STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13A003	A. BUILDING: _____ B. WING _____	C 05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWOOD ESTATES ASSISTED LIVING RESIDENC	ONE APPLEWOOD DRIVE FREEHOLD, NJ 07728

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ00172127 CENSUS: 34 SAMPLE SIZE: 3 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 235	8:36-2.4(d) Licensure Procedures (d) Survey visits may be made to a facility at any time by authorized staff of the Department. Such visits may include, but not be limited to, the review of all facility documents and resident records and conferences with residents. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00172127 Based on observation, interview, review of	A 235		

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

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A 235	Continued From page 1	A 235		

medical records and pertinent facility documents, it was determined the facility failed to provide the surveyor with an incident report, witness statements, visual access to security footage, and other pertinent documents upon initial request for 1 of 3 residents reviewed, Resident #1. This deficient practice was evidenced by the following:

On NJ ex order 26.4b1 at 12:32 p.m., The New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by healthcare facilities to report incidents to the NJDOH, alleging on NJ ex order 26.4b1, two Certified Medication Aide (CMA) witnessed a staff member touching Resident #1's NJ ex order 26.4b1

On 4/12/2024 at 9:45 a.m., the surveyor requested the incident report, the incident summary, witness interviews, access to security footage and any additional documents related to the alleged incident of NJ ex order 26.4b1.

At 10:23 a.m., the Senior Director of Health Services (SDHS) provided an incident summary report on a blank sheet of paper and stated the incident is an ongoing NJ Ex Order 26.4(b)(1) and the Legal Department requested that the surveyor reach out to the local NJ Ex Order 26.4(b)(1) before allowing visual access to the security footage, incident report and interviews done with the facility staff. The SDHS further stated the facility would not provide access to the staff for interviews by the surveyor.

At 10:30 a.m., the Director of Facilities (DF) provided the surveyor with a printed timeline of the event taken from the facility security cameras.

At 10:40 a.m., the surveyor reviewed Resident

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A 235	Continued From page 2 #1's Medical Record (MR) which revealed the resident moved into the facility on NJ ex order 26.4b1 with diagnoses NJ ex order 26.4b1 [redacted] At 11:16 a.m., the surveyor reviewed the policy and procedure titled, "Employee or Volunteer Reporting of Abuse, " which states: 8. The Administrator and the RN Coordinator will ensure that the necessary documentation and investigation is completed which may include but not limited to: a. Incident Reports. b. Statements from the resident or other resident witnesses c. Statements from staff members, contracted individuals or volunteers including those who reported the alleged incident. d. Police investigation, if any e. Wellness record documentation f. Any other documentation as needed such as shift schedules. At 12:01 p.m., the surveyor spoke with the NJ Ex Order [redacted] who stated the surveyor would need to place a request with their Records Department for release of the NJ Ex Order 26.4(b)(1). At 12:29 p.m., the surveyor requested a formal incident report summary on company letterhead signed by the SDHS. The surveyor also read Assisted Living Regulation 8:36-2.4(d) to the SDHS and indicated the facility would be cited for non-compliance with this regulation if the requested documents and visual access to the security footage was not provided. At 1:33 p.m., the surveyor was allowed visual access to the incident report, staff statements,	A 235		

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A 235	Continued From page 3	A 235		

education in-service information; however, the request for copies of the documents was denied. The SDHS also provided the names and contact phone numbers for the staff involved in the alleged incident.

At 2:03 p.m., DF provided the surveyor with visual access to the security footage related to the alleged incident on NJ ex order 26.4b1

On 4/17/2024 at 9:30 a.m., the surveyor again requested copies of the incident report, witness statements and other pertinent documents as required by Assisted Living Regulation 8:36-2.4(d) .

At 11:22 a.m., access to the NJ Ex Order 26.4(Unit Communication Log (a book staff use to leave each other resident related information) was requested.

At 11:40 a.m., The surveyor was provided with copies of incident report, witness statements and other pertinent documents. The surveyor was also provided access to the NJ Ex Order 26.4(Unit Communication Log.

The surveyor was not granted full visual access to security footage and copies of the incident report, witness statements and other pertinent documents related to the alleged incident of NJ Ex Order 26.4(b)(1) involving Resident #1, upon initial request.

A revisit survey was conducted on 5/06/2024 to confirm the implementation of the Removal Plan and was found to be implemented. A review of Resident #1's MR revealed an updated care plan and a late entry in the Progress Notes regarding the alleged incident on NJ ex order 26.4b1. In addition,

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A 235	Continued From page 4 NJ Ex Or assessments and updated care plans were implemented for all memory care residents. The Employee or Volunteer Reporting of Abuse, Abuse, Exploitation and Misappropriation Prevent Program, and Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy and procedures were revised and staff were in-serviced, and attendance records were obtained.	A 235		
A 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights; This REQUIREMENT is not met as evidenced by: Complaint #: NJ00172127 Based on observation, interview, review of medical records and pertinent facility documents, it was determined that the facility failed to ensure the development of a policy and procedure which included physician notification and documentation	A 310		

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A 310	Continued From page 5	A 310		

of physician notification in the resident record after a report of alleged [NJ Ex Order 26.4(b)(1)]. In addition, the facility failed to ensure the posting of Resident Right in the facility for 1 out of 7 residents, Resident #1. This deficient practice was evidenced by the following:

On [NJ Ex Order 26.4(b)(1)] at 12:32 p.m., The New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by healthcare facilities to report incidents to the NJDOH, which alleging on [NJ ex order 26.4b1], two Certified Medication Aide (CMA) witnessed a staff member [NJ ex order 26.4b1] Resident #1's [NJ ex order 26.4b1] A further review of the FRE revealed the physician was notified of the alleged resident [NJ ex order 26.4b1] by the facility on [NJ ex order 26.4b1].

On 4/12/2024 at 10:40 a.m., the surveyor reviewed Resident #1's Medical Record (MR) which revealed the resident moved into the facility on [NJ ex order 26.4b1] with diagnoses which [NJ ex order 26.4b1]. A review of the resident's Progress Notes revealed no entries dated [NJ ex order 26.4b1]. A further review of the Progress Notes showed no references to physician notification related to the alleged resident [NJ ex order 26.4b1] on [NJ ex order 26.4b1].

On 4/17/2024 at 11:00 a.m., the surveyor toured the Assisted Living facility and was unable to locate a posting of Resident Rights.

At 2:00 p.m., the surveyor interviewed the Senior Director of Healthcare Services (SDHS) who stated she didn't think it was appropriate to call the physician at midnight, so she called him the next day on [NJ ex order 26.4b1]. The SDHS further stated Resident Rights was posted, but was removed for

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A 310	Continued From page 6 painting and needed to be put back up. A review of the policy and procedure titled, "Employee or Volunteer Reporting of Abuse," revealed no mention of physican notification as part of the procedure along with a timeframe the physician should be notified by in response to an allegation of resident abuse. A further review of the policy revealed: 8. The Administrator and the RN Coordinator will ensure that the necessary documentation and investigation is completed which may include but not limitied to: e. Wellness record documentation. A revisit survey was conducted on 5/06/2024 to confirm the implementation of the Removal Plan and was found to be implemented. A review of Resident #1's MR revealed an updated care plan and a late entry in the Progress Notes regarding the alleged incident on [redacted]. In addition, skin assessments and updated care plans were implemented for all memory care residents. The Employee or Volunteer Reporting of Abuse, Abuse, Exploitation and Misappropriation Prevent Program, and Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy and procedures were revised and staff were in-serviced, and attendance records were obtained.	A 310		
A 389	8:36-4.1(a)(16) Resident Rights (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights:	A 389		

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A 389	Continued From page 7 16. The right to be free from physical and mental abuse and/or neglect; This REQUIREMENT is not met as evidenced by: Complaint #: NJ00172127 Based on interview, medical record review, and review of other pertinent facility documents, it was determined that the facility failed to ensure each resident's right to be free from [NJ Ex Order 2] was enforced when 1 of 7 residents reviewed for [NJ Ex Order 2] experienced NJ Ex Order 26.4(b)(1), Resident #1. This deficient practice was evidenced by the following: On [NJ Ex Order 26.4(b)(1] at 12:32 p.m., The New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by healthcare facilities to report incidents to the NJDOH, which alleging on [NJ ex order 26.4b1], two Certified Medication Aide (CMA) witnessed a staff member [NJ ex order 26.4b1] Resident #1's NJ ex order 26.4b1 [redacted] At 10:23 a.m., the surveyor reviewed the facilities incident summary which stated, on [NJ ex order 26.4b1] at around 11:15 p.m., two CMA's and one Agency Licensed Practical Nurse claim to have witnessed a CMA [NJ ex order 26.4b1]" with Resident #1 through the NJ ex order 26.4b1 [redacted]. The summary further states the facility was unable to substantiate the allegation of [NJ ex order 26] [redacted] for the following reasons: the inability to properly view inside the resident's room from the	A 389		

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A 389	Continued From page 8	A 389		

exterior window due to low level of light given the time of day, the blinds drawn covering majority of the window, and varying inconsistent statements.

At 10:30 a.m., the surveyor reviewed the printed timeline of the alleged event taken from security footage which revealed the whereabouts of Resident #1 and the CMA. On NJ ex order 26.4b1: At 11:03 p.m., the CMA entered Resident #1's room. At 11:12 p.m., Resident #1 and the CMA exit Resident #1's room together and proceeded up the hallway towards the main area. Resident #1 is holding the CMA's hand, both take a seat in the Wellness Office. At 11:23 p.m., the RN Supervisor enters the Wellness Office to speak with the CMA.

At 10:40 a.m., the surveyor reviewed Resident #1's Medical Record (MR) which revealed the resident moved into the facility on NJ ex order 26.4b1 with diagnoses which include NJ ex order 26.4b1

At 12:01 p.m., the surveyor spoke with the US FOIA (B)(6) who confirmed they had been called to the facility regarding an incident on NJ ex order 26.4b1 and that the incident was under investigation.

At 3:04 p.m., the surveyor interviewed CNA #1, who stated at the end of my shift, while walking out to her car, she saw a light go on in Resident #1's room. The CNA further stated, "it was strange because everyone was good, and I put everyone to bed." The CNA stated she went up to the window and saw the CMA with NJ Ex Order 26.4(b)(1) Resident #1. The CNA further stated she ran back into the building and alerted the nursing supervisor.

At 3:54 p.m., the surveyor spoke with the RN

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A 389	Continued From page 9	A 389		

Supervisor who stated she received a call from LPN #2 regarding the Nj ex order 26.4b1. The RN Supervisor further stated she went down to the NJ Ex Order 26.4(Unit, saw the CMA with Resident #1 in the Wellness Office watching a music video, asked Resident #1 to Nj ex order 2, told the CMA of the complaint of abuse and asked the CMA to leave the facility. The RN Supervisor stated the CMA denied the NJ ex order 26.4b1, but Nj ex order 26.4b1r, and left the facility.

At 4:10 p.m., the surveyor interviewed CNA #2 who stated CNA #1 called her over to Resident #1's window and she saw the CMA NJ ex order 26.4b1 Resident #1's NJ ex order 2 as Resident #1 NJ ex order 26.4b1 CNA #2 further stated she called over LPN #1, who was also walking to her car, to come over and see.

On 4/15/2023 at 12:58 p.m., the surveyor spoke with the Licensed Practical Nurse (LPN #2) who stated she was the 3 p.m. to 11 p.m. nursing supervisor at the time of the alleged resident NJ ex order 2. LPN #2 further stated she was inside the facility doing the narcotics count with LPN #3 when CNA #1 and LPN #1 came into the building to tell her what they saw outside. LPN #2 stated she then notified the RN Supervisor. LPN #2 further stated since she had three people telling her what they saw she decided to call the RN supervisor first. LPN #2 also contacted the Senior Director of Healthcare Services to make her aware of the alleged NJ ex order 26

At 2:35 p.m., the surveyor interviewed the LPN #1 via phone who stated as she was leaving the facility on NJ ex order 26.4b1, when CNA #1 and CNA #2 called her over and indicated she needed to see something by an exterior window of the facility. The LPN further stated the blinds on the window

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were open approximately 4-6 inches and she had to knell down to see. The LPN stated she saw Resident #1 on the left and the CMA was on the right, Resident #1 Nj ex order 26.4b1 , Nj ex order 26.4b1 , and the CMA Nj ex order 26.4b1 . The LPN further stated, she thinks the CMA might have heard CNA #1 yelling outside because the CMA moved away from Resident #1 as if he was looking for something in the closet. The LPN also stated, Nj ex [redacted] The LPN further stated she took CNA #1 back inside the facility, Nj ex order 26.4b1 and notified LPN #2.

The surveyor reviewed the policy and procedure titled, "Resident Rights," which states Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: c. be free from abuse, neglect, misappropriation of property, and exploitation."

A revisit survey was conducted on 5/06/2024 to confirm the implementation of the Removal Plan and was found to be implemented. A review of Resident #1's MR revealed an updated care plan and a late entry in the Progress Notes regarding the alleged Nj ex order 26.4b on NJ ex order 26.4b1. In addition, Nj ex order 26.4b1 for all memory care residents. The Employee or Volunteer Reporting of Abuse, Abuse, Exploitation and Misappropriation Prevent Program, and Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy and procedures were revised and staff were in-serviced, and attendance records were obtained.

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A 615	Continued From page 11	A 615		
A 615	8:36-5.15(b) General Requirements (b) Notification of any occurrence noted in (a) above shall be documented in the resident's record. The documentation with regard to an occurrence noted in (a)4 above shall include confirmation and written documentation of that notification. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00172127 Based on interview and record review it was determined that the facility failed to immediately notify and maintain documented evidence that the Responsible Party (RP) was notified after the reported occurrence of Nj ex order 26.4b1 for 1 of 7 residents reviewed, Resident #1. This deficient practice was evidenced by the following: On NJ Ex Order 26.4(b)(1 at 12:32 p.m., The New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by healthcare facilities to report Nj ex order 26.4b1 to the NJDOH, which alleging on Nj ex order 26.4b1, two Certified Medication Aide (CMA) witnessed a NJ Ex Or [redacted] Resident #1's Nj ex order 26.4b1 [redacted] The FRE further revealed that Resident #1's RP was notified of the occurrence on Nj ex order 26.4b1 On 4/12/2024 at 10:40 a.m., the surveyor reviewed Resident #1's Medical Record (MR) which revealed the resident moved into the facility on Nj ex order 26.4b1 with diagnoses which included Nj ex order 26.4b1, and Nj ex order 26.4b1 A review of the resident's Progress Notes revealed no entries on Nj ex order 26.4b1 indicating	A 615		

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A 615	Continued From page 12 Resident #1's RP was notified of the alleged [NJ ex order 26] On 4/17/2024 at 2:00 p.m., the surveyor interviewed the Senior Director of Healthcare Services who stated she didn't think it was appropriate to call the RP at midnight, so she called him/her the next day on [NJ ex order 26.4b1]. A review of the policy and procedure titled, "Employee or Volunteer Reporting of Abuse," revealed: Procedures: The employee receiving the report of alleged abuse will immediately respond as indicated: 4. Any one of the 4 Key Individuals in coordination will conduct a preliminary investigation and notify the follows: b. the resident's family or responsible party. A revisit survey was conducted on 5/06/2024 to confirm the implementation of the [NJ ex order 26.4b1] and was found to be [NJ ex order 26.4b1]. A review of Resident #1's MR revealed an updated care plan and a late entry in the Progress Notes regarding the alleged incident on [NJ Ex Order 26.4(b)(1]. In addition, skin assessments and updated care plans were implemented for all memory care residents. The Employee or Volunteer Reporting of Abuse, Abuse, Exploitation and Misappropriation Prevent Program, and Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy and procedures were revised and staff were in-serviced, and attendance records were obtained.	A 615		
A 749	8:36-7.3(a) Resident Assessments and Care Plans (a) The resident general service plan shall be reviewed and, if necessary, revised	A 749		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13A003	A. BUILDING: _____ B. WING _____	C 05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWOOD ESTATES ASSISTED LIVING RESIDENC	ONE APPLEWOOD DRIVE FREEHOLD, NJ 07728

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 749	Continued From page 13	A 749		

semi-annually, and more frequently as needed based upon the resident's response to the care provided and any changes in the resident's physical or cognitive status.

This REQUIREMENT is not met as evidenced by:
Complaint #: NJ00172127

Based on staff interview, review of medical records and pertinent facility documents, it was determined that the facility failed to ensure that the resident's General Service Plan was updated to include NJ Ex Order 26.4(b)(1) and monitoring for any NJ Ex Order 26.4(or NJ Ex Order 26.4(b)(1) changes after an allegation incident of NJ Ex Order 26.4(b)(1) by a staff member was reported for 1 of 7 residents reviewed, Resident #1.

On NJ Ex Order 26.4(b)(1 at 12:32 p.m., The New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by healthcare facilities to report incidents to the NJDOH, which alleging on NJ ex order 26.4b1 two Certified Medication Aide (CMA) witnessed a NJ Ex Or NJ ex order 26.4b1 Resident #1' NJ ex order 26.4b1

On 4/12/2024 at 10:40 a.m., the surveyor reviewed Resident #1's Medical Record (MR) which revealed the resident moved into the facility on NJ ex order 26.4b1 with diagnoses which NJ ex order 26.4b1 . A review of the resident's Progress Notes revealed no entries on NJ ex order 26.4b1 . A further review of the Progress Notes revealed a late entry on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13A003	A. BUILDING: _____ B. WING _____	C 05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWOOD ESTATES ASSISTED LIVING RESIDENC	ONE APPLEWOOD DRIVE FREEHOLD, NJ 07728

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A 749	Continued From page 14	A 749		

NJ ex order 26.4b1 indicating the Director of Nursing (DON) and the Administrator met with Resident #1, who did not recall any incident that Nj ex order 2 him/her or made him/her Nj ex order 26.4b1 A review the residents Health Care Plan revealed no changes to the Health Care Plan were made after the alleged incident on NJ ex order 26.4b1

On 4/16/2024 at 8:27 a.m., the surveyor interviewed the DON via telephone who stated a NJ Ex Or assessment of Resident #1 was done by the RN Supervisor the night of the NJ ex order 26.4b1 . The DON further stated no changes were made to the care plan as a result of the incident.

A review of the policy and procedure titled, "Employee or Volunteer Reporting of Abuse," revealed 8. The Administrator and the RN Coordinator will ensure that the necessary documentation and investigation is completed which may include but not limited to: e. Wellness record documentation. A review of the policy and procedure titled, "General Service Plans" revealed: "General service plans (GSP) shall be reviewed and, if necessary, revised every six months, with readmissions and with significant changes in resident's condition.

A revisit survey was conducted on 5/06/2024 to confirm the implementation of the Removal Plan and was found to be implemented. A review of Resident #1's MR revealed an updated care plan and a late entry in the Progress Notes regarding the alleged incident on NJ ex order 26.4b1. In addition, skin assessments and updated care plans were implemented for all memory care residents. The Employee or Volunteer Reporting of Abuse, Abuse, Exploitation and Misappropriation Prevent Program, and Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13A003	A. BUILDING: _____ B. WING _____	C 05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWOOD ESTATES ASSISTED LIVING RESIDENC	ONE APPLEWOOD DRIVE FREEHOLD, NJ 07728

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 749	Continued From page 15 policy and procedures were revised and staff were in-serviced, and attendance records were obtained.	A 749		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
13A003 Y1	A. Building B. Wing Y2	5/30/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWOOD ESTATES ASSISTED LIVING RESIDENCE	ONE APPLEWOOD DRIVE FREEHOLD, NJ 07728

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0235	Correction	ID Prefix A0310	Correction	ID Prefix A0389	Correction
Reg. # 8:36-2.4(d)	Completed	Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(16)	Completed
LSC	04/17/2024	LSC	04/18/2024	LSC	04/17/2024
ID Prefix A0615	Correction	ID Prefix A0749	Correction	ID Prefix	Correction
Reg. # 8:36-5.15(b)	Completed	Reg. # 8:36-7.3(a)	Completed	Reg. #	Completed
LSC	04/26/2024	LSC	04/18/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
5/6/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO