 and LPN #1 via telephone. RN #1 and LPN #1 confirmed that they did not initiate the emergency transport services nor did they notify the physician of the resident's NJ EX Order. 264b1 in condition.

On NJ EX Order 2 at 8:30 a.m., RN #3 documented that Resident #2 was observed in a NJ EX Order 2 situation in the resident's apartment and was immediately transferred to the Emergency Room (ER) for evaluation. At 11:30 a.m., the Wellness Director (WD) documented that she spoke to an ER nurse who indicated that the resident was NJ EX Order. 264b1 NJ EX Order to the ER. At 5:30 p.m., the WD documented that the admitting diagnosis was NJ EX Order. 264b1 and remained on a NJ EX Order. 264b1

The surveyor reviewed the facility's policy and procedure titled, "Emergency Transfer of Residents to Acute Care Facility NJ" revised 8/11 which revealed, "For life threatening emergencies, a telephone call to activate the emergency transport services system, i.e.., 911, will be placed. The dispatcher will be notified of

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A 310	Continued From page 4 the resident name, location, clinical status and need for urgent transportation to an acute medical facility..." In addition, the policy revealed, "The attending physician will be immediately notified of the clinical status and emergency transport..." The facility failed to provide Resident #2 services to an acute medical facility for further evaluation when the resident continued to decline after being located in the NJ EX Order. 264b1 in the community's NJ EX Order. 264b1. Refer to 4.1(a)(2)	A 310		
A 357	8:36-4.1(a)(2) Resident Rights (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: 2. The right to receive a level of care and services that addresses the resident's changing physical and psychosocial status; This REQUIREMENT is not met as evidenced by: Complaint: NJ 001622369 Based on interview and record review it was determined that the facility failed to consistently monitor and address the residents changing	A 357		

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physical and psychosocial needs for 1 of 4 residents, Resident #2. The deficient practice was evidenced by the following:

On 03/14/23, the Department of Health (DOH) received a Facility Reportable Event Record (FRE) dated NJ EX Order 2 from the Executive Director (ED). The ED documented on the FRE that on NJ EX Order. 2 Resident #2 left the facility at approximately 4:30 p.m., and at approximately 11 p.m., the resident was observed NJ EX Order in the NJ EX Order. 264b1 of the resident's NJ EX in the NJ EX Order. 264b1 of the community. In addition, the ED documented that staff investigated and observed the resident "Intoxicated with a bottle of bourbon in the resident's possession."

On 03/27/23 at 10:25 am, the surveyor reviewed Resident #2's closed medical record (MR)which indicated that Resident #2 moved into the facility on NJ EX Order. 2 with diagnoses which included NJ EX Order. 264b1. According to the Care Plan (CP) dated NJ EX Order 2, Resident #2 was NJ EX Order. 264b1 to NJ EX Order. 264b1 NJE independent with Activities of Daily Living (ADL) and NJ EX Order. 264b1.

During surveyor review of the MR, the surveyor reviewed the "Nurses Note" (NN) dated NJ EX Order 2 at 12:30 a.m., written by a Registered Nurse (RN) #1 which showed, "Writer received a call from the outgoing Care Manager (CM) that resident car was noted in the NJ EX Order. 26 area. Writer went to inspect and noted resident NJ EX Order. 264b1 NJ EX Or, when she open the door she was greeted with a NJ EX Order. 264b1 l and the resident who was NJ EX Order. 264b1 but NJ EX Order 2 and NJ EX Order. 264b with NJ EX Order. 264b1. Writer noted a bottle of NJ EX Order. 264b1 left sitting between his/her NJ EX O in the car. She immediately called for

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assistance from other staff members and he/she was transferred from car to wheelchair x 4 [4 staff members] and transferred back to apartment where he/she was assisted with ADL and transferred to his/her bed. v/s [Vital signs] done. NJ EX Order. 264b1 rr [respiration] NJ EX. Resident was noted with NJ EX Order. 264b1 but was positioned in bed with sideway head elevation NJ EX Order. 264b1 to avoid a NJ EX Order. 264b1 because he/she was showing signs of NJ EX Order. 264b1 that could lead to NJ EX Order. 264b1."

At 12:50 p.m., the surveyor interviewed the facility Registered Nurse (RN) #1 via telephone regarding her documentation on NJ EX Order. 2 at 12:30 a.m. RN #1 stated that she was called to the resident's car between 11:00 p.m. and 11:30 p.m., by the outgoing CM #1 whose shift had ended. RN #1 stated that she knocked on the NJ EX Order. 264b1 and realized that the resident was inside the NJ EX Or RN #1 stated that she observed a NJ EX Order. 264b1 NJ EX Order. 264b1 and a NJ EX Order. 264b1 in the car. She stated that only NJ EX Order. 264b1 was left in the bottle. RN #1 added that she shook and called the resident by name but the resident only responded to a NJ EX Order. 264b1" and then, she wheeled the resident into the resident's apartment with the assistance of RN #2, LPN #1 and CM #2. RN #2 and CM #1 were not available for interview.

During the interview, the surveyor asked RN #1 if the Wellness Director (WD) and the physician were notified of the aforementioned incident. In addition, the surveyor inquired if Resident #2 was sent to the Emergency Room (ER) for evaluation when the resident was first observed in the resident's car NJ EX Order. 264b1. RN #1 stated that she communicated with the WD and the resident's NJ EX Order. 264b1 through text messages

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and confirmed that she did not notify the physician. RN #1 explained that she did not send the resident to the ER for evaluation because the resident was only "[redacted] and that she thought the resident would "[redacted]" In addition, RN #1 stated that she endorsed report to LPN #1 who assisted with the transfer of the resident out from [redacted]. The RN concluded that she went home at approximately 12:30 a.m.

At 1:00 p.m., the surveyor interviewed the facility Receptionist regarding Resident #2's whereabouts on [redacted] The Receptionist stated that at approximately 3:40 p.m., she observed the resident in the [redacted] and when questioned, the resident stated that he/she was going to put the [redacted] in the [redacted] The Receptionist stated that the resident told her that he/she was going for a walk in the [redacted] and would be back, "Resident walks a lot." She explained that she left work at 4 p.m., and did not see Resident #2 return but that the resident's car was still in the [redacted]

At 1:12 p.m., via telephone, the surveyor interviewed CM #2 who assisted with Resident #2's transfer from the car into a [redacted]. CM #2 stated that she was in the laundry room and heard a code blue [emergency assistance] announced via radio by a staff member. She explained that she was instructed to bring a [redacted] to the [redacted]. CM #2 stated that she assisted in providing care to the resident and checked on the resident when she provided care to the resident's [redacted] who resided with Resident #2 in the same apartment. CM #2 stated that she last saw Resident #2 at 6:45 a.m., and that the resident was [redacted] and [redacted]

At 1:27 p.m., the surveyor interviewed the WD

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regarding the incident with Resident #2. The WD stated that at on [redacted] at 8:34 p.m., she was notified via text message that the resident was not in the community. She stated that the resident's [redacted] was also notified and told staff, "NJ EX Order. 264b1 [redacted] The WD stated that she later received a text message at 11:43 p.m., that the resident was found inside of the resident's car, "[redacted] " but was not aware of the resident's change in condition. The WD added that she instructed RN #1 to take the [redacted] from the resident to prevent the resident from further [redacted]

Then the surveyor asked the WD if the resident had been intoxicated before at the facility and she stated "No." She added that according to the resident's [redacted] the resident had history of NJ EX Order. 264b1 and NJ EX Order. 264b1 [redacted]. Further, the WD explained that the resident resided in the same apartment with the [redacted] and that the resident had difficulty adjusting to the [redacted] decline in health.

On 3/28/23 at 10:20 a.m., the surveyor interviewed the Assistant Wellness Director (AWD) RN #3 regarding Resident #2. RN #3 stated that on [redacted] at approximately 8 a.m., she received report from LPN #2 that she [LPN #2] received report from LPN #1 that Resident #2 was "NJ EX Order. 264b1 [redacted] but was fine. RN #3 stated that she proceeded to read the daily report in the system and was concerned with the documentation for Resident #2. RN #3 stated that she immediately went to assess the resident which was at approximately 8:30 a.m., She stated that the resident was observed in a [redacted] BP was [redacted] and was unable to obtain the resident's

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NJ EX Order. 264b1, and in NJ EX Order. 264b1." She stated that she immediately called a code blue for assistance to transfer the resident to the ER.

At 10 a.m., the surveyor interviewed LPN #1 via telephone regarding Resident #2. LPN #1 stated that a code blue was called and was informed that her assistance was needed in the NJ EX Order. 264b1. LPN #1 explained that Resident #2 was in the NJ EX Order. 264b1 of the resident's NJ EX Order. 264b1 and NJ EX Order. 264b1 The LPN stated that the resident groaned and shoved the LPN's hand away when she rubbed the resident's NJ EX Ord for a response. LPN #2 stated that the resident attempted to NJ EX Order described as NJ EX Order. 264b1 when the resident was brought back into the apartment and was assisted into bed and personal care was provided to the resident.

LPN #1 continued that CM #2 checked on the resident at 3 a.m., and at 6:30 a.m., and she (LPN #1) stated that she took the resident's vital signs which included BP of NJ EX Order. 3 The surveyor inquired if she notified the physician and the RN of the resident's NJ EX Order. 3, or sent the resident to the ER for evaluation. LPN #1 confirmed that she did not notify the physician or the RN of the resident's NJ EX Order. 3 nor sent the resident to the ER for evaluation. She told the surveyor that she did not think there was an acute change, it was almost 7 a.m., the end of her shift and that she endorsed report to the on-coming 7:00 a.m. - 3:00 p.m. shift.

On 3/3/23 at 5:30 p.m., the WD documented that Resident #2 was admitted to the hospital with NJ EX Order. 264b1 and remained NJ EX Order. 264b1 on a NJ EX Order. 264b1.

On 3/4/23 at 1:15 p.m., an LPN documented that

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A 357	Continued From page 10 the resident expired at the hospital. On NJ EX Order. 2 the facility reported the event to the Department of Health (DOH). The "Response to questions" dated NJ EX Order. 2, written by the WD and faxed to the DOH revealed, "Resident's physician reached on 3/8 to determine official cause of death a NJ EX Order. 2 and NJ EX Order. 2 NJ EX Order. 2" Post survey, on 4/3/23, the surveyor reviewed the resident's hospital record dated NJ EX Order. 2 which revealed that while at the facility, "The resident was found in bed NJ EX Order. 264b1 this morning, surrounded NJ EX Order. 264b1. EMS [Emergency Medical Service] was called and ... [Resident] was NJ EX Order. 264b1..." In addition, the hospital record indicated that the resident was pronounced dead on NJ EX Order. 2 The facility failed to ensure Resident #2 was provided the appropriate medical interventions to address the resident's change in condition from 11 p.m., on NJ EX Order. 2 to 8:30 a.m., on NJ EX Order. 2 when Resident #2 was observed in the resident's NJ EX. 2 in the NJ EX Order. 264b1.	A 357		
A 749	8:36-7.3(a) Resident Assessments and Care Plans (a) The resident general service plan shall be reviewed and, if necessary, revised semi-annually, and more frequently as needed based upon the resident's response to the care provided and any changes in the resident's physical or cognitive status.	A 749		

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A 749	Continued From page 11 This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00162369 Based on interview and record review it was determined that the facility failed to revise and update the General Service Plan (GSP) with interventions to address the resident's psychosocial needs for 1 of 4 residents reviewed, Resident #2. The deficient practice was evidenced by the following: On 3/27/23 at 10:25 a.m., the surveyor reviewed Resident #2's closed medical record and according to the "Resident Information" the resident move-in date [redacted] with diagnoses which included NJ EX Order. 264b1 [redacted]. In addition, surveyor continued review of the record observed [redacted] consult dated [redacted] which indicated that the resident was evaluated via telehealth due to history of [redacted] and [redacted]. The [redacted] documented, "Moved in facility 1 week ago with ..[redacted]]. Overwhelmed with caring for ..[redacted]], worries about future... [redacted] at times" The [redacted] documented that the resident was prescribed [redacted] mg [milligrams] for NJ EX Order. 264b1. And in addition, to monitor NJ EX Order. 264b1, report changes to [redacted] and continue to engage in group/unit activities, "Case was discussed with team in collaboration." The [redacted] consult dated [redacted] revealed, "Reports NJ EX Order. 264b1." Reports [redacted] "everyday [redacted] reports get	A 749		

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NJ EX hours at night, reports NJ EX Order is interrupted when making sure ... NJ EX Order. 264b1 is okay." The NJ EX Order. 264b1 documented to continue to engage the resident in group/unit activities, monitor NJ EX Order. 264b1, and address NJ EX Order. 264b1 as they arise.

The NJ EX Order. 264b1 consult dated NJ EX Order. 26 indicated, "Reports NJ EX Order. 264b1." Reports periods of low mood-having a hard time adjusting to ALF [Assisted Living Facility] move. Reports NJ EX Order. 264b1 about NJ EX Order. 264b1 reports NJ EX Order is interrupted when making sure ... NJ EX Order. 264b1 is okay."

The NJ EX Order. 264b1 consult dated NJ EX Order. 264b1 revealed, "Reports NJ EX Order. 264b1 "there are days when NJ EX Order. 264b1 and other days NJ EX Order. 264b1."

The NJ EX Order. 264b1 consult dated NJ EX Order. 2 specified, "Reports enjoys walking "It's my meditation." Reports periods of NJ EX Order. 264b1. Reports periods of NJ EX Order. 264b1 Verbalized caring for ... NJ EX Order. 264b1 can at times be NJ EX Order. 264b for him/her."

The surveyor reviewed Resident #2's "Care Plan" (CP) dated NJ EX Order. 2 provided by the Wellness Director (WD) and there was no documented evidence that the resident's CP had been revised with interventions to address the resident's NJ EX Order. 264b1 after the resident was seen by the NJ EX Order. 264b1 on NJ EX Order. 264b1 and NJ EX Order. 2.

On 3/28/23 at 12:55 p.m., the surveyor interviewed the WD regarding Resident #2's CP following NJ EX Order. 264b1 consults. The WD acknowledged that the CP was not updated with interventions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80a005	A. BUILDING: _____ B. WING _____	C 03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING AT MOUNTAIN RIDGE	680 MOUNTAIN BOULEVARD WATCHUNG, NJ 07069

(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) COMPLETE DATE
A 779	8:36-7.5(c) Resident Assessments and Care Plans (c) The registered professional nurse shall be called at the onset of illness, injury or change in condition of any resident to arrange for assessment of the resident's nursing care needs or medical needs and for needed nursing care intervention or medical care. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00162369 Based on interview and record review it was determined that a Licensed Practical Nurse (LPN)failed to notify a Registered Professional Nurse (RN) of a resident's change in condition and need for the resident to be evaluated by a physician for 1 of 4 residents reviewed, Resident #2. This deficient practice was evidenced by the following: On 3/27/23 at 10:45 a.m., the surveyor reviewed Resident #2's closed medical record which revealed that the resident moved into the community on [redacted] and expired at the hospital on [redacted] with diagnoses which included [redacted] NJ EX Order. 264b1 The surveyor reviewed the "Nurses Notes" (NN) dated [redacted] at 6:45 a.m., written by LPN #1 which indicated, "Resident continue with sleeping	A 779		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80a005	A. BUILDING: _____ B. WING _____	C 03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING AT MOUNTAIN RIDGE	680 MOUNTAIN BOULEVARD WATCHUNG, NJ 07069

(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) COMPLETE DATE
A 779	Continued From page 14	A 779		

comfortably in bed with NJ EX Order. 264b1, V/s [vital sign] noted at 6:30 a.m., NJ EX Order. 264b1 NJ EX Order. 264b1

The NN dated 3/3/23 at 8:30 a.m., written by the Assistant Wellness Director (AWD) RN #3 documented that she received the resident in the resident's apartment in a NJ EX Order. 264b1 n in bed and that the resident's NJ EX Order. 264b1 appeared " NJ EX Order. 264b1 and NJ EX Order. 264b1." RN #3 documented that the resident's NJ EX Order. 264b1 was NJ EX Order. 264b1 and that she was unable to obtain the resident's NJ EX Order. 264b1 RN #3 documented that the resident was transferred to the emergency room for further evaluation.

On 3/28/23 at 10 a.m., the surveyor interviewed LPN #1 via telephone and inquired if the facility's RN was notified of the resident's change in condition. The LPN confirmed that she did not notify the RN and that she endorsed report to the next shift for follow up. She added that the resident's NJ EX Order. 264b1 was not labored, "... [Resident] was NJ EX Order. 264b1."

At 10:20 a.m., the surveyor interviewed RN #3 regarding her documentation on NJ EX Order. 264b1 at 8:30 a.m. The RN stated that she arrived to the facility and received a verbal report from LPN #2 who was scheduled on another unit. The RN stated that LPN #2 told her that she [LPN #2] received report that Resident #2 was NJ EX Order. 264b1 and NJ EX Order. 264b1 and was NJ EX Order. 264b1 RN #3 stated that she read the resident's report and was concerned and immediately went to assess the resident. RN #3 stated that the resident was in a NJ EX Order. 264b1 " and she immediately initiated a 911 call to transfer the resident to the Emergency Room (ER) for further evaluation. RN #3 confirmed that she was not notified of Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80a005	A. BUILDING: _____ B. WING _____	C 03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING AT MOUNTAIN RIDGE	680 MOUNTAIN BOULEVARD WATCHUNG, NJ 07069

(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) COMPLETE DATE
A 779	Continued From page 15 #2's condition prior to arriving to work the morning of NJ EX Order. 26	A 779		
	At 12:55 p.m., during continued interview with the Wellness Director (WD) she confirmed that she was not notified of Resident #2's NJ EX Order. 264b1 NJ EX Or s and NJ EX Order. 264b1 on NJ EX Order. 2 at 6:30 a.m.			
	The surveyor reviewed the policy and procedure titled, " Emergency Transfer of Residents to Acute Care Facility NJ" which revealed, "A. Residents presenting with an acute change in medical condition will be assessed by the Licensed Nurse to determine the chief complaint, duration of symptoms, vital signs and acute clinical assessment changes... B. The RN will be immediately notified to assess the resident and to determine the priority for emergency transportation..."			
	Refer to 4.1(a)(2)			
A 781	8:36-7.5(d) Resident Assessments and Care Plans	A 781		
	(d) The resident's physician or the physician's designee, that is, another physician or an advanced practice nurse or physician assistant, shall be notified by the licensed professional nurse of any significant changes in the resident's physical or cognitive/mental condition and any intervention by the physician shall be recorded.			
	This REQUIREMENT is not met as evidenced by:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80a005	A. BUILDING: _____ B. WING _____	C 03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING AT MOUNTAIN RIDGE	680 MOUNTAIN BOULEVARD WATCHUNG, NJ 07069

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A 781	Continued From page 16 Complaint #: NJ 00162369 Based on interview and record review it was determined that the facility failed to notify the physician of a resident's change in condition which resulted in the resident's transfer to the hospital for 1 of 4 residents reviewed, Resident #2. The deficient practice was evidenced by the following: On 3/27/23 at 10:45 a.m., the surveyor reviewed Resident #2's closed medical record and observed a late entry "Nurses Notes" (NN) dated, NJ EX Order. at 12:30 a.m., written by a Registered Nurse (RN) #1. RN #1 documented that she received a call from the outgoing Care Manager (CM) #1 that the resident's NJ EX was in the NJ EX Order. 264 area. RN #1 documented that she observed the resident NJ EX Order. 264b1 and was "greeted with a NJ EX Order. 264b1." In addition, RN #1 documented that the resident was NJ EX Order. 264b1 h tactile NJ EX Order. 264 Further, RN #1 revealed that she observed a bottle of NJ EX Order. 264b1 NJ EX Order. 264b1 in the bottle sitting between the resident's NJ EX Order. 264b1]." The RN documented that the resident was transferred into a wheelchair with the assistance of 4 staff members and transported back into the resident's apartment. RN #1 indicated that the resident showed, "NJ EX Order. 264b1 that could lead to NJ EX Order. 264b1" and that the NJ EX Order. was NJ EX Order. and the NJ EX Order. 264b1 was NJ EX Order. 264b1 On 3/3/23 at 6:45 a.m., a Licensed Practical Nurse (LPN) #1 documented that at 6:30 a.m., the resident continued sleeping and vital signs,	A 781		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80a005	A. BUILDING: _____ B. WING _____	C 03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING AT MOUNTAIN RIDGE	680 MOUNTAIN BOULEVARD WATCHUNG, NJ 07069

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A 781	Continued From page 17 NJ EX Order. 264b1." On the same date at 8:30 a.m., the Assistant Wellness Director (AWD) RN #3 documented that she received the resident in the resident's apartment in a supine position in bed and that the resident's respiration appeared "NJ EX Order. 264b1 and did not NJ EX Order. 264b1." In addition, RN #3 documented that the resident's BP was NJ EX Order. 264b1 and that she was unable to obtain the resident's NJ EX Order. 264b1 RN #3 documented that the resident was transferred to the emergency room for further evaluation. On 3/27/23 at 12:50 p.m., and on 3/28/23 at 10 a.m., the surveyor interviewed RN #1 and LPN #1 via telephone and inquired if the resident's physician was notified of above incident including the resident's change in condition. Both confirmed that they did not notify the physician. RN #1 stated that she endorsed report to LPN #1 (11-7 shift) who assisted with the resident's transfer into a wheelchair to the resident's apartment. RN #1 stated that she went home at approximately 12:30 a.m. Also, LPN #1 stated that she endorsed report to the next shift, "the resident's NJ EX Order. 264b1 and was sleeping comfortably." The facility failed to notify Resident #2's physician when the resident was observed in the resident's NJ EX Order. 264b1 and continued to show signs of change in NJ EX Order. 264b1 condition. Refer to 4.1(a)(2)	A 781		

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June 28, 2023

Ms. NJ EX Order. 264b1
Program Manager
New Jersey Department of Health
Health Facility Survey & Field Operations
PO Box 367
Trenton, NJ 08625-0367

RE: POC – Brandywine Living at Mountain Ridge
Identification: 80a005

Dear Ms. Johnson,

Please find enclosed the revised plan of correction for Brandywine Living at Mountain Ridge Complaint Survey conducted by Opunne Odulana, RN, BSN and Christopher Pecci, BA, RN on March 28, 2023.

As always, I appreciate the guidance the Department of Health provided during their visit on March 28, 2023. The submission of this plan of correction, as required by state regulation, represents our efforts to address and correct the issues raised in the Statement of Deficiencies and provide better services for our residents.

If you require any additional information; please do not hesitate to contact me.

Sincerely,

Marie Milano

Marie Milano, LNHA, CDAL, CDP
Executive Director

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Plan of Correction for Brandywine Living at Mountain Ridge – 80a005
680 Mountain Boulevard
Watchung, NJ 07069

A310 8:36-3.4(a)(1) Administration

1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
   Resident #2 no longer resides at the community, expired.

2) How the facility will identify other residents having the potential to be affected by the same deficient practice.
   All residents have the potential to be affected by the same deficient practice.

3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
   All staff in-services were completed by June 4, 2023, and all nurses are currently aware to follow the policy Emergency Transfer of Residents to Acute Care Facility NJ. The education provided by the Wellness Director included providing each staff member with a copy of the Brandywine policy titled Emergency Transfer of Residents to Acute Care Facility NJ. The education focused on how to evaluate a resident for acute change and determine the clinical need for transfer to an acute care facility. The Wellness Director provided specific examples of common reasons for geriatric residents to require hospitalization. All Wellness Nurses signed off signifying their understanding and acknowledged receipt of the policy. This policy will be reviewed ongoing during quarterly nursing meetings and upon hire for all new nurses.

4) How the facility will monitor it's corrective actions to ensure that the deficient practice is being corrected and will not recur, i. e. what program will be put into place to monitor the continued effectiveness of the systemic changes.
   By June 4, 2023 all in-services were completed and all nurses are currently aware to follow the policy Emergency Transfer of Residents to Acute Care Facility NJ. The facility will monitor its corrective actions by having the Executive Director or Designee review the quarterly nursing meeting minutes and attendance to ensure that the policy has been reviewed and that all nursing staff has an understanding of this policy. In addition the Executive Director or designee will review the orientation checklist for all newly hired nurses to ensure that the policy has been reviewed during orientation, and that all new staff understands the policy. The Executive Director or Designee will review their findings quarterly during the quality improvement committee.

Date of Completion June 4, 2023

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A357 8:36-4.1(a)(2) Resident Rights

1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
   Resident #2 no longer resides in the facility, expired.

2) How the facility will identify other residents having the potential to be affected by the same deficient practice.
   All residents have the potential to be affected by the deficient practice.

3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
   The Wellness Director provided education/in service to all Wellness Nurses on assessing residents for a change in status. In addition, all in services will include a copy of the Declaration of Resident Rights for Assisted Living Community with emphasis on the right to receive a level of care and services that addresses the resident's changing physical and psychological status. The education will also focus on how to evaluate a resident for acute change and determine the clinical need for transfer to an acute care facility for appropriate medical interventions to be provided. Subsequently, RN#1, RN#2 and LPN #1 received disciplinary action in accordance with Brandywine protocol. The Wellness Director or designee will read the twenty-four-hour communication logs daily to monitor the effectiveness of education given. They will sign off indicating that they have reviewed the communication log and that any change in a resident's status was addressed. In addition, this topic and resident rights will be addressed repeatedly during all quarterly nursing meetings and during orientation of new nurses.

4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected, and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.
   The Executive Director or designee will review the minutes and attendance from the quarterly nursing meetings and new nurses orientation checklist during the quarterly quality improvement meetings to ensure the ongoing reinforcement of this education for all new nurses and existing nurses.

Date of Completion June 4, 2023 and ongoing

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A749 8:36-7.3(a) Resident Assessments and Care Plans

1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
   Resident #2 no longer resides in the facility, expired.

2) How the facility will identify other residents having the potential to be affected by the same deficient practice.
   All residents have the potential to be affected by this deficient practice.

3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
   All residents identified as having a change in condition will have care plans revised with interventions to address their needs. This will be done semi-annually or as needed based on a change in status. Education was provided to the nurse-managers responsible for care plans regarding the need for semiannual and as-needed revision of care plans based on change in status. The Wellness Director and Assistant Wellness Director have completed an audit of all resident care plans to ensure that any change in condition has been captured.

4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.
   The Wellness Director or designee will review all assessments and care plans every six month and as-needed to ensure that care plans are updated to reflect any change in condition.

Date of Completion June 14, 2023 and ongoing

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A779 8:36-7.5(c) Resident Assessments and Care Plans

1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
Resident #2 no longer resides in the facility, expired.

2) How the facility will identify other residents having the potential to be affected by the same deficient practice.
All residents residing in the facility have the potential to be affected by this deficient practice.

3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
The Wellness Director provided education/training to all Wellness Nurses regarding the need for an RN to be immediately notified to assess a resident presenting with an acute change in medical condition. In addition, proper method of communication was also discussed indicating a phone call is necessary for an acute change. A text message is not sufficient. All Wellness Nurses signed off signifying their understanding. RN #1, RN#2 and LPN #1 received the appropriate disciplinary action following the reportable event. In addition, RN# 1 was later terminated for exhibiting a pattern of not properly notifying an RN for an acute change in resident status. This topic will be covered as part of all new nurse training and reinforced during all quarterly nursing meetings.

4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.
The Wellness Director or designee will monitor the 24 hour communication logs on a daily basis and sign off that they have been reviewed to ensure the RN has been called immediately for any change in condition. In addition, the Executive Director or designee will review all nursing meeting minutes and all new nurses orientation checklists during the quarterly quality improvement meeting to ensure that education is being provided on an ongoing basis regarding RN notification.

Date of Completion: June 4, 2023 and ongoing

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A781 8:36-7.5(d) Resident Assessments and Care Plans

1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
Resident #2 no longer resides in the facility, expired.

2) How the facility will identify other residents having the potential to be affected by the same deficient practice.
All residents have the potential to be affected by this deficient practice.

3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
The Wellness Director provided education/training to all Wellness Nurses regarding the need for physician notification when a resident is experiencing a change in mental or physical condition. Educational material has been posted in all three nurses' stations with detailed instructions and phone numbers of all resident primary physicians. All Wellness nurses signed off indicating their knowledge of the proper method of physician notification. In addition, RN#1, RN#2 and LPN#1 received disciplinary action in accordance with Brandywine protocol. The Wellness Director or designee will update all doctors' contacts information quarterly and as needed.

4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.
The Wellness Director or designee will monitor the 24 hour communication logs on a daily basis and sign off that they have been reviewed to ensure the physician has been notified for any change in condition. In addition, the Executive Director or designee will review all nurse meeting minutes and attendance along with the new nurse orientation checklist during the quarterly quality improvement meetings to ensure that ongoing education regarding proper notification of the MD is taking place as stated.

Date of Completion: June 4, 2023 and ongoing

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H5790 8:43E-13.4(d) Universal Transfer Form: Mandatory Use of Form

1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
   Resident #2, no longer resides at our community, expired.

2) How the facility will identify other residents having the potential to be affected by the same deficient practice.
   All residents have the potential to be affected by this deficient practice.

3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
   The Wellness Director has in-serviced all Wellness Nurses on the use of the electronic Universal Transfer Form. The electronic charting system used at the community has the option to complete the Universal Transfer form electronically. This enables the nurse to keep an electronic record of all copies without actually having to make a physical copy. All nursing staff members will have the ability to produce a copy of all prior universal transfer forms previously completed during resident transfer. These forms will be kept indefinitely as part of the resident's medical record. This in-service will be provided upon hire of new nurses and quarterly during nursing staff meetings.

4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.
   Wellness Director or designee will monitor the 24 hour communication log daily and review the chart of any resident who was transferred out of the facility to ensure a copy of the Universal Transfer Form is on record. In addition, Administrator or designee will review nursing meeting minutes and attendance during the quarterly quality improvement committee meeting to ensure this policy is being reviewed on a continual basis.

Date of Completion: June 22, 2023

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STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
80a005 Y1	A. Building B. Wing Y2	6/29/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING AT MOUNTAIN RIDGE	680 MOUNTAIN BOULEVARD WATCHUNG, NJ 07069

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 A0310	Correction	ID Prefix A0357	Correction	ID Prefix A0749	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(2)	Completed	Reg. # 8:36-7.3(a)	Completed
LSC	06/04/2023	LSC	06/04/2023	LSC	06/14/2023
ID Prefix A0779	Correction	ID Prefix A0781	Correction	ID Prefix	Correction
Reg. # 8:36-7.5(c)	Completed	Reg. # 8:36-7.5(d)	Completed	Reg. #	Completed
LSC	06/04/2023	LSC	06/04/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/28/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
80a005 Y1	A. Building B. Wing Y2	6/29/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING AT MOUNTAIN RIDGE	680 MOUNTAIN BOULEVARD WATCHUNG, NJ 07069

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 A0310	Correction	ID Prefix A0357	Correction	ID Prefix A0749	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(2)	Completed	Reg. # 8:36-7.3(a)	Completed
LSC	06/04/2023	LSC	06/04/2023	LSC	06/14/2023
ID Prefix A0779	Correction	ID Prefix A0781	Correction	ID Prefix	Correction
Reg. # 8:36-7.5(c)	Completed	Reg. # 8:36-7.5(d)	Completed	Reg. #	Completed
LSC	06/04/2023	LSC	06/04/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/28/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
80a005 (Y1)	(Y2)	6/29/2023 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING AT MOUNTAIN RIDGE	680 MOUNTAIN BOULEVARD WATCHUNG, NJ 07069

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 H5790 Reg. # 8:43E-13.4(d) LSC	Correction Completed 06/22/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
3/28/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
80a005 Y1	A. Building B. Wing Y2	6/29/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING AT MOUNTAIN RIDGE	680 MOUNTAIN BOULEVARD WATCHUNG, NJ 07069

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0310	Correction	ID Prefix A0357	Correction	ID Prefix A0749	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(2)	Completed	Reg. # 8:36-7.3(a)	Completed
LSC	06/04/2023	LSC	06/04/2023	LSC	06/14/2023
ID Prefix A0779	Correction	ID Prefix A0781	Correction	ID Prefix	Correction
Reg. # 8:36-7.5(c)	Completed	Reg. # 8:36-7.5(d)	Completed	Reg. #	Completed
LSC	06/04/2023	LSC	06/04/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/28/2023	☐ YES ☐ NO