

New Jersey Department of Health

| | | | |
|--------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: COGCWM | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 07/02/2025 |
|--------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------------------|

| | |
|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER SUNRISE ASSISTED LIVING OF LINCROFT | STREET ADDRESS, CITY, STATE, ZIP CODE 734 NEWMAN SPRINGS ROAD LINCROFT, NJ 07738 |
|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|

| (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 | <p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Complaint</p> <p>COMPLAINT #: NJ00187452</p> <p>CENSUS: 57</p> <p>SAMPLE SIZE: 3</p> <p>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.</p> | A 000 | | |
| A 389 | <p>8:36-4.1(a)(16) Resident Rights</p> <p>(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:</p> <p>16. The right to be free from physical and mental abuse and/or neglect;</p> | A 389 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

09/18/25

New Jersey Department of Health

| | | | |
|--------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: COGCWM | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 07/02/2025 |
|--------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------------------|

| | |
|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER SUNRISE ASSISTED LIVING OF LINCROFT | STREET ADDRESS, CITY, STATE, ZIP CODE 734 NEWMAN SPRINGS ROAD LINCROFT, NJ 07738 |
|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|

| (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 389 | <p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00187452</p> <p>Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure a resident's right to be free from NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) was enforced for 3 of 3 residents reviewed, Residents #1, 2, and 3. This deficient practice was evidenced by the following:</p> <p>On 6/17/25, the Department of Health (DOH) received a Reportable Event Record (RER) completed by the Executive Director (ED) for NJ Ex Order 26.4(b)(1) that occurred on NJ Ex Order 26.4(b)(1) and NJ ex order 26.4b1. The RER indicated that on NJ ex order 26.4b1 it was reported by four Home Health Aide (HHA) students that on NJ ex order 26.4b1, a Care Manager (CM) showered Resident #3, NJ ex order 26.4b1, and NJ ex order 26.4b1. The RER also indicated that the CM NJ Ex Order 26.4(b)(1) Resident #3's NJ ex order 26.4b1 and that after the NJ ex order 26.4b1 and NJ ex order 26.4b1. The RER indicated that Resident #3 NJ ex order 26.4b1 and that the CM told the resident to NJ ex order 26.4b1. Additionally, the RER indicated that on the same day NJ ex order 26.4b1, the CM NJ ex order 26.4b1 Resident #2. The RER indicated that the CM also NJ ex order 26.4b1 Resident #2 and NJ ex order 26.4b1 the resident's NJ ex order 26.4b1. The RER indicated that the NJ Ex Order 26.4(b)(1) was NJ Ex Order 26.4(b)(1) and that the CM NJ ex order 26.4b1 Resident #2's NJ ex order 26.4b1.</p> <p>Additionally, the RER indicated that the four HHA students also reported that on NJ ex order 26.4b1, the CM assisted Resident #1 NJ Ex Order 26.4(b)(1) without first testing the NJ Ex Order 26.4(b)(1), and that the CM</p> | A 389 | | |
|-------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|--|--|

New Jersey Department of Health

| | | | |
|--------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: COGCWM | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 07/02/2025 |
|--------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------------------|

| | |
|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER SUNRISE ASSISTED LIVING OF LINCROFT | STREET ADDRESS, CITY, STATE, ZIP CODE 734 NEWMAN SPRINGS ROAD LINCROFT, NJ 07738 |
|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|

| (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 389 | <p>Continued From page 2</p> <p>NJ ex order 26.4b1 Resident #1's NJ ex order 26.4b1, which NJ ex order 26.4b1. The RER further indicated that while the CM assisted Resident #1 NJ Ex Order 26.4(b)(1) the resident had NJ Ex Order 26.4(b). The RER indicated that the CM provided hygiene care to Resident #1 and NJ ex order 26.4b1</p> <p>Further, the RER indicated that the registered nurse, medical doctor, resident responsible parties, and NJ Ex Order 26.4(b)(1) were notified of the above-mentioned NJ Ex Order 26.4b1 NJ ex order 26.4b1.</p> <p>On 7/2/25 at 10:18 a.m., the surveyor interviewed the ED, who confirmed the information indicated in the RER.</p> <p>The surveyor then reviewed the Electronic Health Record (EHR) of Resident #1, which revealed that the resident was admitted to the facility's NJ Ex Order 26.4(b)(1) in NJ ex order 26.4b1 with diagnoses of NJ ex order 26.4b1</p> <p>The surveyor also reviewed the EHR of Resident #2, which revealed that the resident was admitted to the facility's NJ Ex O in NJ ex order 26.4b1</p> <p>Lastly, the surveyor reviewed the EHR of Resident #3, which revealed that the resident was admitted to the facility's NJ Ex O in NJ ex order 26.4b1</p> <p>At 11:11 a.m., the surveyor observed Resident's #1, 2, and 3 as they listened to music in the NJ Ex O unit. The surveyor was unable to interview the residents due to their NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1)</p> | A 389 | | |

New Jersey Department of Health

| | | | |
|--------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------|----------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: COGCWM | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 07/02/2025 |
|--------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------|----------------------------------------------------------|

| | |
|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER SUNRISE ASSISTED LIVING OF LINCROFT | STREET ADDRESS, CITY, STATE, ZIP CODE 734 NEWMAN SPRINGS ROAD LINCROFT, NJ 07738 |
|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|

| (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 389 | <p>Continued From page 3</p> <p>The surveyor reviewed witness statements written by the four mentioned HHA students, HHA #s 1, 2, 3, and 4, regarding the following NJ ex order 26.4b NJ ex order 26.4b1:</p> <p>1. HHA student #1's written statement indicated that on NJ ex order 26.4b, "[the CM] NJ Ex Order 26.4(b)(1) [Resident #3]. It was in [the resident's] NJ Ex Order 26.4(b)(1). [The CM] was NJ Ex Ord with the NJ Ex Order and was NJ Ex Order 26.4(b)(1) [Resident #3] NJ Ex Order 26.4b that [the resident] NJ Ex Order 26.4(b)(1). [The CM] NJ Ex Order 26.4(b)(1) [Resident #3] to NJ Ex Order 26.4(b)(1) ..." In addition, the statement also indicated that on the same day NJ Ex Order 26.4b, the CM "...was NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) all in [Resident #2's] NJ Ex Order 26.4(b)(1). Then when it came to NJ Ex Order 2 [Resident #2's] NJ Ex Order 2 [the CM] NJ Ex Order 26.4(b)(1) [the resident's] NJ Ex Order 26.4(b)(1) that [the resident] started NJ Ex Order 26.4(b)(1) ..." </p> <p>2. HHA student #2's written statement indicated that on NJ Ex Order 26.4b, "...[The CM] did not test NJ Ex Order 26.4b and began NJ Ex Order 26.4(b)(1) [Resident #1] w NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and [the resident] was NJ Ex Order 26.4(b)(1) throughout NJ Ex Order 26.4(b)(1). [The CM] NJ Ex Order 26.4(b)(1) [Resident #1's] NJ Ex Order [the resident] NJ Ex Order 26.4b and NJ Ex Order 26.4(b)(1)." The statement also indicated that Resident #1 had NJ Ex Order 26.4(b)(1) during the resident's NJ Ex Order 26.4(b) and NJ Ex O after the NJ Ex Order 26.4(b). The statement indicated that after Resident #1's NJ Ex Order 26.4(b)(1), the CM NJ Ex Order 26.4(b)(1) [Resident #1's] NJ Ex O [The CM] abruptly said, NJ Ex Order 26.4(b)(1) ..." </p> <p>3. HHA student #3's written statement indicated that on NJ ex order 26.4b1 the CM NJ Ex Order 26.4(b)(1) Resident #1 and that the CM turned the NJ Ex Order 26.4(b)(1) on and put NJ Ex Order 26.4(b)(1) the resident's NJ Ex Ord</p> | A 389 | | |
|-------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|--|--|

New Jersey Department of Health

| | | | |
|--------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: COGCWM | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 07/02/2025 |
|--------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------------------|

| | |
|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER SUNRISE ASSISTED LIVING OF LINCROFT | STREET ADDRESS, CITY, STATE, ZIP CODE 734 NEWMAN SPRINGS ROAD LINCROFT, NJ 07738 |
|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|

| (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 389 | <p>Continued From page 4</p> <p>"without first testing the NJ Ex Order 26.4(b)(1)." The statement also indicated, "...the CM NJ Ex Order 26.4(b) Resident #1's NJ ex order 26.4b1 Further, the statement indicated that Resident #1 NJ ex order 26.4b1, and NJ ex ord The statement indicated that after Resident #1's NJ ex order 26.4b1, the CM NJ ex order 26.4b1 The statement indicated that while the CM NJ Ex Order 26.4(b) Resident #1's NJ ex order 26.4b1, the CM NJ ex order 26.4b1 [the resident NJ ex order 26.4b1"</p> <p>4. HHA student #4's written statement regarding the incident on NJ ex order 26.4b1 indicated, "...the CM NJ ex order 26.4b1 [Resident #3], and NJ ex order 26.4b1]. [The CM] NJ ex o [Resident #3's] NJ ex order 26.4b1 [the CM] NJ ex order 26.4b1 [the resident's] NJ ex order 26.4b1 [the resident] NJ ex order 26.4b1 [the CM] NJ ex order 26.4b1 [the resident's] NJ ex order 26.4b1 [the resident] NJ ex order 26.4b1 [The CM] NJ ex order 26.4b1 at [Resident #3] NJ ex order 26.4b1 [Resident #3] NJ ex order 26.4b1 told us to NJ Ex Order 26.4b1 the resident and walked out of the room." The statement indicated that the CM did the same thing to Resident #2. The statement indicated that the CM, NJ ex order 26.4b1 NJ ex order 26.4b1 [Resident #2] NJ ex ord The statement also indicated that the CM hit Resident #2's NJ ex order 26.4b1 Further, the CM, " NJ ex order 26.4b1 [Resident #2] NJ ex order 26.4b1 . [Resident #2's] NJ ex order 26.4b1 [The CM] let [Resident #2] NJ ex order 26.4b1 Lastly, the statement indicated that the CM told the HHA students NJ Ex Order 26.4b1 Resident #2 NJ Ex and walked out.</p> | A 389 | | |

New Jersey Department of Health

| | | | |
|--------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: COGCWM | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 07/02/2025 |
|--------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------------------|


| | |
|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER SUNRISE ASSISTED LIVING OF LINCROFT | STREET ADDRESS, CITY, STATE, ZIP CODE 734 NEWMAN SPRINGS ROAD LINCROFT, NJ 07738 |
|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|

| (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 389 | <p>Continued From page 5</p> <p>On 7/2/25 at 2:04 p.m., the surveyor conducted a telephone interview with the CM, who was the NJ Ex Order 26.4(b)(1) in the previously mentioned NJ ex order 26.4b1 to inquire what happened on NJ ex order 26.4b1 and NJ ex order 26.4b1. The CM stated that she could not answer any questions and that she did not NJ Ex Order 26.4(b)(1).</p> <p>The surveyor reviewed the facility's investigation report provided by the ED, which indicated, "...a thorough investigation that included statements and interviews was conducted. The NJ ex order 26.4b1 NJ ex order 26.4b1" The investigation report indicated that the CM NJ ex order 26.4b1 Resident #'s 1, 2, and 3, and that the HHA students were present during that time. However, the investigation report indicated that the CM NJ ex order 26.4b1. Further, the investigation report indicated that the CM's NJ ex order 26.4b1 on NJ ex order 26.4b1, and that the CM NJ ex order 26.4b1 NJ ex order 26.4b1.</p> <p>The ED provided the surveyor with the CM's job file with details that included information that the CM NJ ex order 26.4b1 NJ ex order 26.4b1.</p> <p>Additionally, the surveyor reviewed the CM's signed job description dated 3/20/23, which indicated, "...responsible for providing the highest degree of quality care and services to a consistent group of residents and their families in our assisted living and reminiscence neighborhoods ... and essential duties ...Helps residents maintain independence, promote dignity and physical safety of each resident adhering to the standards of Resident Rights and Sunrise Principles of Service. Actively participates/leads</p> | A 389 | | |

New Jersey Department of Health

| | | | |
|--------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: COGCWM | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 07/02/2025 |
|--------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------------------|

| | |
|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER SUNRISE ASSISTED LIVING OF LINCROFT | STREET ADDRESS, CITY, STATE, ZIP CODE 734 NEWMAN SPRINGS ROAD LINCROFT, NJ 07738 |
|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|

| (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 389 | <p>Continued From page 6</p> <p>and assists residents with activities of daily living (ADLs) ... Strives to understand and respond to each resident with empathy, always remaining mindful of the resident's unique communication patterns or history, and basic human needs. Maintains an atmosphere of warmth, personal interest and positive emphasis as well as a calm environment"</p> <p>Additionally, the surveyor reviewed the facility's policy titled, "Resident Rights and Principles of Service" revised on 8/20/13, which indicated, "... B. Preserving Dignity 1. Residents have the right to be valued and receive ethical treatment. Every interaction a Team Member has with a resident has the power to strengthen and restore a resident's sense of dignity. 2. Residents Rights ... b. Freedom from abuse, neglect, exploitation, punishment, humiliation, and intimidation. c. Treatment with dignity, respect, kindness, consideration as a person of worth"</p> <p>During the exit conference on 7/2/25, the facility ED indicated that they will be reporting the  incidents involving the CM to the Board of Nursing. The facility provided the surveyor with a post survey reporting receipt that they sent to the Board of Nursing</p> | A 389 | | |
| A1073 | <p>8:36-15.6(b) Resident Records</p> <p>(b) All assessments and treatments by health care and service providers shall be entered according to the standards of professional practice. Documentation and/or notes from all health care and service providers shall be entered according to the standards of professional practice.</p> | A1073 | | |

New Jersey Department of Health

| | | | |
|--------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: COGCWM | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 07/02/2025 |
|--------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------------------|

| | |
|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER SUNRISE ASSISTED LIVING OF LINCROFT | STREET ADDRESS, CITY, STATE, ZIP CODE 734 NEWMAN SPRINGS ROAD LINCROFT, NJ 07738 |
|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|

| (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 |
|--------------------|------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------------------------------------------------------------------------|--------------------|
|--------------------|------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------------------------------------------------------------------------|--------------------|

| | | | | |
|-------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|--|--|
| A1073 | <p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00187452</p> <p>Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that Progress Notes (PNs) for NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) were documented in the Electronic Health Record (EHR) of 3 of 3 residents, Residents #1, 2, and 3. This deficient practice is evidenced by the following:</p> <p>On 6/17/25, the Department of Health (DOH) received a Reportable Event Record (RER) completed by the Executive Director (ED) for NJ Ex Order 26.4(b)(1) that occurred on NJ Ex Order 26.4b1 and NJ ex order 26.4b1. The RER indicated that on NJ ex order 26.4b1 it was reported by four Home Health Aide (HHA) students that on NJ ex order 26.4b1, a Care Manager (CM) NJ ex order 26.4b1 Resident #3, NJ ex order 26.4b1. The RER also indicated that the CM NJ ex order 26.4b1 Resident #3's NJ ex order 26.4b1 the CM NJ ex order 26.4b1. The RER indicated that Resident #3 NJ ex order 26.4b1 and that the CM told the resident to NJ ex order 26.4b1 " Additionally, the RER indicated that on the same day NJ ex order 26.4b1 the CM NJ ex order 26.4b1 Resident #2. The RER indicated that the CM also NJ ex order 26.4b1 Resident #2 and NJ ex order 26.4b1. The RER indicated that the NJ ex order 26.4b1 was NJ ex order 26.4b1 and that the CM NJ ex order 26.4b1 Resident #2's NJ ex order 26.4b1.</p> | A1073 | | |
|-------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|--|--|

New Jersey Department of Health

| | | | |
|--------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: COGCWM | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 07/02/2025 |
|--------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------------------|

| | |
|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER SUNRISE ASSISTED LIVING OF LINCROFT | STREET ADDRESS, CITY, STATE, ZIP CODE 734 NEWMAN SPRINGS ROAD LINCROFT, NJ 07738 |
|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|

| (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 |
|--------------------|------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------------------------------------------------------------------------|--------------------|
|--------------------|------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------------------------------------------------------------------------|--------------------|

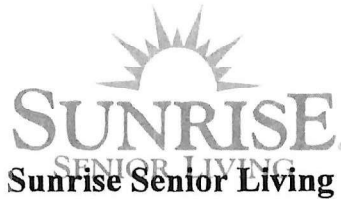
| | | | | |
|-------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|--|--|
| A1073 | <p>Continued From page 8</p> <p>Further, the RER indicated that the four HHA students also reported that on [redacted] the CM assisted Resident #1 [redacted] without first testing the [redacted], and that the CM [redacted] Resident #1's [redacted]. The RER further indicated that while the CM assisted Resident #1 from [redacted], the resident [redacted]. The RER indicated that the CM provided hygiene care to Resident #1 and [redacted].</p> <p>1. On 7/2/25, the surveyor reviewed the EHR of Resident #1 and was not able to locate any documentation regarding the [redacted] of [redacted].</p> <p>2. The surveyor also reviewed the EHR of Resident #2 and was not able to locate any PN regarding the [redacted] that occurred on [redacted].</p> <p>3. The surveyor then reviewed the EHR of Resident #3 and was not able to locate any PN regarding the [redacted].</p> <p>At 2:30 p.m. the surveyor interviewed the Resident Care Director (RCD) to inquire if she documented the above-mentioned [redacted] in the EHRs of Resident #'s 1, 2, and 3. The RCD stated that she did not document the [redacted] in the EHRs because the investigation was still taking place. The surveyor then inquired if the RCD was aware that the facility's policy indicated that licensed nurses and/or designees</p> | A1073 | | |
|-------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|--|--|

New Jersey Department of Health

| | | | |
|--------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: COGCWM | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 07/02/2025 |
|--------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------------------|

| | |
|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER SUNRISE ASSISTED LIVING OF LINCROFT | STREET ADDRESS, CITY, STATE, ZIP CODE 734 NEWMAN SPRINGS ROAD LINCROFT, NJ 07738 |
|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|

| (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 |
|--------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------------------------------------------------------------------------|--------------------|
| A1073 | <p>Continued From page 9</p> <p>should record events/incidents in the resident's PNs, the RCD then stated that she was not aware.</p> <p>The surveyor reviewed the facility's policy, revised on 4/24/25, titled, "Incident and Event Reporting" which indicated, "Policy Statement: It is the policy of the community to ensure that [Facility] team members promptly and accurately report and document incidents to promote early intervention, improve quality of care for our residents, improve safety for residents, team members and visitors, and reduce the risk of harm ... Documentation 10. The Licensed Nurse/designee will record the event/incident in the resident's progress notes...."</p> <p>Reference 8:36-4.1(a)(16) A-0389</p> | A1073 | | |



POC # 4
Accepted
10/3/25 BS

Plan of Correction

Name of Facility: Sunrise of Lincroft
Address of Facility: 734 Newman Springs Road, Lincroft, NJ 07738
License number: COGCWM
Inspection date(s): 7/2/2025
Name and Title of Legal Entity
Representative Signing the Plan of Correction: NJ Ex Order 26.4(b)(1)
Signature of Sunrise Representative: NJ Ex Order 26.4(b)(1)
Date of Submission: 10/3/25

A389 8:36-4.1(a)(16) Resident Rights

Target Completion Date: September 30, 2025

1. Full body assessments were completed and documented in the resident records by the Resident Care Director for Residents 1, 2 and 3 on NJ ex order 26.4b1. No signs or symptoms of abuse were noted. On NJ ex order 26.4b1 Residents 1, 2 and 3 NJ ex order 26.4b1 and NJ Ex Order 26.4(b)(1) were noted. The Care Manager involved was suspended on NJ ex order 26.4b1 pending an investigation. Or NJ ex order 26.4b1 the Care Manager involved was terminated. Residents 1,2 and 3 reside in the community.
2. All Residents in the memory care neighborhood have the potential to be affected by this deficient practice.
3. On 6/13/25 the Executive Director and the Resident Care Director reported the incident to NJDOH, the office of the ombudsman, Middletown Police Department, notified the physician and the POA's for Resident 1,2 and 3. On 7/29/25 the Executive Director reported the care manager involved to the NJ State Board of Nursing. The Executive Director and Resident Care Director completed re-education to all staff on the Abuse, Neglect and Exploitation-Prevention, reporting and Investigation Policy, and Mandated Reporting, checking hot water temperatures for Resident showers. Education was completed on 6/30/2025 and ongoing upon hire, annually and if there are any other incidents. Executive Director and Resident Care Director started re-education to all staff on the Resident Rights policy on 9/4/25 and will be completed by 9/24/25 and ongoing upon hire, annually and if there are any other incidents. An audit of the incident reports was conducted and completed by the Executive Director on 9/5/25 to identify any other potential abuse incidents involving memory care residents within in the last 4 months. If potential abuse is suspected related to any of the audited incidents, required reporting, documentation, and thorough investigations will be completed.
4. Unannounced observations of direct care rendered by facility staff to Memory Care Residents will be completed by an RN 1x/weekly for 4 weeks and 1x/monthly for 2 months. The RN started the audit on 9/8/25. Immediate education and/or corrective action (up to an including suspension or termination) will occur as needed at the time of the above observations. The results of the above observations/audits will be reviewed at the Quarterly QAPI meetings for

734 Newman Springs Road • Lincroft, NJ 07738 • main 732-212-1910 • fax 732-212-1912

www.sunriseseniorliving.com

Licensing



6 months. The next quarterly QAPI meeting will be held in October 2025. At the following QAPI meeting in January 2026, it will be determined by the committee if the continuation of the audits is warranted.

5. Completion date on September 30, 2025

A1073 8:36-15.6(b) Resident Records

Target Completion Date: September 30, 2025

1. Late entry documentation regarding the Reportable Events was completed for Residents #1, #2 and #3 on 9/18/25. Residents 1,2 and 3 reside in the community.
2. All Residents in the memory care neighborhood have the potential to be affected by this deficient practice.
3. On 6/13/25 the Executive Director and the Resident Care Director reported the incident to NJDOH, the office of the ombudsman, Middletown Police Department, notified the physician and the POA's for Resident 1,2 and 3. The care manager involved was immediately suspended on NJ ex order 26.4(b) pending an investigation and her employment was subsequently terminated on NJ Ex Order 26.4(b). On 7/29/25 the Executive Director reported the care manager involved to the NJ State Board of Nursing. The Executive Director reviewed the Incident and Event reporting policy with the Resident Care Director on 9/4/25. On 9/4/25 the Resident Care Director provided re-education on the Incident and Event Reporting Policy including documentation to all community RNs and LPNs. The re-education was completed by 9/12/25. The Executive Director and Resident Care Director conducted an audit of incident reports completed within the last 4 months to assure that required progress notes have been entered into the affected resident's medical records. This audit was started on 9/15/25 and completed on 9/30/25.
4. A weekly audit of incidents and reportable events will be conducted by Executive Director and the Resident Care Director weekly x 1 month, and then monthly x 3 months to assure that the required documentation has been completed. The audit was started on 9/5/25. The results of the above audits will be reviewed at quarterly QAPI meetings for 6 months. The next quarterly QAPI meeting will be held in October 2025. At the following QAPI meeting in January 2026, it will be determined by the committee if the continuation of the audits is warranted.
5. Completion date on September 30, 2025

Sunrise of Lincroft

734 Newman Spring Road • Lincroft, NJ 07738 • main 732 212-1910

www.sunrise-seniorliving.com

Licensing

STATE FORM: REVISIT REPORT

| | | |
|--------------------------------------------------------------|-------------------------------------------------|----------------------------------------------------------------------------------------|
| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER COGCWM | MULTIPLE CONSTRUCTION A. Building B. Wing | DATE OF REVISIT 10/3/2025 |
| Y1 | Y2 | Y3 |
| NAME OF FACILITY SUNRISE ASSISTED LIVING OF LINCROFT | | STREET ADDRESS, CITY, STATE, ZIP CODE 734 NEWMAN SPRINGS ROAD LINCROFT, NJ 07738 |

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 A0389 | Correction | ID Prefix A1073 | Correction | ID Prefix | Correction |
| Reg. # 8:36-4.1(a)(16) | Completed | Reg. # 8:36-15.6(b) | Completed | Reg. # | Completed |
| LSC | 09/30/2025 | LSC | 09/30/2025 | 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 | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |

| | | | | |
|---------------------------------------------------|------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|------|
| REVIEWED BY STATE AGENCY <input type="checkbox"/> | REVIEWED BY (INITIALS) | DATE | SIGNATURE OF SURVEYOR | DATE |
| REVIEWED BY CMS RO <input type="checkbox"/> | REVIEWED BY (INITIALS) | DATE | TITLE | DATE |
| FOLLOWUP TO SURVEY COMPLETED ON 7/2/2025 | | <input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO | | |