STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315222	A. BUILDING _____ B. WING _____	C 05/23/2023

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BARNEGAT REHABILITATION AND NURSING CENTER	**859 WEST BAY AVE BARNEGAT, NJ 08005**

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F 000	INITIAL COMMENTS Complaint #: NJ00164050 Census: 93 Sample Size: 3 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary	F 657		6/7/23

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

Electronically Signed | 06/26/2023

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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F 657	Continued From page 1 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Complaint #NJ00164050 Based on interviews and review of the medical records (MRs) and other facility documentation on 5/17/23 and 5/23/23, it was determined that the facility failed to update and/or initiate care plan interventions timely for a resident who was at NJ Exec. Order 26:4.b.1 and was found NJ Exec. Order 26:4.b.1 The facility also failed to follow their policy for care plans. This deficient practice was identified for 1 of 3 sampled resident (Resident #2) reviewed for care plans. This deficiency is evidenced by the following: 1. According to the Admission Record, Resident #2 was admitted to the facility on Ex Order 26. 4B1 with diagnoses that included but were not limited to: *Ex Order 26. 4B1* . A Minimum Data Set (MDS), an assessment tool, dated Ex Order 26. 4B1, revealed the resident had a Brief Interview for Mental Status (BIMS) score of Ex Ord, which indicated *Ex Order 26. 4B1* and the resident did not require assistance with *Ex Order 26. 4B1* . The Order Summary Report (OSR) revealed a physician order (PO) initiated on Ex Order 26. 4B1 included that Resident #2 may go out with a responsible person. A Care Plan (CP), revised on NJ Exec. Order 26:4.b.1, included that Resident #2 had *Ex Order 26. 4B1* ,	F 657	F657 Care Plan timing and Revision 1. The corrective action for Resident #2 included the care plan being reviewed and revised immediately. Resident #2 is no longer a resident at the center. 2. Residents that have a diagnosis of *Ex Order 26. 4B1* have the potential to be affected. The center audited residents that have a diagnosis of *Ex Order 26. 4B1* and no other residents were affected. 3. Measures that were put into place included the Staff Educator/designee providing education to staff related to: a) the care plan process, review of the care plan, revisions, as well as the initiation of a new care plan focus; b) implementing interventions noted on the care plan; c) communication/notification of care plan updates. 4. Monitoring by the Director of Nursing/designee will capture Care plan audit for timing of the comprehensive care plan and revisions. These audits will be completed weekly on up to ten records for a period of four weeks, then twice monthly for one month, then monthly for one month. Results of the audits will be provided to the Administrator by the Director of Nursing and be presented for review at the monthly Quality Assurance	

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F 657	Continued From page 2 [redacted]. Interventions included but were not limited to: Notify the physician of [redacted], monitor and report to physician [redacted] and monitor for signs/symptoms of [redacted]. Review of the CP did not reveal CP interventions for Resident #2's [redacted] incident on [redacted]. Review of the nursing progress notes (NPN) revealed a "late entry" on [redacted] at 5:31 PM which indicated Resident #2 was noted with [redacted] and acknowledged he/she was [redacted]. Resident #2 was transferred to the hospital as ordered for evaluation during that time. Furthermore, the NPN revealed that Resident #2 was readmitted to the facility on [redacted] and the hospital discharge diagnoses were [redacted]. The facility's investigation report (IR), dated [redacted] included that Resident #2's family/representative (RP) called the facility on 5/7/23 at 3:30 PM to inform them Resident #2 could be [redacted]. The nurse (Licensed Practical Nurse [LPN] #1) found Resident #2 in Resident #1's room with an [redacted]. Resident #2 was noted with a [redacted] and the resident admitted he/she was [redacted]. The physician, attending for both residents, was notified. During that time, Resident #2 was transferred to the hospital for evaluation and returned to the facility on [redacted]. Both residents were referred to the [redacted]. The conclusion of the investigation indicated the facility was able to validate both residents [redacted]. However, the conclusion on how the [redacted] entered the facility remained pending because	F 657	Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

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F 657	Continued From page 3 the facility was waiting on the statements from the transportation driver who transported Resident #1 to a medical appointment on [redacted], prior to the incident. The facility's IR revealed no indication that CP interventions were initiated immediately/timely to address Resident #2's [redacted] and prevent reoccurrence of the incident. During an interview with the surveyor on 5/17/23 at 11:04 AM and 5/23/23 at 12:45 PM, the UM confirmed she was at the facility and was called to assist on [redacted]. She stated that depending on who was on duty, the UMs or nursing supervisors (NS) are responsible for completing an incident report, initiating an investigation and initiating/updating residents CP immediately when an incident/accident occur. The UM was unable to explain why Resident #2's CP was not updated after the incident. During an interview with the surveyor on 5/17/23 at 11:30 AM, the evening shift (3PM-11PM) NS (ENS) on 5/7/23 stated that she was unsure if the aforementioned incident required an incident report or investigation. She was unsure if Resident #2's CP was updated and stated that the UM was at the facility and assisted Resident #2. During an interview with the surveyor on 5/23/23 at 10:09 AM and 11:45 AM, the Director of Nursing (DON) stated that resident's CP initiation/revision required an interdisciplinary team decision. UMs and NSs are responsible for initiating an investigation, completing an incident report, and updating the resident's CP immediately after an incident/accident. The DON	F 657		

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F 657	Continued From page 4 confirmed that interventions should have been initiated immediately/timely after Resident #2 was found [redacted]. She added she immediately initiated Resident #2's CP upon realizing it was not done when it was discussed during the survey. During an interview with the surveyor on 5/23/23 at 9:15 AM, the Administrator stated that nurses are expected to ensure resident's safety. As per facility policy, they should notify the Physician and administration staff and initiate an investigation and interventions immediately after an incidents or accidents occur. Review of the facility's policy titled "Goals and Objectives Care Plans" revised 4/2009 revealed "Care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence. Policy Interpretation and Implementation: 1. Care plan goals and objectives are defined as the desired for a specific resident problem. 2. When goals and objectives are not achieved, the resident's clinical record will be documented as to why the results were not achieved and what the new goals and objectives have been established. Care plans will be modified accordingly....5 Goals and objectives are reviewed and/or revised: a. when there has been a significant change in the resident's condition, b. when the desire outcome has not been achieved...c. when the resident has been readmitted to the facility from a hospital...d.at least quarterly..." NJAC 8:39-11.1 NJAC 8:39-11.2 (i) (g)	F 657		

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F 689	Continued From page 5	F 689		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Complaint# NJ00164050 Based on interviews and review of medical records (MRs) and other pertinent facility documents on 5/17/23 and 5/23/23, it was determined the facility failed to consistently implement interventions and consistently follow their policy for accidents and incidents and changes in a resident's condition to ensure the safety of a resident who was NJ Exec. Order 26:4.b.1 and was repeatedly observed with signs of possible NJ Exec. Order 26:4.b.1. This deficient practice was identified for 1 of 3 sampled residents (Resident #1) reviewed for incidents and accidents. The deficient practice is evidenced by the following. 1. According to the Admission Record, Resident #1 was admitted to the facility on Ex Order 26. 4B1. The Physician progress notes (PNs) dated Ex Order 26. 4B1 revealed diagnoses which included but were not limited to: *Ex Order 26. 4B1* A Minimum Data Set (MDS), an assessment tool, dated Ex Order 26. 4B1, revealed that Resident #1 had a	F 689	F689 Free of Accidents/Hazards/Supervision/Devices 1. The corrective action for resident #1 included his physician being notified of prior intermittent episodes of where he may have been using alcohol. Resident #1 care plan was reviewed and revised. 2. The center reviewed resident records to identify others having the potential to be affected. A review of residents who have a diagnosis of *Ex Order 26. 4B1* have the potential to be affected. Residents were screened and no other residents were affected. 3. Measures that were put into place included the Staff Educator/designee providing education to staff related to: a) the care plan process, review of the care plan, revisions, as well as the initiation of a new care plan focus; b) reporting of incidents to direct Supervisors in which alcohol maybe involved for initiation of an investigation or evaluation in change in status; d) physician notification to be	6/7/23

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F 689	Continued From page 6 Brief Interview for Mental Status (BIMS) score of [redacted], which indicated Ex Order 26. 4B1, and the resident required supervision with Ex Order 26. 4B1 [redacted]. A review of an inactive care plan (CP) revised on 2/5/2019, closed on NJ Exec. Order 26:4.b.1, included that Resident #1 had a Ex Order 26. 4B1 [redacted]. Interventions included but were not limited to: Check belongings after each outing for [redacted] remove and report findings to the unit supervisor, if NJ Exec. Order 26:4.b.1 is identified, monitor closely for safety. A review of an active care plan (CP) dated Ex Order 26. 4B1 included that Resident #1 had Ex Order 26. 4B1 [redacted]. Interventions included but were not limited to: reviewed with the resident to avoid Ex Order 26. 4B1. The Order Summary Report (OSR) revealed a physician order (PO) initiated on Ex Order 26. 4B1 included that Resident #1 may go out with a responsible person. A. A review of nursing PNs (NPN) revealed that on Ex Order 26. 4B1, Resident #1 appeared NJ Exec. Order 26:4.b.1 with Ex Order 26. 4B1, and a strong NJ Exec. Order 26:4.b.1. A NJ Exec. Order 26:4.b.1 was found in the resident's room. The Physician was notified, medications were held as ordered and the resident was monitored. The facility's investigation dated Ex Order 26. 4B1 revealed Resident #1 had consumed NJ Exec. Order 26:4.b and was found with an NJ Exec. Order 26:4.b.1 in the room on Ex Order 26. 4B1. The nurse secured the NJ Exec. Order 26:4.b.1, and the physician was notified. The facility's conclusion on how the NJ Exec. Order 26:4 entered the facility remained pending because the facility was waiting on the statements from the transportation	F 689	completed when a change in status is observed; e) re-education provided related to the accident and incident documentation. Residents who have the potential to consume alcohol were provided re-education and literature regarding resources available. 4. Monitoring by the Director of Nursing/designee will be captured through auditing (ten records will be reviewed weekly for four weeks, then twice monthly for one month, then monthly for one month). Records will be reviewed related to documentation of a change in status including an accident or incident, notification to the physician, and the documented review of the care plan. Results of the audits will be provided to the Administrator by the Director of Nursing and be presented for review at the monthly Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

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driver who transported Resident #1 to a medical appointment on [redacted], prior to the incident.

A CP initiated on [redacted] included that Resident #1 had a *Ex Order 26. 4B1* [redacted] and still likes to [redacted]. Interventions included but were not limited to: the resident had been educated that [redacted] is against facility policy and could cause negative consequences, the resident was educated about the negative effects of [redacted] and NJ Exec. Order 26:4.b.1, staff would monitor possible engaging in [redacted] and changes in [redacted] and would observe the resident's room for [redacted] when appeared to be [redacted]

B. A review of a reportable event record (RER) sent to the New Jersey Department of Health (NJ DOH) on *Ex Order 26. 4B1* [redacted] revealed that on [redacted] at 9:30 PM, Resident #1 [redacted] the roommate (Resident #3) on the [redacted] after a verbal argument. During that time, Resident #1 was transferred to the hospital due to [redacted]. The CP was updated which included that Resident #1 did not like to share the room. Interventions included but were not limited to: the resident would learn to be considerate of having a roommate, and social service would discuss appropriate roommate with the resident.

Review of the NPN dated [redacted] revealed Resident #1 *Ex Order 26. 4B1* [redacted], Resident #3, on the [redacted] after a verbal altercation. The residents room NJ Exec. Order 26:4.b.1 [redacted]. Resident #1 was observed with *Ex Order 26. 4B1* [redacted], *Ex Order 26. 4B1* [redacted], [redacted], appeared to be [redacted] and later became *Ex Order 26. 4B1* [redacted]

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F 689	Continued From page 8 so the [Ex Order 26. 4B] was called. The physician was notified, and the resident was transported to the [Ex Order 26. 4B1]. On [Ex Order 26. 4B], Resident #1 returned to the facility on every 15 minutes check until [Ex Order 26. 4B1]. Review of the physician PNs dated [Ex Order 26. 4B1] revealed that the Physician examined Resident #1 following readmission from the hospital secondary to an altercation on [Ex Order 26. 4B]. The physician documented that Resident #1 was found [NJ Exec. Order 26:4.b.1] with multiple [NJ Exec. Order 26:4.b.1] in the room. The RER sent to the NJDOH on [Ex Order 26. 4B] did not indicate that Resident #1 was found [Ex Order 26. 4B1], and review of the updated CP did not include interventions to prevent reoccurrence of the incident. C. Further review of NPN revealed on [Ex Order 26. 4B] at 5:47 PM, Resident #1 was observed [Ex Order 26. 4B1] [redacted], eyes were [NJ Exec. Order 26:4.b.1] [redacted], and [NJ Exec. Order 26:4.b.1] towards staff. On [Ex Order 26. 4B] at 1:07 PM, Resident #1 was again noted with [Ex Order 26. 4B1], [NJ Exec. Order 26:4.b.1] and [NJ Exec. Order 26:4.b.1] [redacted] The administration staff was notified. The nurse practitioner ordered to transfer Resident #1 to the hospital. However, the resident refused and was placed on every 30 minutes monitoring. D. The NPN dated [Ex Order 26. 4B1] at 10:58 PM indicated that Resident #1 was observed with [Ex Order 26. 4B1] [redacted] and [NJ Exec. Order 26:4.b.1], [NJ Exec. Order 26:4.b] [redacted] E. The NPN dated [Ex Order 26. 4B] at 10:56 PM indicated that Resident #1 was noted with uncoordinated movements, [Ex Order 26. 4B1], [NJ Exec. Order 26:4.b.1] pupils, and a strong [NJ Exec. Order 26:4.b.1].	F 689		

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F. The NPN dated [redacted] at 9:56 PM indicated that Resident #1 was observed loud with [redacted].

There was no indication in the NPN that the nurses notified the nursing supervisor or the Physician on [redacted], and [redacted] of Resident #1's changes in condition. Additionally, there was no indication that a Registered Nurse (RN) assessed Resident #1 or incident reports were initiated.

During an interview with the surveyor on 5/17/23 at 10:05 AM, Resident #1 stated he did not [redacted] or provide Resident #2 with [redacted]. Resident #1 refused further interview with the surveyor.

During a telephone interview with the surveyor on 5/23/23 at 1:47 PM, LPN #3 stated she observed "something was off" with Resident #1 on [redacted]. She confirmed she did not notify the Physician or the night shift (11PM-7AM) nursing supervisor (NNS) of the resident's changes in condition. Additionally, she confirmed she did not initiate an incident report and a Registered Nurse (RN) did not assess the resident.

During an interview with the surveyor on 5/23/23 at 6:57 PM, LPN #2 stated on [redacted], a Certified Nursing Assistant (CNA) (unable to recall), reported that Resident #1 was [redacted] and could be [redacted]. LPN #2 explained she could not assess the resident due to [redacted] and [redacted]. Furthermore, LPN #2 confirmed the resident was acting loud and had another episode of [redacted] on [redacted]. She stated that the abovementioned [redacted]

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were unusual for the resident. However, LPN #2 was unable to explain why the evening shift (3PM-11PM) NS (ENS) or the physician was not notified of the aforementioned incidents. Additionally, LPN #2 confirmed a RN did not assess the resident and the resident's room was not inspected for [redacted].

During a telephone interview with the surveyor on 5/23/23 at 2:05 PM, the NNS was unable to recall if LPN #2 or LPN #3 notified her of the incidents on the aforementioned dates and stated she would have documented in the NPN if she was made aware.

During a telephone interview with the surveyor on 5/23/23 at 2:14 PM, the ENS stated that an incident report or investigation would have been completed if LPN #2 or LPN #3 had reported the incidents to her.

During an interview with the surveyor on 5/23/23 at 12:45 PM, the LPN/unit manager (LPN/UM) for Resident #1 stated that Resident #1 was not escorted by facility staff to any scheduled medical appointments prior to the incident on [redacted] because a driver accompanied the resident. However, the resident must be accompanied by a family member or responsible person when going out other than scheduled appointments. Furthermore, the LPN/UM confirmed that nurses must notify her or the nursing supervisor and the physician of incidents or changes in the resident's condition. She added there would have been documentation in the MRs if the aforementioned incidents had been reported to her.

During an interview with the surveyor on 5/23/23 at 2:30 PM, Resident #1's Physician stated that

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 11 Resident #1 had a long a [redacted] and had [redacted], but it remained unclear how the [redacted] entered the facility. The Physician explained that Resident #1 must not be left unattended and must be escorted by facility staff for any outside appointments to limit the opportunity of him/her obtaining [redacted]. However, he was unaware the resident was not escorted by a facility staff to any of his/her outside appointments. Furthermore, the Physician stated he expects nurses to notify him if Resident #1 is observed with symptoms of [redacted] or for changes in status. During an interview with the surveyor on 5/23/23 at 10:09 AM and 11:45 AM, the Director of Nursing (DON) stated that nurses are expected to notify the supervisor and the physician for incidents and changes in residents' condition. She agreed that the aforementioned incidents should have been investigated and reported to the nursing supervisor and the physician. Furthermore, the DON explained she completed the RER on [redacted] and Resident #1's [redacted] was not included because she was not initially informed about it. There was no indication the DON sent a follow-up addendum to include how the [redacted] was obtained. Additionally, she could not explain why the resident's CP which was updated on [redacted] did not include interventions to ensure the incident would not reoccur but stated she thought the interdisciplinary team had done it. The DON confirmed that Resident #1 was not provided a facility staff escort to any of his/her scheduled appointments prior to the recent incident on [redacted] due to the pandemic staffing needs. During an interview with the surveyor on 5/23/23	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315222	A. BUILDING _____ B. WING _____	C 05/23/2023

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F 689	Continued From page 12 at 9:15 AM, the Administrator stated that nurses are expected to ensure resident's safety. As per facility policy, they should notify the Physician and administration staff and initiate an investigation and interventions immediately after an incidents or accidents occur. Review of the facility's policy titled "Accidents and Incidents-Investigating and Reporting" revised on 7/2017 revealed that "All accidents or incidents involving residents, employees, visitors...occurring on premises shall be investigated and reported to the Administrator. Policy Interpretation and Implementation: 1. The nurse supervisor/charge nurse and/or the department director or supervisor shall promptly initiate and document the investigation...2. The following data shall be included on the report of incident/accident form: a. date and time...c. the circumstances...g. the time the injured person's attending physician was notified...k. any corrective action...n. signature and title of the person completing the report...5. The nurse supervisor/charge nurse and/or the department director or supervisor shall complete a report...submit the original to the Director of Nursing Services within 24 hours...7. Incident/Accident report will be reviewed by the safety committee for trends related to accident or safety hazards in the facility and to analyze any individual vulnerabilities..." Review of the facility's policy titled "Change in a Resident's Condition or Status" revised 2/2021 revealed "Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status...Policy Interpretation and Implementation:	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 13 1. The nurse will notify the resident's attending physician or physician on call when there has been a(an): a. incident or accident involving the resident...d. significant change in the resident's physical/emotional/mental condition..." Review of the facility's policy titled "Goals and Objectives Care Plans" revised 4/2009 revealed "Care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence. Policy Interpretation and Implementation: 1. Care plan goals and objectives are defined as the desired for a specific resident problem. 2. When goals and objectives are not achieved, the resident's clinical record will be documented as to why the results were not achieved and what the new goals and objectives have been established. Care plans will be modified accordingly....5 Goals and objectives are reviewed and/or revised: a. when there has been a significant change in the resident's condition, b. when the desire outcome has not been achieved...c. when the resident has been readmitted to the facility from a hospital...d.at least quarterly..." NJAC 8:39-27.1(a)	F 689		

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
315222 Y1	A. Building B. Wing Y2	6/28/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNEGAT REHABILITATION AND NURSING CENTER	859 WEST BAY AVE BARNEGAT, NJ 08005

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 F0657 Reg. # 483.21(b)(2)(i)-(iii) LSC	Correction Completed 06/07/2023	ID Prefix F0689 Reg. # 483.25(d)(1)(2) LSC	Correction Completed 06/07/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
5/23/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO