STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315313	A. BUILDING _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT CRESSKILL	**221 COUNTY ROAD CRESSKILL, NJ 07626**

(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 000	INITIAL COMMENTS COMPLAINT # NJ00170331 CENSUS: 80 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 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-	F 842		2/21/24

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

Electronically Signed | 02/21/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315313	A. BUILDING _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT CRESSKILL	**221 COUNTY ROAD CRESSKILL, NJ 07626**

(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 842	Continued From page 1 (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315313	A. BUILDING _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT CRESSKILL	**221 COUNTY ROAD CRESSKILL, NJ 07626**

(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 842	Continued From page 2 services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: C# NJ00170331 Based on interviews, medical record review, and review of other pertinent facility documents on 1/25/24, it was determined that the facility staff failed to consistently document in the "Documentation Survey Report" (DSR) the NJ Ex Order 26.4(b)(1) [redacted]) status and care provided to the resident according to facility policy and protocol for 2 of 3 residents (Resident #1 and Resident #2) reviewed for documentation. This deficient practice was evidenced by the following: 1. According to the "Admission Record" (AR), Resident #2 was admitted with diagnoses that included but were not limited to: NJ Exec Order 26.4b1 [redacted] The Admission Minimum Data Set (MDS), an assessment tool, dated NJ Exec Order 26.4b [redacted], revealed a Brief Interview of Mental Status (BIMS) of [redacted] which indicated the resident's NJ Exec Order 26.4b1 [redacted] The MDS further revealed that the resident needed assistance with NJ Ex Order 26.4(b)(1) [redacted]) including NJ Ex Order 26.4(b)(1). A review of the Care Plan (CP), dated NJ Ex Order 26.4(b) [redacted], indicated that Resident #2 needed NJ Ex Order 26.4(b)(1) [redacted] Review of Resident #2's DSR (ADL Record) and the progress notes (PN) for the month of NJ Exec Order 26.4b [redacted] revealed a lack of documentation to indicate that the care for NJ Ex Order 26.4(b)(1) was	F 842	How the corrective action will be accomplished for those residents found to have been affected by the deficient.- Resident #1 was screened by NJ Exec Order 26.4b [redacted] There was no change in NJ Ex Orde [redacted] status. Resident #1 had [redacted] effects related to this practice. Resident #2 was screened by NJ Exec Order 26.4 [redacted]. There was [redacted] status. Resident #2 had [redacted] effects related to this practice. How the facility will identify other residents having the potential to be affected by the same deficient practice.- All residents have the potential to be affected by this practice. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.- On 1/25/2024 the DON re-educated CNAs on point of care completion. On 1/25/24 the DON conducted an audit of POC documentation for all residents to ensure POC completion. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change.- The DON and/or designee will review the Documentation Survey Report to verify compliance and completion of POC by the CNA staff. The audit will be completed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315313	A. BUILDING _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT CRESSKILL	221 COUNTY ROAD CRESSKILL, NJ 07626

(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 842	Continued From page 3 provided and/or that the resident refused care on the following dates and shifts: 7:00 a.m. to 3:00 p.m. shift on [redacted] 2. According to the AR, Resident #1 was admitted with diagnoses that included but were not limited to: NJ Exec Order 26.4b1 [redacted]. The Annual MDS, dated [redacted] revealed a BIMS of [redacted], which indicated the resident's NJ Exec Order 26.4b1. The MDS further revealed that the resident needed assistance with [redacted] including [redacted]. A review of the CP, dated [redacted], indicated that Resident #1 needed assistance with [redacted] Review of Resident #1's DSR and the PN for the month of NJ Exec Order 26.4b1, revealed a lack of documentation to indicate that care for [redacted] was provided and/or that the resident refused care on the following dates and shifts: 7:00 a.m. to 3:00 p.m. shift on [redacted] During an interview with the surveyor on 1/25/24 at 11:29 a.m., the U.S. FOIA (b)(6) [redacted]	F 842	each shift for 5 days, then daily for 5 days, then weekly for 4 weeks, and then monthly for 5 months. The DON will present the results of the audit to the QAPI Committee for review and determine the need for futher perfromance improvement monthly for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315313	A. BUILDING _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT CRESSKILL	**221 COUNTY ROAD CRESSKILL, NJ 07626**

(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 842	Continued From page 4	F 842		

U.S. FOIA (b)(6) explained that after providing care to a resident, she would document in the electronic medical record (NJ Ex Order 2 at the end of the shift. The NJ Exec Ord further explained that she is responsible for documenting the NJ Ex Ord care provided into the NJ Ex Order 2

During an interview with the surveyor on 1/25/24 at 12:18 p.m., the U.S. FOIA (b)(6) stated that the U.S. FOIA (b)(6) are to document in the NJ Ex Order that the care was provided to the residents at the end of the shift.

During an interview with the surveyor on 1/25/24 at 12:33 p.m., the U.S. FOIA (b)(6) stated that U.S. FOIA (b)(6)'s are to document in the NJ Ex Order the care was provided. U.S. FOIA further stated that if there are blanks on the DSR it indicates that the U.S. FOIA (b) did not document the care they provided during the shift. The U.S. FOIA explained that she would check on the residents during this shift to ensure that care was administered.

A review of the facility's policy, edited on 5/27/22, titled "Charting and Documentation Policy" revealed under the Policy Statement "All services provided to the resident ...shall be documented in the resident's medical records. The medical record should facilitate communication between interdisciplinary team regarding the resident's condition and response to care." Under Policy Interpretation and Implementation "1. Documentation in the medical record maybe electronic, manual, or a combination ...4. The following information is to be documented in the resident medical record ...c. Treatments or services performed ...5. Documentation in the medical record will be objective (not opinionated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315313	A. BUILDING _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT CRESSKILL	**221 COUNTY ROAD CRESSKILL, NJ 07626**

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F 842	Continued From page 5 or speculative), complete, timely ..." NJAC 8:39-35.2(d)(9)	F 842		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060208	A. BUILDING: _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT CRESSKILL	221 COUNTY ROAD CRESSKILL, NJ 07626

(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
S 000	Initial Comments CENSUS: 80 SAMPLE SIZE: 3 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. 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 the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on facility document review on 1/25/2024, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratio as mandated by the State of New Jersey for 12 of 14 day shifts. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated)	S 560	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.- The facility leadership team has met on an ongoing basis and continued to identify staffing challenges and areas of improvement for licensed and certified staffing needs. How the facility will identify other residents having the potential to be affected by the	2/21/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 02/21/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060208	A. BUILDING: _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT CRESSKILL	221 COUNTY ROAD CRESSKILL, NJ 07626

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S 560	Continued From page 1 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a certified nurse aide and shall perform nurse aide duties; and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The survey team requested staffing for the weeks of 1/7/24 to 1/14/24 and 1/15/24 to 1/20/24. The facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows: 1. 01/07/24 had 7 CNAs for 89 residents on the day shift, required at least 11 CNAs. 2. 01/08/24 had 8 CNAs for 89 residents on the day shift, required at least 11 CNAs. 3. 01/09/24 had 8 CNAs for 86 residents on the day shift, required at least 11 CNAs. 4. 01/10/24 had 9 CNAs for 84 residents on the day shift, required at least 10 CNAs. 5. 01/12/24 had 8 CNAs for 83 residents on the day shift, required at least 10 CNAs. 6. 01/13/24 had 8 CNAs for 83 residents	S 560	same deficient practice.- All residents have the potential to be affected by this practice. What measures will be put into place or systemic chamges will be made to ensure that the deficient practice will not recur.- The DON conducted an audit with the current facility census to ensure requirements per shift. The facility has implemented an incentive program including referral bonuses for employees referring staff where appropriate, conducting job fairs, immediate interviews with contingency offers and expedited the onboarding process for new hires. The DON and DOR continue to partner in addressing staffing challenges. Where appropriate, the occupational therapy staff assist in providing care and activities of daily living to residents. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change.- The DON and/or designee will meet with the staffing coordinator daily to review facility census, call outs if any, and staffing needs. The DON and/or designee will monitor callouts and staffing ratios weekly until the requirement is met. The results of the audits will be forwarded to the facility administrator and QAPI Committee for futher review and recommendations as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060208	A. BUILDING: _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT CRESSKILL	**221 COUNTY ROAD CRESSKILL, NJ 07626**

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S 560	Continued From page 2 on the day shift, required at least 10 CNAs. 7. 01/14/24 had 6 CNAs for 83 residents on the day shift, required at least 10 CNAs. 8. 01/15/24 had 7 CNAs for 83 residents on the day shift, required at least 10 CNAs. 9. 01/16/24 had 6 CNAs for 83 residents on the day shift, required at least 10 CNAs. 10. 01/17/24 had 9 CNAs for 80 residents on the day shift, required at least 10 CNAs. 11. 01/19/24 had 8 CNAs for 78 residents on the day shift, required at least 10 CNAs. 12. 01/20/24 had 9 CNAs for 78 residents on the day shift, required at least 10 CNAs.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315313	A. Building B. Wing	2/23/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT CRESSKILL	221 COUNTY ROAD CRESSKILL, NJ 07626

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 F0842 Reg. # 483.20(f)(5), 483.70(i)(1)-(5) LSC	Correction Completed 02/21/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
1/25/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060208 Y1	A. Building B. Wing Y2	2/23/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT CRESSKILL	221 COUNTY ROAD CRESSKILL, NJ 07626

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 S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 02/21/2024	ID Prefix Reg. # LSC	Correction Completed	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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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 1/25/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			