STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315115	A. BUILDING **01** B. WING _____	**01/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC COAST REHAB & HEALTH	**485 RIVER AVE** **LAKEWOOD, NJ 08701**

(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
E 000	Initial Comments . An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 01/10/23. The facility was found to be in compliance with 42 CFR 483.73. .	E 000		
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 01/10/23 and was found not to be in compliance with requirements for participation in Medicare/Medicaid at 42 CFR 483.90 (A) Life Safety from fire and the 2012 edition of the National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), chapter 19 EXISTING health care occupancy. The facility is one story first occupied in 1960 and also has a walk out lower-level storage area. Residents are on the first floor. Various additions have occurred over the years including the front foyer area all of the same construction type. The facility has concrete flooring, concrete roofing, and block bearing walls. The facility is noted to be a type II (222) with complete sprinkler system and complete fire alarm system with smoke detection in all corridors and bedrooms. The facility has a 150 KW (kilowatt) diesel generator. The facility has eight smoke compartments. The facility has 127 occupied beds. .	K 000		
K 222	Egress Doors	K 222		4/5/23

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

Electronically Signed | 02/06/2023

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K 222 SS=F	Continued From page 1 CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be	K 222		

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K 222	Continued From page 2 permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: . Based on observations and interviews, the facility failed to ensure that exit doors were not equipped with a latch or lock that requires the use of a tool or key or special knowledge from the egress side for five exit doors due to the fire alarm configuration in accordance with NFPA 101 Life Safety Code (2012 edition) section 7.2.1.6.1. This deficient practice had the potential to affect 20 residents. Findings include: An observation of the exit door near bedroom 17 on 01/10/23 at 10:35 AM revealed the door would only open from the egress side using special	K 222	we are requesting a time-limited waiver with a estimated completion date of 03/31/2024 to protect the residents during the upgrades, the facility will be inspected daily to ensure all exits are free from obstruction and the job site is free from any hazardous and unsafe material. All systems will be checked monthly. All staff working in the affected area will receive additional in-service training on fire safety, prevention, and response. Director of Maintenance or designee will monitor monthly	

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K 222	Continued From page 3 knowledge or a key pad code or the fire alarm system activation. Each door also lacked any type of delay egress. An observation of the exit doors near the time clock area on 01/10/23 at 10:55 AM revealed the doors opened to a sidewalk and a locked gate that required special knowledge or a key pad code or the fire alarm system activation. Each door also lacked any type of delay egress. An observation of the exit door near bedroom 51 on 01/10/23 at 10:11 AM revealed the door would only open from the egress side using special knowledge or a key pad code or the fire alarm system activation. Each door also lacked any type of delay egress. An observation of the exit doors at the therapy area on 01/10/23 at 11:50 AM revealed the doors would only open from the egress side using special knowledge or a key pad code or the fire alarm system activation. Each door also lacked any type of delay egress. An observation of the front door on 01/10/23 at 3:30 PM revealed the first set of doors from the inside opened, however the second set of doors on the egress side required special knowledge of a key code to access or would also open with the activation of the fire alarm system. Each door also lacked any type of delay egress. Each observation revealed that the exit doors were located in areas that did not provide smoke detection in resident rooms that were connected to the fire alarm system to release the exit doors upon activation but rather had battery operated smoke detectors in these rooms. This condition	K 222	Director of Maintenance will bring Qapi to quarterly meetings to go over with the group UPDATED 4/4/23 Facility will install new fire panel and new smoke detectors in every area that will release the doors in smoke compartment upon activation of devices. New devices will enable facility to be compliant that doors will be connected to fire panel and will release upon activation. All staff are educated and familiar with keypad exit code. Doors will release upon activation of fire panel, and loss of power, and keypads. TASK: obtain architectural \engineering plans START DATE: March 5 2023 END DATE: May 31 2023 TASK: DCA approval START DATE: June 1 2023 END DATE: August 31 2023 TASK: Local approval START DATE: September 1 2023 END DATE: October 15 2023 TASK: contractor bids START DATE October 16 2023 END DATE November 16 2023 TASK: Fire panel upgrade to be completed	

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K 222	Continued From page 4 does not meet the stipulations of NFPA 101:2012 Section 19.2.2.2. to permit these types of locks on exit discharge doors. An interview with the Maintenance Director at the time of each observation verified the condition of the doors noted above. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72 .	K 222		
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: . Based on a review of fire safety records and interview, the facility failed to complete a smoke detection sensitivity test for all 110 photo electric	K 341	K341 F No residents were identified as having a negative impact from this deficient practice.	2/28/23

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K 341	Continued From page 5 smoke detectors in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 edition) section 14.4.5.3.2. This deficient practice had the potential to affect all 127 residents. A review of fire safety records from the "Fire Alarm" folder in the Fire Safety Book revealed the most recent four fire alarm inspections or past two years on 03/09/22 and 09/30/22, 03/17/21 and 09/27/21 did not include a smoke detection sensitivity test. Requests were made to the contractor regarding the most recent smoke detection sensitivity test to be forwarded to the facility and was not completed. No smoke detection sensitivity test was provided. An interview with the Regional Consultant on 01/10/23 at 12:10 PM revealed he did not have a smoke detection sensitivity test for all 110 photo electric smoke detectors for the past two years. He also verified through the fire alarm contractor that the fire alarm system is not a self testing system. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72 .	K 341	The deficient practice had the potential to affect all residents residing at this facility. Smoke detection sensitivity tests were complete for the 110 photo electric smoke detectors identified in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 edition) section 14.4.5.3.2 by the facility□s contractor. The Director of Maintenance will request and maintain records of annual smoke detection sensitivity tests performed by the facility contractor to assure compliance. Any infractions will be rectified immediately. The Director of Maintenance will report the results of the smoke detection sensitivity tests completed and any corrective actions required to the Quality Assessment and Assurance (QAA) Committee for quarter 1 2023. The QAA Committee will determine the need for any additional monitoring of the smoke detectors in addition to routine monitoring at the quarter 1 2023 meeting.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.	K 345		2/28/23

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K 345	Continued From page 6 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: . Based on observations and interviews, the facility failed to ensure that five smoke detectors were greater than 36 inches from air supply diffusers in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 edition) section 29.8.3.4.(6). This deficient practice had the potential to affect all 127 residents. Findings include: An observation of a smoke detector in the corridor near bedroom 2 on 01/10/23 at 10:15 AM revealed the smoke detector was seven inches from a supply air diffuser. An observation of the smoke detector in the corridor near bedroom 11 on 01/10/23 at 10:30 AM revealed the smoke detector was 10 inches from a supply air diffuser. An observation of a smoke detector in the corridor near bedroom 60 on 01/10/23 at 11:10 AM revealed the smoke detector was 17 inches from a supply air diffuser. An observation of a smoke detector near the manor nursing station in the corridor on 01/10/23 at 11:15 AM revealed the smoke detector was 10 inches from a supply air diffuser. An observation of a smoke detector in the corridor near bedroom 64 on 01/10/23 at 11:15 AM revealed the smoke detector was nine inches from a supply air diffuser.	K 345	K345 F 1) The five smoke detectors identified less than 36 inches from air supply diffusers were relocated in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 edition) section 29.8.3.4.(6) to maintain compliance. 2) The Director of Maintenance conducted an audit to verify that all smoke detectors were greater than 36 inches from an air supply diffuser. No other smoke detectors were identified with this practice. No residents were identified as having a negative impact from this deficient practice. The deficient practice had the potential to affect all residents residing at this facility. 3) The Director of Maintenance will audit the smoke detectors once a month for 2 more months to ensure that they are greater than 36 inches from air supply diffusers, then semiannually thereafter; to ensure that there are no smoke detectors with this issue. Education was provided by the Maintenance Director to all members of the Maintenance team regarding the need for smoke detectors to be greater than 36 inches from air supply diffusers in accordance with NFPA 72 National Fire Alarm and Signaling Coe (2010 edition) section 29.8.3.4(6). 4) The Director of Maintenance will report the results of the smoke detection location audit and any corrective actions required to the Administrator and the audit will be presented at the Quality	

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K 345	Continued From page 7 An interview with the Maintenance Director and Regional Consultant at the time of each observation verified the measurements of the smoke detectors to the supply air diffusers. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72 .	K 345	Assessment and Assurance (QAA) Committee for the 1st Quarter of 2023. The QAA Committee will determine the need for any additional monitoring of the smoke detectors in addition to routine monitoring at the 1st Quarter2023 meeting.	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: . Based on observation and interview, the facility failed to ensure that sprinkler coverage was provided under a staircase landing in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (2010 edition) section	K 351	K351 E No residents were identified to have had any negative impact from this deficient practice. The deficient practice had the potential to affect all residents residing at this facility.	3/1/23

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K 351	Continued From page 8 8.15.3.2.1. This deficient practice had the potential to affect two residents in the therapy area. Findings include: An observation of the lower-level stairway landing used as an exit leading to a door accessing the therapy area on 01/10/23 at 11:50 AM revealed the landing was lacking sprinkler protection. The nearest sprinkler was located at the landing above the lower-level landing and did not cover the lower landing or under the lower landing staircase. An interview with the Regional Director at the time of the observation verified that no sprinkler was beneath the staircase leading to therapy. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25 .	K 351	An automatic fire sprinkler was installed in the area identified at the lower-level stairway landing used as an exit leading to the door accessing therapy. The Director of Maintenance will conduct monthly audits of the installed sprinkler system ensuring there is no dust and nothing blocking the sprinkler head. A quarterly, semi-annual, and annual inspection is conducted by the facility fire sprinkler vendor to ensure the function and maintenance of the automatic fire sprinkler system. The Director of Maintenance will report the results from the monthly audits at the next quarterly Quality Assessment and Assurance (QAA) Committee for quarter 1 2023 for follow-up and to determine if additional oversight of this area is required.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that	K 363		2/24/23

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K 363	Continued From page 9 do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: . Based on observations and interviews, the facility failed to ensure that three corridor doors did latch into the frames or had impediments to closing in accordance with NFPA 101 Life Safety Code (2012 edition) section 19.3.6.3.10. This deficient practice had the potential to affect 12 total residents in three smoke zones. Findings include: An observation on 01/10/23 at 10:10 AM revealed	K 363	K363 E No residents were identified to have had any negative impact from this deficient practice. The deficient practice had the potential to affect 12 residents residing at this facility. The hardware on the door to bedroom 9 was realigned by Maintenance and was able to catch the latch appropriately. The items in front of bedroom door 19 were removed and the hardware was realigned by Maintenance, so the hardware was able to catch the latch appropriately. The	

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K 363	Continued From page 10 that when closed, the door to bedroom 9 was stuck in the frame and did not have a means for keeping the door closed. An observation on 01/10/23 at 10:50 AM revealed that when closed, the door to bedroom 19 had an impediment to closing. An empty box and cabinet door would not permit the door to close. An observation on 01/10/23 at 11:00 AM revealed the door knob was very loose, allowing for the passage of smoke from bedroom 40 to the exit corridor. An interview with the Regional Director and Maintenance Director at the time of each observation verified the deficient practices with each door. NJAC 8:39-31.1(c), 31.2(e) .	K 363	doorknob on bedroom 40 was tightened to prevent the potential passage of smoke to the exit corridor. The Director of Maintenance/Designee provided education to facility staff on the importance of not blocking fire-rated doors with any items in the event of a fire/smoke emergency. The Director of Maintenance/Designee provided education to facility staff on the importance of ensuring that room doors will close and latch to properly confine fire and smoke products and to properly defend occupants in place in the event of an emergency. The Director of Maintenance will conduct monthly audits on the closing and latching of resident room doors to ensure that the corridor doors properly confine fire and smoke products and properly defend occupants in place per NFPA requirements. The Director of Maintenance will report the results from the monthly audits at the next quarterly Quality Assessment and Assurance (QAA) Committee for quarter 1 2023 for follow-up and to determine if additional oversight of this area is required. Date of compliance: February 24, 2023	
K 711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept	K 711		2/24/23

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ATLANTIC COAST REHAB & HEALTH	**485 RIVER AVE** **LAKEWOOD, NJ 08701**

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K 711	Continued From page 11 informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: . Based on a review of the facility's fire plan and interview, the facility failed to ensure that the fire plan referenced moving residents beyond the smoke compartment affected by fire to an unaffected smoke compartment in accordance with NFPA 101 Life Safety Code (2012 edition) section 19.7.2.2. This deficient practice had the potential to affect all 127 residents. Findings include: A review of the fire plan located in the "Disaster Manual" revealed the fire plan lacked reference to moving residents beyond the smoke compartment affected by fire to an unaffected smoke compartment. An interview with the Regional Director on 01/10/23 at 4:00 PM verified the plan did not address the above areas. NJAC 8:39-31.2(e) .	K 711	K711 F No residents were identified to have had any negative impact from this deficient practice. The deficient practice had the potential to affect all residents residing at this facility. The Administrator and Director of Maintenance updated the facility□s fire plan to include procedures for moving residents beyond the smoke compartment affected by fire to an unaffected smoke compartment in accordance with NFPA 101 Life Safety Code (2012 edition) section 19.7.2.2. The Director of Maintenance/Designee provided education to facility staff on the updated fire plan to include the basic response required by staff for moving residents beyond the smoke compartment affected by fire to an unaffected smoke compartment. The Director of Maintenance/Designee will conduct a survey of facility staff during monthly fire drills to ensure staff understand their responsibility to move residents beyond the smoke compartment affected by fire to an unaffected smoke compartment. Staff will receive	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315115	A. BUILDING **01** B. WING _____	**01/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 711	Continued From page 12	K 711	re-education as needed at the time of these surveys. The Director of Maintenance will report the results from the monthly fire drill surveys and any re-education of staff required at the next quarterly Quality Assessment and Assurance (QAA) Committee for quarter 1 2023 for follow-up and to determine if additional oversight of this area is required.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315115 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	4/14/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC COAST REHAB & HEALTH	485 RIVER AVE LAKEWOOD, NJ 08701

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0222	03/21/2023	LSC K0341	02/28/2023	LSC K0345	02/28/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	03/01/2023	LSC K0363	02/24/2023	LSC K0711	02/24/2023
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	
1/11/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO