STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315523	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	**537 MOUNTAIN AVENUE , NEW PROVIDENCE, New Jersey, 07974**

(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
F0000	INITIAL COMMENTS Complaint # 2690327 Census: 37 Sample Size:4 A complaint survey was conducted on 12/18/25 to determine compliance with 42 CFR Part 483 for Long Term Care facilities. During the survey, a finding which constituted Immediate Jeopardy (IJ) was identified under 42 CFR 483.45(f)(2) F760 as the facility failed to [NJ Exec Order] a resident (Resident #1) from significant medication error when on [NJ Exec Order] the Licensed Practical Nurse, LPN #1, administered [NJ Exec Order 26.4b1] to Resident #1 and administered [NJ Exec Order 26.4b1] to Resident #2. Resident #1 had a physician's order for [NJ Exec Order 26.4b1] every [NJ Exec Order 26.4b1] hours for their [NJ Exec Order 26.4b1] and Resident #2 had a physician order for [NJ Exec Order] -gram [NJ Exec Order 26.4b1] every [NJ Exec Order] hours for [NJ Exec Order 26.4b1] for their [NJ Exec Order 26.4b1] The [U.S. FOIA (b)(6)]) was notified immediately with orders to [NJ Exec Order] the residents [NJ Exec Order] Resident #1 was [NJ Exec Order 26.4b] and [NJ Exec Order 26.4b1] at lunchtime, face [NJ Exec Order] [NJ Exec Order 26.4b1]. [U.S. FO] was present and administered [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b1] to hospital [NJ Exec Order 26.4b1] by [NJ Exec Order 26.4b1] and was [NJ Exec Order 26.4] The Administration was notified of the F760 IJ and was provided with the IJ template on 12/18/25 at 6:00 PM. An acceptable Removal Plan (RP) was submitted by the facility on 12/19/25 at 6:21 PM indicating the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including: On [NJ Exec Order 26] LPN #1 was found to administer the [NJ Exec Order 26.4b1] medications to Resident #1 and Resident #2; [U.S. FO] was notified immediately and both residents were [NJ Exec Order 26.4b1]; [NJ Exec Order 26] at lunchtime, Resident	F0000		01/07/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315523	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/23/2025

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CONTINUING CARE AT LANTERN HILL	537 MOUNTAIN AVENUE , NEW PROVIDENCE, New Jersey, 07974

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F0000	Continued from page 1 #1 NJ Exec Order 26.4b1, face NJ Exec Order and NJ Exec Order 26.4b1 NJ Exec O... U.S. FOIA , at bedside and the resident was NJ Exec Order 26.4b1 to the NJ Exec Resident #2 had NJ Exec Order 26.4b1 NJ Exec Order 26.4 to the medication error; on NJ Exec Order 26 nurse medication administration observation checklist was completed and LPN #1 demonstrated competency immediately after medication error was found; LPN #1 was NJ Exec Order 26.4b1 on NJ Exec Order 26 and NJ Exec Order 26.4b1 on NJ Exec Order ; on 12/3/25, a 100% audit of all current residents that have physician order of NJ Exec Order 26.4b1 were reviewed by the U.S. FOIA (b)(6) U.S. FOIA (b)(6)) to validate the correct NJ Exec Order 26.4b1 orders and that NJ E medications were in the medication room; medication administration education began on 12/3/25 and NJ E competencies began for all nurses - all nursing staff must complete education and competencies before their next scheduled shift; all newly hired nurses will be educated on proper medication administration including return demonstration during orientation; on 12/4/25 a new process was created requiring two nurses to verify the correct NJ E medication before administering to residents, and random audits were being conducted monitoring nurses who were administering NJ Exe started on 12/4/25. The surveyor verified the implementation of the RP on-site on 12/23/25 and determined the immediacy was removed as of 12/19/25.	F0000		01/07/2026
F0760 SS = SQC-J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Complaint #2690327 Based on interviews and review of pertinent facility documents on 12/18/25, it was determined that the facility failed to NJ Exec Orde t a resident (Resident #1) from a significant medication error when the Licensed Practical Nurse, LPN #1, administered NJ Exec Order 26.4b1 NJ Exec Order 26.4b1] to Resident #1 and administered NJ Exec Order 26.4b1] to Resident #2. Resident #1 had a physician's order for NJ Exec Order 26.4b1 NJ Ex Ord NJ Exec Order 26.4b1 every NJ Exec Ord hours for their NJ Exec Order 26.4b1 and Resident #2 had a physician order for NJ Exec Orde NJ Ex Ord NJ Exec Order 26.4b1 every NJ Exec O hours for NJ Exec Order 26.4b1 for their NJ Exec Order 26.4b1	F0760	What correction action will be accomplished for those residents found to have been affected by the deficient practice? Resident #1 NJ Exec Order 26 to the facility on NJ Exec Order 26 with NJ Exec Order 26.4b1. Resident #2 is NJ Exec Order 26.4 a resident of the facility. Employee #1 is NJ Exec Order 26.4 employed at the facility. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The ADON (Assistant Director of Nursing) or designee completed a 100 percent audit of all current residents that had physician orders for IV antibiotics to validate the correct IV antibiotic orders and IV medication is in the medication room. Any discrepancies were corrected promptly. What measures will be put into place or what system changes will you make to ensure that the	01/23/2026

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F0760 SS = SQC-J	Continued from page 2 NJ Exec Order 26.4. The U.S. FOIA (b)(6) was notified immediately and ordered to NJ Exec Order r the residents NJ Exec Order 2 Resident #1 NJ Exec Order 26.4b1 at lunchtime, face NJ Exec Order , NJ Exec Order 26.4b1 . U.S. FO was present and administered NJ Exec Order 26.4b1]. Resident #1 was NJ Exec Order 26.4b1 to hospital NJ Exec Order 26.4b1 by NJ Exec Order 26.4b1] and was NJ Exec Order 26.4 On NJ Exec Order 26 it was found that LPN #1 administered 6:00 AM dose of NJ Exec O gram NJ Exec Order 26.4b1 to Resident #2 instead of to Resident #1. Also on NJ Exec Order 2 , it was found that LPN #1 administered 6:00 AM dose of NJ Exe gram NJ Exec Order 26 to Resident #1 instead of to Resident #2. U.S. FO was immediately notified and the residents were NJ Exec Order 26.4b1 . Resident #2 was NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 from NJ Exec dose of NJ Exe medication. Resident #1 was NJ Exec Order 26.4b and NJ Exec Ord at lunch to NJ Exec Order 26.4b1 , face NJ Exec Order 26 NJ Exec Order 26.4b1 NJ Exec Ord U.S. FO administered NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 the resident out to NJ Exec Order 2 for possible side effects o NJ Exec Order 26.4b1 . Resident #1 was admitted to hospital with dx [diagnosis NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 The facility's failure to protect a resident from a significant medication error placed Resident #1 as well as other residents at risk for significant medication error. This posed the likelihood of serious physical harm injury, or death which resulted in an immediate jeopardy (IJ) situation. The IJ began on NJ Exec Order 2 at 6:00 AM when LPN #1 administered the NJ Exec Order 26.4b1 medications to Residents #1 and Resident #2. The facility's Administration was notified of the IJ on 12/18/25 at 6:00 PM. The facility submitted an acceptable Removal Plan (RP) on 12/19/25 at 6:21 PM. The surveyor verified the implementation of the RP on-site during the continuation of the survey 12/23/25. The deficient practice was evidenced as follows: A review of the facility's policy on "Medication Administration, Receipt, Storage & Disposal", version dated 10/2023, included under Procedure: Medication Administration/Assistance ...2. Medications are administered in accordance with Nursing Standards of practice and state law; 4. Trained staff designated to administer medications will verify that he/she is administering medications using the 5 Rights of Medication Administration/Assistance and are documented immediately following completion of task for each resident: i) Right resident ii) Right medication iii)	F0760	Continued from page 2 deficient practice does not recur? The SDC (staff development coordinator) or designee educated all current licensed nurses on the facility policy for proper medication administration of IV antibiotics to include a return demonstration to validate proper and correct IV medication administration. Education was completed on all nursing staff. SDC will educate all newly hired nurses on the facility policy for proper medication administration of IV antibiotics to include a return demonstration to validate proper and correct IV medication administration. Residents receiving IV antibiotics will have two nurses validate the correct medication prior to administration. How will the corrective action be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established? ADON or designee will perform biweekly random med pass IV medication competency to validate proper and correct medication administration for all licensed nurses for one month, and then every other week for one month then monthly for one month. Audit findings will be reported to QAPI monthly for review, additional audits and education will be determined based on findings.	01/23/2026

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F0760 SS = SQC-J	Continued from page 3 Right dose iv) Right time, v) Right route. A review of the Reportable Event Record/Report (FRE) submitted by the facility to the New Jersey Department of Health (NJDOH) on [redacted], included the date and time of event [redacted] at 5:30 AM. The FRE further included under Narrative that on [redacted] it was found that LPN #1 administered 6:00 AM dose of [redacted] to Resident #2 instead of Resident #1. Also, on [redacted], it was found that LPN #1 administered 6 AM dose of [redacted] to Resident #1 instead of Resident #2...Resident #1 was [redacted] and was [redacted] at lunch to [redacted], face [redacted], [redacted] administered [redacted] and [redacted] the resident to hospital for possible side effects of [redacted] A review of the facility's Investigation Summary (IS) dated [redacted] under Incident Summary: Resident #1...primary dx includes [redacted]...has a physician order for [redacted] every [redacted] hours for indication of [redacted] or [redacted] Resident #2...primary dx includes [redacted] and [redacted]...has physician orders for NJ Exec Order 26.4b1 gram NJ Exec Order 26.4b1 every [redacted] hours for [redacted] for indication NJ Exec Order 26.4b1 [redacted]. The IS further indicated on [redacted] it was found that LPN #1 administered [redacted] to Resident #2 and [redacted] to Resident #1 [redacted] immediately notified and residents NJ Exec Order 26.4b1. Resident #2 [redacted] with NJ Exec Order 26.4b1. Resident #1 [redacted] and at lunch [redacted] face [redacted], [redacted] administered [redacted]...and the resident was [redacted] to hospital and was [redacted]...Resident #1 was [redacted] from the hospital on [redacted] and [redacted] to facility with new orders for [redacted] to [redacted] and [redacted]...At the time of incident, LPN #1 was immediately educated by the U.S. FOIA (b)(6) [redacted]) and was [redacted] pending investigation. LPN #1 was [redacted] from employment by [redacted] on [redacted] A review of the facility's IS included statements from staff. According to the U.S. FOIA (b)(6), U.S. FOIA (b)(6) [redacted]), on the morning of [redacted], they heard [redacted] from their office. The nurse on the floor at the time was busy in another room so they decided to silence the alarms and [redacted] for Resident #1 and Resident #2. Both of their [redacted] had [redacted] When the [redacted] went to Resident #2's room, they noticed that Resident #1's [redacted] was [redacted] for	F0760		01/23/2026

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CONTINUING CARE AT LANTERN HILL	**537 MOUNTAIN AVENUE , NEW PROVIDENCE, New Jersey, 07974**

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F0760 SS = SQC-J	Continued from page 4 Resident #2. The NJ Exec Order 26.4b1 was clearly marked with Resident #1's name, medication name, and dose. Resident #2 NJ Exec Order 26.4b to be in NJ Exec Order 26.4b1 and was not NJ Exec Order 26.4b any NJ Exec Order 26.4b1. The U.S. FOIA (b)(6) then proceeded to Resident #1's room and discovered that Resident #2's NJ Exec Orde had been NJ Exec Ord and was NJ Exec Order 2. This NJ Exec O was also clearly marked with Resident #2's name, medication, and dose. The U.S. FOIA (b)(6) immediately informed LPN #1 who then did a brief assessment and immediately called the doctor for directions and orders. There were NJ Exec Order 26 of NJ Exec Order 26.4b1 at this point. The U.S. FOIA (b)(6) further included in their statement that when NJ Exec Order 26.4b1 medications the NJ Exec Ord that they used launched a NJ Exe warning window as the last step in the set-up process. The U.S. FOIA (b) stated it would take the nurse to confirm the medication being administered. A review of the statements obtained from LPN #1 dated NJ Exec Order 26 According to LPN #1, at around 5:30 AM, a medication error occurred whereby resident was administered the NJ Exec Order 26.4b1. LPN #1 stated there were some computer issues and poor lighting and they did not give the med to the right patient. U.S. FO on call was promptly notified and instructed to NJ Exec Order 26.4b1 the residents. The U.S. FOIA (b) and the U.S. FOIA (b) assisted in resolving the issues surrounding the error, provided education. The residents remained stable and showed no reactions in the immediate hours. Family was notified, [U.S. FOIA (b)(6)] came to follow up and reassessed. A review of the statement made and signed by the U.S. FOIA (b)(6) In their statement, the U.S. FOIA (b)(6) stated they were notified of the medication error with LPN #1 administering the NJ Exec Order 26.4b1 to two residents. When they interviewed LPN #1, LPN #1 stated that they were setting up NJ Exec Order 26.4b1 at Nurse Station desk top area. When questioned why, LPN #1 stated that one computer was not working and the other was not charged. LPN #1 said they prepared both residents' NJ Exec Order 26.4b1 and NJ Exec O the NJ Exec Order 26.4b1. The U.S. FOIA (b)(6) later informed the U.S. FOIA (b) that when they were going to silence the alarm from NJ Exec Order 26.4b1 completion of NJ Exec Order 2 to find the NJ Exec Order 26.4b1 was NJ Exec O for the two residents. The U.S. FOIA (b) further said that the U.S. FOIA (b) that the physician was called immediately to NJ Exec Order 2 both residents... Resident #1 was NJ Exec Order 26.4b1 to hospital and NJ Exec Order 26 with dx [diagnosis] NJ Exec Order 26.4b1, NJ Exec Order 26.4b1. U.S. FOIA (b) further included in their statement that LPN #1 did not follow medication administration and Nursing Standard of Practice for the following three checks and 5 rights. The U.S. FOIA (b) stated they did med pass [medication pass] to LPN #1 to determine	F0760		01/23/2026

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F0760 SS = SQC-J	Continued from page 5 competency medication administration. U.S. FOIA (b) said that when started med pass with LPN #1, the U.S. FOIA stated they was having problem with laptop NJ Exec Order 26.4b1 (Laptop 1) again. Laptop was exchanged for another laptop with no problems. The U.S. FOIA (b)(brought Laptop 1back to cart and completed med pass with LPN #1. The U.S. FOIA (b)(stated the employee were educated in medication administration. Medication Administration Observation completed. Educated and reviewed triaged problems with computers and kept laptop charged at all times with all nurse. The surveyor reviewed the medical record for Resident #1. A review of the Face Sheet (FS), an admission record summary, revealed that Resident #1 was admitted to the facility with diagnoses which included but were not limited to: NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 ; NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 ; NJ Exec Order 26.4b1 , and NJ Exec Order 26.4b1 A review of the Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26, indicated the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec out of 15, which reflected an NJ Exec Order 26.4b1 . The MDS further revealed that the resident NJ Exec Order 26.4b1 from NJ Exec in the completion of their activities of daily living (ADLs). The resident's MDS further revealed in Section N-Medications, under N0415. NJ Exec Order 26.4b1 Classes: Use and Indication, that the resident was NJ Exec Order 26.4b1 and an Indication was NJ Exec Orde A review of Resident #1's individual Holistic Care Plan (HCP) under 10. Medications which included a Goal: "The nurse and/or caregiver will administer my medications as prescribed and monitor for side effects...I will not experience any complications as a result of medication administration", and Care Plan Approaches which included but not limited to: "I will not have complications related to my medication regimen...". A review of the resident's Clinical Notes Report (CNR) with effective date entered as NJ Exec Order 26.4b1 at 7:00 AM, authored and e-signed [electronically signed] by LPN #1. The CNR revealed LPN #1 documented "...At 5:30am there were issues with computers NJ Exec Orde was NJ Exec Order 26.4b1 administered in lieu of NJ Exec Order 26.4b1 , as the 3 steps check could not be applied effectively. Upon notification of error, on	F0760		01/23/2026

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F0760 SS = SQC-J	Continued from page 6 call [name redacted] was promptly notified. Patien was reviewed with and no order was given. Resident was with frequent and . Spoke with [resident's][name redacted] and made her aware. Endorsed to incoming nurse to follow up...". A review of Resident #1's Medication Administration Record (MAR) titled Medications" indicated an entry order of gram Every Hours for Starting Order ID: with Order Date: ;); Notes: Indication . The MAR revealed under Schedule of 6:00 am and column 03 [stands for date 12/03] showed LPN #1 initial of [redacted] indicating the nurse administered the medication. The surveyor reviewed the medical record for Resident #2. A review of the Face Sheet (FS), an admission record summary, revealed that Resident #2 was admitted to the facility with diagnoses which included but were not limited to: and ; and ; , and . A review of the Minimum Data Set (MDS), an assessment tool dated , indicated the resident had a Brief Interview for Mental Status (BIMS) score of out of 15, which reflected the resident's was . The MDS further revealed that the residen from in the completion of their activities of daily living (ADLs). The resident's MDS further revealed in Section N-Medications, under N0415. Classes: Use and Indication, that the resident was and an Indication was . A review of Resident #2's individual HCP under 10. Medications which included a Goal and Care Plan Approaches which included but not limited to: "The nurse and/or caregiver will administer my medications as prescribed and monitor for side effects daily." A review of Resident #2's Medication Administration Record (MAR) titled Medications" indicated an entry order of	F0760		01/23/2026

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F0760 SS = SQC-J	Continued from page 7 NJ Exec Order 26.4b1 NJ Ex Ord NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(1 NJ Ex Orde NJ Exec Orde NJ Exec Ord ; Every Hours for Starting NJ Exec Order 26.4b 5 Order ID: NJ Exec Order 26 with Order Date NJ Exec Order 26.4b1 : NJ Exec Order 26.4b1 Notes: Indication: NJ Exec Order 26.4b1 . The MAR revealed under Schedule of 6:00 am and column 03 [stands for date 12/03] showed LPN #1 initial of [redacted] indicating the nurse administered the medication. On 12/18/25 at 2:52 PM, the surveyor interviewed the U.S. FOIA (b)(6) in the presence of the U.S. FOIA (b)(6)). The U.S. FOIA stated LPN #1 did not follow the facility's medication administration procedure. The U.S. FOIA further stated the U.S. FOIA was NJ Exec Ord around NJ Exec Order 26.4b1 NJ Exec and NJ Exec Order her medication administration pass competencies with both the U.S. FOIA (b and the U.S. FOIA (b)(6)), attended the education in-services as required. U.S. FOIA said that when they knew of the incident on medication error on NJ Exec Order 2 with the two residents, the U.S. FOIA was educated on medication administration competency. The U.S. FOIA (b stated LPN #1 was NJ Exec Order 26.4b1 pending investigation and was eventually NJ Exec Order 26.4b1 on NJ Exec Order 2 . The U.S. FOIA (b stated LPN #1 did not follow the medication pass protocol and procedure despite education in-services that were done with her by the facility. A Removal Plan (RP) was submitted by the facility on 12/19/25 at 6:21 PM indicating the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including: On NJ Exec Order 26 LPN #1 was found to administer the NJ Exec Order 26.4b1 medications to Resident #1 and Resident #2; U.S. FO was notified immediately and both residents were NJ Exec Orde NJ Exec Order 2 at lunchtime, Resident #1 NJ Exec Orde 26.4b1 face NJ Exec Order 2 and NJ Exec Order 26.4b1 NJ Exec Ord U.S. FO at bedside and the resident was NJ Exec Order 26.4b1 to the NJ Exec O Resident #2 had NJ Exec Order 26.4b1 NJ Exec Order 26.4 to the medication error; on NJ Exec Order 2 , nurse medication administration observation checklist was completed and LPN #1 demonstrated competency immediately after medication error was found; U.S. FOIA #1 was NJ Exec Order 26.4b1 on U.S. FOIA (b)(6 and NJ Exec Order 26.4b1 on U.S. FOIA (b)(6) ; on NJ Exec Order 26 , a 100% audit of all current residents that have physician order of NJ Exec Order 26.4b1 were reviewed by the U.S. FOIA (b)(6) U.S. FOIA (b)(6) to validate the correct NJ Exec Order 26.4b1 orders and that NJ E medications were in the medication room; medication administration education began on 12/3/25 and NJ E competencies began for all nurses -	F0760		01/23/2026

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CONTINUING CARE AT LANTERN HILL	**537 MOUNTAIN AVENUE , NEW PROVIDENCE, New Jersey, 07974**

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F0760 SS = SQC-J	Continued from page 8 all nursing staff must complete education and competencies before their next scheduled shift; all newly hired nurses will be educated on proper medication administration including return demonstration during orientation; on 12/4/25 a new process was created requiring two nurses to verify the correct [redacted] medication before administering to residents, and random audits were being conducted monitoring nurses who were administering [redacted] started on 12/4/25. The surveyor verified the implementation of the RP on-site during the continuation of the survey on 12/23/25. NJAC 8:39-29.2(d)	F0760		01/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315523	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0000	INITIAL COMMENTS An on-site revisit for the facility's Plan of Correction was conducted on 02/03/2026 in relation to the 12/23/2025 Complaint survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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 reverse for further 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.

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