	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		E SURVEY IPLETED
		062103	B. WING		/24/2021
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY,	STATE, ZIP CODE	24/2021
FOREST	MANOR HCC	145 STAT HOPE, N	E PARK RO J 07844	AD	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
S 000	Initial Comments		S 000		
	WITH THE STAND ADMINISTRATIVE STANDARDS FOR TERM CARE FACI SUBMIT A PLAN C INCLUDING A COI DEFICIENCY AND IS IMPLEMENTED DEFICIENCIES MA ENFORCEMENT A WITH THE PROVIS JERSEY ADMINIS	MPLETION DATE, FOR EACH ENSURE THAT THE PLAN D. FAILURE TO CORRECT AY RESULT IN ACTION IN ACCORDANCE SIONS OF THE NEW TRATIVE CODE, TITLE 8, NFORCEMENT OF			
S 560	(a) The facility shal	tory Access to Care Il comply with applicable I local laws, rules, and	S 560		10/1/21
	by: Based on observat pertinent facility do determined the fac required minimum ratios as mandated This deficient pract following: Reference: NJ Stat 112. An Act concer	NT is not met as evidenced tion, interview, and review of cumentation, it was ility failed to maintain the direct care staff-to-resident d by the state of New Jersey. tice was evidenced by the te requirement, CHAPTER ning staffing requirements for d supplementing Title 30 of the		<ol> <li>The facility is monitoring acuity and nursing staffing hours and CNA ratios daily. Nursing overtime shifts, bonus shifts, and per diem shifts are being utilized when needed to maintain the required hours and ratios. The facility continues to aggressively to recruit, hire and retain nursing staff.</li> <li>The facility recognizes that all resident have the potential to be affected by this deficient practice. The facility will track</li> </ol>	5

Electronically Signed

6899

If continuation sheet 1 of 11

	Sey Department of H IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	
		062103	B. WING		08/2	4/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
OREST	MANOR HCC	145 STAT HOPE, N	E PARK RO J 07844	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
S 560	Continued From pa	ge 1	S 560			
	Be It Enacted by Assembly of the Sta	/ the Senate and General ate of New Jersey:		and log all the results of th recruitment and retention of		
	nursing homes effe 1. a. Notwithsta requirements as ma every nursing home P.L.1976, c.120 (C. to P.L.1971, c.136	m staffing requirements for ctive 2/1/21. nding any other staffing ay be established by law, as defined in section 2 of .30:13-2) or licensed pursuant (C.26:2H-1 et seq.) shall ng minimum direct care staff		<ul> <li>3) Staffing Coordinator job was reviewed and revised Staffing Performance Im Project team has been est will meet weekly to review patterns, Staffing per patie nursing assistant ratios, re retention efforts.</li> <li>4) The results of the Performance Internation</li> </ul>	provement ablished and current staffing ent day Certified cruitment and	
	residents for the da (2) one direct of residents for the ev fewer than half of a certified nurse aide shall be signed in to aide and shall perfor and (3) one direct of residents for the nig direct care staff me	d nurse aide to every eight y shift; are staff member to every 10 ening shift, provided that no II staff members shall be s, and each staff member o work as a certified nurse orm certified nurse aide duties; are staff member to every 14 ght shift, provided that each mber shall sign in to work as de and perform certified nurse		Improvement Projects will the quarterly Quality Assur Performance Improvemen ensure compliance and to trends or patterns requiring corrective actions.	be reviewed at rance t meeting to identify any	
	the nursing home, the exempt from any in ratios for a period of the date of the expansion of the computation	nsion of resident census by the nursing home shall be crease in direct care staffing of nine consecutive shifts from ansion of the resident census. tion of minimum direct care be carried to the hundredth				
	place. (2) If the applic	ation of the ratios listed in s section results in other than				

STATEMEN	rsey Department of H NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		062103	B. WING		08/	24/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
FOREST	MANOR HCC	145 STAT HOPE, N	E PARK ROA J 07844	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC <sup>1</sup>	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
S 560	a whole number of certified nurse aide required direct care rounded to the next the resulting ratio, of is fifty-one hundred (3) All computa midnight census for begins. d. Nothing in this s affect any minimum nursing homes as r Commissioner of H care staff, including restrict the ability of staffing levels, at ar established minimu On 08/13/21, 08/16/ 08/19/21, 08/20/21, observed six to eigl (CNA)'s or Nursing throughout the facil the resident's who n Review of the, "Ney Health Long Term O Program NURSE S week of July 25th, 2 week of July 25th, 2 we	direct care staff, including s, for a shift, the number of e staff members shall be t higher whole number when carried to the hundredth place, ths or higher. ations shall be based on the r the day in which the shift section shall be construed to n staffing requirements for may be required by the lealth for staff other than direct g certified nurse aides, or to f a nursing home to increase my time, beyond the				

STATEMEN	Sey Department of H IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		062103	B. WING		08/	24/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S <sup>-</sup>	TATE, ZIP CODE		
OREST	MANOR HCC	145 STAT HOPE, N	E PARK ROA J 07844	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
S 560	7:00 AM - 3:00 PM 3:00 PM shift. Review of the, "New Health Long Term O Program NURSE S week of August 1st was not in complian requirements on Su Saturday 08/07/21 shifts. Review of the facilit Form revealed the On Friday 08/13/21 of residents who re 7:00 AM - 3:00 PM NAs on the schedu (equals) 11.4 3:00 PM - 11:00 PM NAs on the schedu 11:00 PM - 7:00 AM the schedule, 80/3 On Saturday, 08/14 81. 7:00 AM - 3:00 PM NAs on the schedu 3:00 PM - 11:00 PM NAs on the schedu 3:00 PM - 11:00 PM NAs on the schedu 3:00 PM - 11:00 PM NAs on the schedu 11:00 PM - 7:00 AM	shift and during the 3:00 PM - w Jersey Department of Care Assessment and Survey TAFFING REPORT" for the , 2021 revealed the facility nee with the daily staffing unday 08/01/21 through during the 7:00 AM - 3:00 PM ty's Nursing Daily Attendance following: , the facility census (number sided in the facility) was 80. shift, there were 7 CNAs or le, 80/ (divided by) 7 = A shift, there were 8 CNAs or le, 80/8 = 10 A shift, there were 3 CNAs on = 26.6 k/21 the facility census was shift there were 8 CNAs or le, 81/8 = 10.1 A shift there were 7 CNAs or le, 81/7 = 11.5 A shift there were 6 CNAs on = 13.5	S 560	DEFICIENC	ΣΥ)	
	7:00 AM - 3:00 PM NAs on the schedu	I shift there were 6 CNAs or				

STATEMEN	rsey Department of H NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		062103	B. WING		08/	24/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
FOREST	MANOR HCC	145 STAT HOPE, N	E PARK ROA J 07844	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S 560	11:00 PM - 7:00 AM the schedule, 81/4 On Monday, 08/16/ 7:00 AM - 3:00 PM the schedule, 80/8 3:00 PM -11:00 PM NAs on the schedu 11:00 PM - 7:00 AM the schedule, 80/4 On Tuesday, 08/17 7:00 AM - 3:00 PM NAs scheduled, 80/ 3:00 PM - 11:00 PM NAs scheduled, 80/ 11:00 PM - 7:00 AM schedules, 80/6 = 1 On Wednesday, 08 79. 7:00 AM - 3:00 PM scheduled, 79/6 = 7 3:00 PM - 11:00 PM NAs scheduled, 79/6 = 1 00 Thursday, 08/19 7:00 AM - 3:00 PM schedules, 79/5 = 1 On Thursday, 08/19 79. 7:00 AM - 3:00 PM NAs scheduled, 79/5 = 1 On Thursday, 08/19 79.	A shift there were 4 CNAs on = 20.25 21 the facility census was 80. shift there were 8 CNAs on = 10 shift there were 8 CNAs or le, 80/8 = 10 A shift there were 4 CNAs on = 20 /21 the facility census was 80. shift there were 8 CNAs or /8 = 10 A shift there were 8 CNAs or /8 = 10 A shift there were 8 CNAs or /8 = 10 A there were 6 CNAs 13.3 /18/21 the facility census was shift there were 6 CNAs 13.1 A shift there were 6 CNAs or /6 = 13.1 A there were 5 CNAs 15.8 10/21 the facility census was shift there were 7 CNAs or /7 = 11.2 A shift there were 5 CNAs				
		1 the facility census was 78. shift there were 6 CNAs or				

STATEMEN	sey Department of H IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```	CONSTRUCTION		E SURVEY PLETED
		062103	B. WING		08/	24/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, ST	TATE, ZIP CODE		
OREST	MANOR HCC	145 STAT HOPE, N	TE PARK ROA J  07844	D		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
S 560	NAs scheduled, 78, 11:00 PM - 7:00 AM schedules, 78/5 = 1 On Saturday, 08/21 83. 7:00 AM - 3:00 PM NAs scheduled, 83, 3:00 PM - 11:00 PM scheduled, 83/6 = 1 11:00 PM - 7:00 AM schedules, 83/7 = 1 On Sunday, 08/22/2 7:00 AM - 3:00 PM NAs scheduled, 83/6 = 1 11:00 PM - 7:00 AM schedules, 83/5 = 1 On Monday, 08/23/ 7:00 AM - 3:00 PM schedules, 83/5 = 1	76 = 13 1 shift there were 7 CNAs or 77 = 11.1 1 there were 5 CNAs 5.6 /21 the facility census was shift there were 6 CNAs or 75 = 16.6 1 shift there were 6 CNAs 1.8 21 the facility census was 83. shift there were 5 CNAs 1.8 21 the facility census was 83. shift there were 6 CNAs or 77 = 11.7 1 shift there were 6 CNAs 1.8 1 there were 5 CNAs 6.6 21 the facility census was 84. shift there were 6 CNAs 1.4 1 there were 6 CNAs 1.4 1 shift there were 6 CNAs	S 560			
	7:00 AM - 3:00 PM scheduled, 84/7 = 1 3:00 PM - 11:00 PM scheduled, 84/6 = 1	1 shift there were 6 CNAs  4 1 there were 6 CNAs				

STATEMEN	Sey Department of H NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		062103	B. WING		08/2	24/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	ATE, ZIP CODE		
FOREST	MANOR HCC	145 STATI HOPE, NJ	E PARK ROAI 07844	D		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETI DATE
S 560	On 08/13/21 at 10:3 interviewed the Lice on the 100 unit in th census on the 100 four CNAs working. CNAs had approxim their care assignme On 08/17/21 at 10:5 interviewed the LPN that the census on stated that there we working on the 7:00 indicated that the C -19 residents on the further stated that the could usually have scheduled, but the toward the lower nut the 3:00 PM - 1:00 three to four CNAs 11:00 PM - 7:00 AM to four CNAs working some staff quit so the agency and make r "they are tired." On 08/17/21 at 11:1 interviewed LPN 3 that she worked for work at the facility f she worked the 7:0 PM - 11:00 PM on the units. LPN 3 stated 200 unit there were when she worked by shifts. LPN 3 furthe	35 AM, the surveyor ensed Practical Nurse (LPN)1 ne facility who stated that the unit was 55 and there were . This indicated that the four nately 13 - 14 resident's on	S 560			

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		062103	B. WING		08/24/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
OREST	MANOR HCC	145 STAT HOPE, N	TE PARK ROAI J 07844	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
S 560	residents and there working on the day On 08/18/21 at 10: interviewed the Lice Manager (LPN/UM) that the census on residents and there working. This indica had 11 residents or LPN/UM further sta usually had 11 -12 during the 7:00 AM On 08/18/21 at 10: interviewed an aler his/her room who s to make her bed an to come in and see yet because she die CNAs weren't doing they would get to it resident stated that running around, nic busy. The surveyor he/she knew the CI stated that he/she of him/her and see that On 08/18/21 at 11:0 interviewed 7:00 AI unit who stated that 11 resident's on ear On 08/18/21 at 11:0	would be four to five CNAs and evening shifts. And evening shifts.				

	IT OF DEFICIENCIES OF CORRECTION	lealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		062103	B. WING		08/24	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
OREST	MANOR HCC	145 STAT HOPE, N	E PARK ROAI J 07844	D		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
S 560	facility and worked during the 7:00 AM PM - 11:00 PM shift usually had around assignment when s was, "a lot." CNA1 fr residents made it et assignment timely. she would take care the most care first, to be fed and had b she felt the resident from more staff becc lot of care. CNA1 ft open door policy wi Director of Nursing both of them that th possible to staff the On 08/19/21 at 11:2 interviewed CNA2 stated her care assignmen CNA2 further stated 3:00 PM - 11:00 PM 22 residents on her PM. At 7:00 PM and work and then from would have 11 -12 to assignment. On 08/19/21 at 11:0 interviewed the NA that she worked the would work from 3:0 PM - 11:00 PM shift	asis for a company) at the on both the 100 and 200 units - 3:00 PM shift and the 3:00 t. CNA1 stated that she 12 residents on her care he worked, which she felt further stated that knowing the asier for her to complete her She gave the example that e of the residents that needed like the residents that needed ehaviors. CNA1 stated that ts at the facility would benefit ause the residents required a orther stated that there was an th the Administration and the (DON) and she was told by ey were trying every means building. 23 AM, the surveyor working on the 200 unit who worked at the facility for four 1 that she had 11 residents on nt that day, but usually had 12. d that when she worked the 1 shift she would have up to care assignment until 7:00 other CNA would come in to 7:00 PM - 11:00 PM she residents on her care				

	Sey Department of H T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		062103	B. WING		08/24/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
FOREST	MANOR HCC	145 STATI HOPE, NJ	E PARK ROAI 07844	D		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S 560	currently four staff r the additional staff was not scheduled stated that she wou care assignment af stayed to help left. the staff would stay help feed the reside must work as a teat "thinks the staff and more staff." The NA management has n incentives in monet extra. The NA state offered money was a 12-hour shift. On 08/20/21 at 9:02 interviewed the Cer Assistant/Staffing O facility who stated t for the State of New per one CNA or NA shift, 10 residents p PM - 11:00 PM shiff CNA or NA on the 1 CNA/SC stated that country like setting, and the facility was made it even more adequate staffing. T that she worked wit companies to try ar residents. The CNA plan her schedule a agencies a month in staffing needs and	nembers working, but one of members that was working for a full shift. The NA further and have 18 residents on her ter that staff member who The NA stated that sometimes late and not get paid just to ents. The NA stated that we m to get the job done and, a residents would benefit from a further stated that the ot recently offered bonuses or ary form for staff to work d that the last time she was a \$25 dollar bonus to pick up	S 560	DEFICIENC		

STATE FORM

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		062103	B. WING		08/	24/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
OREST	MANOR HCC	145 STAT HOPE, N	TE PARK ROAI J  07844	D		
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S 560	obtain staffing for th stated, "I am trying building." On 08/24/21 at 9:50 Operations stated th everything that she Administrative staff facility. The Director surveyor with a det included lists of me hire and recruit mo Review of the docu Director of Operation Registered Nurse ( offering sign on both \$14/hourly with ber differentials for eve shifts, paid time off tuition reimburseme postings throughou offices, newspaper Documentation for indicated the facility	he building. The CNA/SC so hard, everyday to staff the 4 AM, the Director of that she has been doing could, along with the to recruit and hire staff for the or of Operations provided the ailed list of documents which thods the facility was doing to re staff. Immentation provided by the ons included CNA, LPN, and RN) recruitment plans such as nuses, starting full-time rate of hefits for CNAs, shift ning, night, and weekend for holiday and sick time, ent, refer a friend bonuses, job it social media, unemployment				

# STATE FORM: REVISIT REPORT

				DATE OF REVIS	SIT
IDENTIFICATION NUMBER	A. Building				
062103 <sub>Y1</sub>	B. Wing		Y2	11/12/2021	Y3
NAME OF FACILITY	•	STREET ADDRESS, CITY, STATE, ZIP CODE			
FOREST MANOR HCC		145 STATE PARK ROAD			
		HOPE, NJ 07844			

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	DATE	ITEM		DATE	ITEM		DATE
Y4	Y5	Y4		Y5	Y4		Y5
ID Prefix S0560	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC	10/01/2021	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		
ID Prefix Reg. # LSC	Correction Completed	ID Prefix _ Reg. # LSC		Correction	ID Prefix Reg. # LSC		Correction Completed
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	— Reg. #		Completed	Reg. #		Completed
LSC		LSC					Completed
REVIEWED BY	REVIEWED BY	DATE	SIGNATURE OF	SURVEYOR		DATE	
STATE AGENCY	(INITIALS)						
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE			DATE	
FOLLOWUP TO SURVEY COMPLETED ON 8/24/2021		CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?					