STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315257	A. BUILDING **01** B. WING ___	**05/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR GROVE RESPIRATORY AND NURSING CENTER	**1420 SOUTH BLACK HORSE PIKE** **WILLIAMSTOWN, NJ 08094**

(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
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 05/09/2023 and 05/10/2023 and Cedar Grove Respiratory and Nursing Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Cedar Grove Respiratory and Nursing Center is a Single-story, Type II Protected building that was built in January 1988. The facility is divided into 12 smoke zones. The facility has one 400 KW Diesel emergency generator.	K 000		
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observations on 05/09//2023 and 05/10/2023 it was determined that the facility failed to ensure continuous illumination for 2 of 19 designated exit discharges was provided and arranged so that the failure of any single lighting unit did not result in an illumination level of lass than 0.2 ft-candle in any designated area in accordance with NFPA 101 Life Safety Code	K 281	K281 1. How corrective actions will be accomplished for those residents found to have been affected by the deficient practice. No residents have been affected by this	6/15/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 06/01/2023

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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K 281

Continued From page 1

(2021 edition) Sections 7.8.1.1, 7.8.1.2 and 7.8.1.4

This deficient practice was evidenced by the following:

On 05/09/2023 (day one of survey) during the survey entrance at approximately 08:37 AM, a request was made to the Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility.

A review of the facility provided lay-out identified the facility is a single-story building with nineteen (19) designated exit discharge (illuminated exit signs above doors) doors in the facility for Residents to use during an evacuation in the facility.

Starting at approximately 09:06 AM on 05/09/2023 and continued on 05/10/2023, in the presence of the facility's DOM, a tour of the facility was conducted.

During the two day building tour the surveyor observed the following,

On 05/09/2023,
1) At approximately 11:20 AM, the surveyor observed outside the designated exit discharge door next to Resident room [redacted], had a single light bulb fixture.

2) At approximately 11:34 AM, the surveyor observed outside the designated exit discharge door [redacted], had a single light bulb fixture.

The DOM confirmed the findings at the time of

K 281

practice.
An additional light fixture with continuous lighting was installed providing two illuminated lamps outside the designated exit discharge door next to resident room [redacted]
An additional light fixture with continuous lighting was installed providing two illuminated lamps outside the designated exit discharge door #[redacted]

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 the deficient practice will not recur.

The Maintenance Director, maintenance staff, and all other staff were in-serviced on the regulation that all means of egress are to be provided with continuous lighting with two lamps. All designated discharge doors were inspected by the Director Of Maintenance and found to have two illuminated lamps outside the door. A log called exit illumination was created to track compliance of two lamp illumination at all exits. The Director of Maintenance or designee will observe and log compliance monthly.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and

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K 281	Continued From page 2 observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 05/10/2023 at approximately 01:22 PM. N.J.A.C. 8:39 -31.2 (e) NFPA 101 2012 -19.2.8	K 281	will not recur. The Director of Maintenance will report compliance monthly to QAPI committee and quarterly to QA committee for six months. The Administrator will observe and monitor for compliance during daily rounds.	
K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility provided documentation on 05/09/2023 and 05/10/2023 in the presence of facility management, it was determined that the facility failed to: provide six (6) illuminated exit signs to clearly identify the exit access path to reach an exit discharge door. This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants.	K 293	K293 1. How corrective actions will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by this practice. Two continuously illuminated exit signs were installed in the small courtyard, one above each of the two designated exit access doors. The two designated exit access doors are clearly identified with the exit access route to reach an exit. Two continuously illuminated exit signs were installed in the large enclosed	6/15/23

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K 293

Continued From page 3

NFPA Life Safety Code 2012 7.10.5.2.1
Continuous Illumination.
Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2

Reference: New Jersey Uniform Construction Code 5:23:
International Building Code,
1. Section 1002 Definitions, Means of egress: "A continuous and unobstructed path of vertical and horizontal egress travel from any occupied portion of a building or structure to a public way. A means of egress consists of three separate and distinct parts, the exit access, the exit and exit discharge."

2. Section 1011, Exit signs: "1011.1 Where required. Exits and exit access doors shall be marked by an approved exit sign readily visible from any direction of egress travel. Access to exits shall be marked by readily visible exit signs in cases where the exit or the path of egress travel is not immediately visible to the occupants. Exit sign placement shall be such that no point in an exit access corridor is more than 100 feet or listed viewing distance for the sign, whichever is less, from the nearest visible exit sign."

On 05/09/2023 (day one of survey) during the survey entrance at approximately 08:37 AM, a request was made to the Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility.

K 293

outside courtyard, one above each of the two designated exit access doors. The two designated exit access doors are clearly identified with the exit access route to reach an exit.
Two continuously illuminated exit signs were installed near the subacute nursing station. The two illuminated exit signs clearly identify the exit access route to reach an exit.

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 practice.

3. What measures will be put into place, or systemic changes made to ensure the deficient practice will not recur.

The Maintenance Director, maintenance staff, and all other facility staff were in serviced on the regulation of exit and directional signage related to continuous illuminated lighting systems. The Director of Maintenance inspected all of the facilities other paths of egress and found all to have visible illuminated exit signs visible per regulation. A log called “egress illumination” was created to track compliance. The Director of Maintenance or designee will observe and log findings and compliance monthly.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and

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K 293	Continued From page 4 A review of the facility provided lay-out identified the facility is a single-story building with two enclosed (surrounded by the building) center courtyards. Starting at approximately 09:06 AM on 05/09/2023 and continued on 05/10/2023 in the presence of the facility's DOM a tour of the facility was conducted. Along the two (2) day tour, the surveyor observed six (6) locations that failed to have illuminated exit signs to clearly identify the exit access route to reach an exit in the following locations, On 05/09/2023: 1) At approximately 10:44 AM, the surveyor observed in the "Small" enclosed outside courtyard that the facility failed the have two (2) illuminated exit signs. One illuminated exit sign above each of the two (2) designated exit access doors that clearly identifies the exit access route to reach an exit. 2) At approximately 10:50 AM, the surveyor observed in the "Large" enclosed outside courtyard that the facility failed the have two (2) illuminated exit signs. One illuminated exit sign above each of the two (2) designated exit access doors that clearly identifies the exit access route to reach an exit. On 05/10/2023: 3) At approximately 10:46 AM, the surveyor observed in the [redacted] Nursing station area the facility failed to provide two illuminated exit signs that clearly identifies the exit access route to reach an exit.	K 293	will not recur. The Director of Maintenance will report compliance monthly to QAPI committee and quarterly to QA committee for six months. The Administrator will observe and monitor for compliance during daily rounds.	

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K 293	Continued From page 5 The DOM confirmed the findings at the time of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 05/10/2023 at approximately 01:22 PM. Fire Safety Hazard. NFPA Life Safety Code 101 2012 -7.7 NFPA 101:2012- 19.2 Means of Egress Requirements NJAC 8:39 -31.1 and 8:39 -31.1 (c) NFPA Life Safety Code 101 2012 -7.7	K 293		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		6/15/23

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K 324	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation on 05/09/2023, it was determined that the facility failed to maintain the range hood grease baffles in accordance with NFPA 101, 2012 Edition, section 19.3.2.5.1, 9.2.3 and NFPA 96, 2011 Edition. The evidence of this deficient practice includes the following, During the building tour on 05/09/2923 in the presence of the facility's Director of Maintenance (DOM) at approximately 09:40 AM an inspection inside the kitchen was performed. The surveyor observed two (2) grease baffle filters were missing metal pieces. This left an approximately 1" opening in each filter. This would allow fire and grease vapors to enter the range hoods exhaust system. The DOM confirmed the findings at the time of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 05/10/2023 at approximately 1:22 PM. NFPA 101, NFPA 96. NJAC 8:39 -31.2 (e).	K 324	K324 1. How corrective actions will be accomplished for those residents found to have been affected by the deficient practice. No residents have been affected by this practice. The two damaged grease baffles on top of the kitchen ranges were removed and were replaced with new sets of grease baffles ensuring full closure with no ability of fire or grease vapors to enter the range hoods exhaust system. 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 the deficient practice will not recur. The Maintenance Director, maintenance department, Food Service Director, and dietary department staff were in-serviced on requirements of ventilation control and fire protection of commercial cooking. All other baffles above the kitchen range	

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K 324	Continued From page 7	K 324	were inspected by the Director Of Maintenance and found to be functioning properly. A log called “baffle protection” was created to track compliance of proper function of baffles. The Food Service or designee will observe and log findings and compliance monthly. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Food Service Director will report compliance monthly to QAPI committee and quarterly to QA committee for six months. The Administrator will observe and monitor for compliance during daily rounds.	
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced	K 374		6/15/23

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K 374

Continued From page 8

by:
Based on observations and review of facility provided documentation on 05/09/2023 and 05/10/2023, it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection. This deficient practice was identified for 1 of 15 sets of corridor smoke barrier doors tested and was evidenced by the following:

Reference 1:
- 8.5.4.1, Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grills. The clearance under the bottom of a new door shall be a maximum of 3/4 of an inch.

On 05/09/2023 (day one of survey) during the survey entrance at approximately 08:37 AM, a request was made to the Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility.

A review of the facility provided lay-out identified the facility is a single-story building with twelve (12) smoke zones.

Along the two (2) day tour of the facility, the surveyor performed a closure test of seventeen (17) sets of double smoke doors in the corridors with the following results,

1) On 05/09/2023 at approximately 11:10 AM, during a closure test of the double smoke doors in the corridor next to Resident room [redacted] when the doors were release from the magnetic

K 374

K374
1. How corrective actions will be accomplished for those residents found to have been affected by the deficient practice.

No resident has been affected by this practice.
An astragal molding was installed on the corridor smoke door next to resident room [redacted]. When the smoke doors release and self-close into their frame, they leave no gap on the bottom edge ensuring no allowance of transfer of smoke, fire, or poisonous gases to pass from one compartment to another.

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 practice.

3. What measures will be put into place, or systemic changes made to ensure the deficient practice will not recur.

The Maintenance Director, maintenance staff, and all other facility staff were in serviced on the requirements of maintain proper smoke barriers. All facility corridor smoke doors were inspected by the Director of Maintenance and found to close without any gaps. A log called “smoke door barriers” was created to track the function of smoke doors. The Director of Maintenance or designee will

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K 374	Continued From page 9 hold open device and allowed to self close into their frame, the surveyor observed and measure a 1/2 inch wide by 8 inch high gap along the bottom meeting edge of the doors. This test was repeated two additional times with the same results. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. The DOM confirmed the finding at the time. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 05/10/2023 at approximately 1:22 PM. N.B. 8:39-31.1(c), 31.2(e)	K 374	observe and log findings and compliance monthly. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Director of Maintenance will report compliance monthly to QAPI committee and quarterly to QA committee for six months. The Administrator will observe and monitor compliance during daily rounds.	
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations on 05/09/2023 and 05/10/2023 in the presence of facility management, it was determined that the facility failed to ensure that the facility's ventilation systems were being properly maintained for 3 of	K 521	K521 1. How corrective actions will be accomplished for those residents found to have been affected by the deficient practice.	6/15/23

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K 521	Continued From page 10 10 Resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: On 05/09/2023 (day one of survey) during the survey entrance at approximately 08:37 AM, a request was made to the Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified that the facility is a single-story building with 103 Resident sleeping rooms and various common areas. Starting at approximately 09:06 AM on 05/09/2023 and continued on 05/10/2023 in the presence of the facility's DOM a tour of the facility was conducted. Along the two (2) day tour the surveyor inspected ten (10) Resident sleeping rooms bathroom exhaust systems. This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in 3 of 10 resident bathrooms in the following locations: On 05/09/2023, 1. At approximately 09:57 AM, inside Resident room # [redacted] bathroom, when tested the exhaust system did not function properly.	K 521	No residents have been noted to be affected by this practice. The facility HVAC vendor evaluated the exhaust system for this unit and noted that the motor needed to be replaced. A new motor was ordered and replaced on May 25, 2023. The exhaust system was tested and functioned properly. Resident bathrooms of room # [redacted], room # [redacted] room [redacted] were tested and are functioning properly. 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 practice. 3. What measures will be put into place, or systemic changes made to ensure the deficient practice will not recur. The Maintenance Director, maintenance staff, and all other staff have been in-serviced on the requirement of maintaining working ventilation and exhaust systems. All ventilation systems throughout the facility have been inspected by the Director of Maintenance and found to be functioning properly. The Director of Maintenance or designee will perform weekly inspections on [redacted] bathrooms numbers [redacted], and [redacted] weekly for three months and monthly thereafter. A log called bathroom ventilation system was created to for these rooms to log findings. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315257	A. BUILDING **01** B. WING ____	**05/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR GROVE RESPIRATORY AND NURSING CENTER	**1420 SOUTH BLACK HORSE PIKE** **WILLIAMSTOWN, NJ 08094**

(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
K 521	Continued From page 11 At that time, the surveyor informed the DOM that the exhaust system did not function properly. The DOM told the surveyor that he is aware that some of the bathroom exhaust systems are not working properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 2. At approximately 10:03 AM, inside Resident room # [REDACTED] bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 3. At approximately 10:41 AM, inside Resident room [REDACTED] bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. The DOM confirmed the findings at the time of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 05/10/2023 at approximately 1:22 PM. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521	Maintenance Director will perform monthly inspections on all ventilation systems throughout the building for six months. A log called ventilation systems has been created to log findings. To ensure that all facility ventilation systems throughout the facility are functioning properly the Director of Maintenance or designee and Administrator has incorporated visual observation and monitoring of ventilation systems on daily preventive rounds. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Director of Maintenance will report compliance monthly to QAPI committee and quarterly to QA committee for six months. The Administrator will observe and monitor compliance during daily rounds.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315257	A. Building 01 - MAIN BUILDING 01 B. Wing	7/6/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR GROVE RESPIRATORY AND NURSING CENTER	1420 SOUTH BLACK HORSE PIKE WILLIAMSTOWN, NJ 08094

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 Reg. # NFPA 101 LSC K0281	Correction Completed 06/15/2023	ID Prefix Reg. # NFPA 101 LSC K0293	Correction Completed 06/15/2023	ID Prefix Reg. # NFPA 101 LSC K0324	Correction Completed 06/15/2023
ID Prefix Reg. # NFPA 101 LSC K0374	Correction Completed 06/15/2023	ID Prefix Reg. # NFPA 101 LSC K0521	Correction Completed 06/15/2023	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

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 5/18/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			