

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>02C003</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/26/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MASONIC VILLAGE AT BURLINGTON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>902 JACKSONVILLE ROAD</b> <b>BURLINGTON, NJ 08016</b>
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A 000	<p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ00188529 CENSUS: 74 SAMPLE SIZE: 3 SURVEY DATE: 08/25/2025 - 08/26/2025</p> <p>The facility is not in substantial compliance with all 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, based on this Complaint Survey.</p> <p>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> <p>This REQUIREMENT is not met as evidenced</p>	A 389		

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

TITLE

(X6) DATE

09/30/25

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A 389	<p>Continued From page 1</p> <p>by: Based on interview, record review, and facility document and policy review, the facility failed to protect a resident's right to be free from [redacted] for 1 (Resident #1) of 3 sampled residents reviewed for [redacted] and [redacted]. Specifically, the facility failed to ensure that Resident #1, who resided on the [redacted] unit, did not [redacted] unit without the facility's knowledge or supervision.</p> <p>Findings included:</p> <p>An undated facility policy titled, "Emergency Procedure - Missing Resident" indicated, "1. Residents at risk for wandering and/or elopement will be monitored and staff will take necessary precautions to ensure their safety."</p> <p>An undated facility policy titled, "Fire Emergency Response Plan" revealed the section titled, "After Hours Fire Alarm Response - Main Building - Weekends, Holidays, Evenings (4pm -8am)," specified, "As a result of alarm activation all doors will be unsecured. Doors in [name of the secure memory care unit] should be physically monitored as closely as possible."</p> <p>A facility document titled "Mandatory Topic for Nursing Team, [facility name], The Educator, Falls, Safety Devices, Restraints &amp; Alternatives," dated 2025, revealed the facility expected staff to perform "Q1 [every one] hour rounding." The document specified, "Hourly rounding to check on residents is not enough. Rounding needs to be done with a purpose to maximize your time with the residents, anticipate needs and have good results. We need to check ALL residents, not just those who are at risk for falls." The document</p>	A 389		

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A 389	<p>Continued From page 2</p> <p>instructed staff to, "2. Describe Hourly Rounding: 'Because we care for your safety, we are going to check on you every hour. We will not wake you if you are sleeping.'"</p> <p>An "Admission Record" indicated the facility admitted Resident #1 on [redacted]. According to the Admission Record, Resident #1 had a medical history that included diagnoses of [redacted].</p> <p>Resident #1's "Service Plan Report" included a focus area, initiated [redacted], that indicated the resident was at risk of [redacted] "and/or" [redacted]. An interventions dated [redacted] indicated the resident, "May have [redacted] management plan in place." No specific interventions addressing the resident's risk of [redacted] were added until [redacted] when the service plan was updated with interventions that directed staff to ensure all [redacted] were properly functioning, provide frequent safety checks per the facility's protocol, maintain a safe and secure environment with doors locked and [redacted], and to use visual cues and barriers such as stop signs.</p> <p>A "Health and Service Evaluation [redacted] Care" record, effective [redacted] at 9:36 AM, indicated Resident #1 had [redacted].</p> <p>[redacted]. The evaluation also indicated Resident #1 had [redacted] and required [redacted], "because the resident made [redacted]." The evaluation indicated Resident #1 ambulated with the use of a walker.</p>	A 389		

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A 389	<p>Continued From page 3</p> <p>A "NJ Exec Order 26.4b1 - Level of Care Assessment," dated NJ Exec Order 26.4b1 indicated Resident #1's NJ Exec Order 26.4b1. The assessment indicated Resident #1 required NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 did not NJ Exec Order 26.4b1, required NJ Exec Order 26.4b1 in NJ Exec Order 26.4b1, and frequently NJ Exec Order 26.4b1, "unable to NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1 without frequent NJ Exec Order 26.4b1. The assessment further indicated that Resident #1 NJ Exec Order 26.4b1 of other residents' rooms and required NJ Exec Order 26.4b1.</p> <p>A facility "LTC [Long Term Care] Reportable Event Survey" record, dated NJ Exec Order 26.4b1 revealed that on NJ Exec Order 26.4b1 at 4:30 AM it was discovered that Resident #1 NJ Exec Order 26.4b1 through an NJ Exec Order 26.4b1 unit into the NJ Exec Order 26.4b1. The LTC Reportable Event Survey record revealed Resident #1 NJ Exec Order 26.4b1 occupied by an NJ Exec Order 26.4b1 resident, the NJ Exec Order 26.4b1 resident called security, and security responded immediately and NJ Exec Order 26.4b1 Resident #1 back to the NJ Exec Order 26.4b1 at approximately 4:30 AM.</p> <p>The facility's investigation revealed the NJ Exec Order 26.4b1 care unit door malfunctioned following a fire drill on NJ Exec Order 26.4b1 at 10:00 PM, which allowed Resident #1 to NJ Exec Order 26.4b1 unit NJ Exec Order 26.4b1. The facility's investigation revealed Resident #1 was observed on video surveillance NJ Exec Order 26.4b1 the facility's NJ Exec Order 26.4b1 and entering the NJ Exec Order 26.4b1 area on NJ Exec Order 26.4b1 at 1:57 AM. The facility's investigation further revealed Home Health Aide (HHA) #7, who was assigned to Resident #1, was NJ Exec Order 26.4b1.</p>	A 389		
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A 389	<p>Continued From page 4</p> <p>from the unit "for NJ Exec Order 26.4b1 " from 2:26 AM until 4:41 AM and "failed to complete timely bed checks" for Resident #1.</p> <p>A review of security camera footage revealed Resident #1 NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 at 12:42 AM, and the resident NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1 area and sat at a table until 1:56 AM. The security camera footage revealed that on NJ Exec Order 26.4b1 at 1:57 AM, Resident #1 NJ Exec Order 26.4b1 toward the NJ Exec Order 26.4b1 and was NJ Exec Order 26.4b1 on any security cameras. The security camera footage revealed that on NJ Exec Order 26.4b1 at 4:35 AM, Resident #1 was NJ Exec Order 26.4b1 by Security Guard (SG) #9 and the Nurse Supervisor NJ Exec Order 26.4b1 to their room.</p> <p>During an interview on 08/25/2025 at 1:03 PM, Licensed Practical Nurse (LPN) #1 stated staff performed hourly resident rounds to make sure every resident was safe. LPN #1 stated that there were NJ Exec Order 26.4b1 unit, and that was why they resided in a NJ Exec Order 26.4b1 unit.</p> <p>During an interview on 08/25/2025 at 1:22 PM, the Plant Operations Director (POD) stated that when they checked the NJ Exec Order 26.4b1 following Resident #1's NJ Exec Order 26.4b1 they found that the NJ Exec Order 26.4b1. The POD stated the door NJ Exec Order 26.4b1, but did not NJ Exec Order 26.4b1, so it was likely the door did NJ Exec Order 26.4b1 after the fire drill on the night of NJ Exec Order 26.4b1. According to the POD, the issues with the door were repaired.</p> <p>During an interview on 08/25/2025 at 3:32 PM, NJ Exec Order 26.4b1 Resident #10 stated one morning at 4:30 AM they discovered Resident #1 in their kitchen. NJ Exec Order 26.4b1 Resident #10 stated Resident #1 was NJ Exec Order 26.4b1 was not NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 and had</p>	A 389		

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A 389	<p>Continued From page 5</p> <p><b>NJ Exec Order 26.4b1</b>. <b>NJ</b> Resident #10 stated they called security, and security and nursing came quickly.</p> <p>During a telephone interview on 08/25/2025 at 3:57 PM, HHA #5 stated she was working the night of Resident #1's <b>NJ Exec Order 26.4b1</b> but was not assigned to Resident #1. HHA #5 stated the other aide working that night, HHA #7, went on a break around 2:30 AM. HHA #5 stated that when HHA #7 went on break, she positioned herself at the center of the <b>NJ Exec Order 26.4b1</b> so she could monitor both hallways while HHA #7 was gone. HHA #5 stated that while HHA #7 was <b>NJ Exec Order 26.4b1</b> from the unit, she watched both halls the entire time until HHA #7 returned to the unit at close to 5:00 AM. HHA #5 stated that during this time, she used the restroom one time and conducted rounds on her assigned group of residents one time. HHA #5 stated she assumed HHA #7 had checked all of her assigned residents prior to going on break, because that was what they were supposed to do. HHA #5 stated HHA #7 was supposed to return to the unit quicker than she did. HHA #5 stated she did not recall hearing a <b>NJ Exec Order 26.4b1</b> and indicated she would have heard it if an <b>NJ Exec Order 26.4b1</b> had sounded.</p> <p>During a telephone interview on 08/25/2025 at 4:16 PM, LPN #6 stated she covered the <b>NJ Exec Order 26.4b1</b> and the second-floor assisted living unit during the night shift of Resident #1's <b>NJ Exec Order 26.4b1</b>. LPN #6 stated she did rounds between 9:30 PM and 10:00 PM, and all the residents were fine. LPN #6 stated the last time she saw Resident #1 was prior to going upstairs for the change of shift report at 11:00 PM. LPN #6 stated the aides reported that all the residents were okay prior to LPN #6 leaving the unit. LPN #6 stated she returned to <b>NJ Exec Order 26.4b1</b></p>	A 389		

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A 389	<p>Continued From page 6</p> <p>midnight, and HHA #7 said she was going to round on her assigned residents at that time. LPN #6 stated that she went back upstairs after that, she was up and down the stairs several times that night, and she did not realize HHA #7 was absent from the unit until security [redacted] Resident #1 [redacted] to the unit.</p> <p>During an interview on 08/26/2025 at 7:00 AM, SG #9 stated he was there the night that Resident #1 [redacted] NJ Exec Order 26.4b1 [redacted]. SG #9 stated he assisted [redacted] NJ Exec Order 26.4b1 Resident #10 when they reported Resident #1 [redacted] NJ Exec Order 26.4b1 apartment. SG #9 stated [redacted] NJ Exec Order 26.4b1 Resident #10 did not [redacted] NJ Exec Order 26.4b1 any [redacted] NJ Exec Order 26.4b1 and he and the nursing supervisor [redacted] NJ Exec Order 26.4b1 Resident #1 back to the [redacted] NJ Exec Order 26.4b1. SG #9 stated he felt that the staff on the [redacted] NJ Exec Order 26.4b1 should have been aware of Resident #1's [redacted] NJ Exec Order 26.4b1</p> <p>During a telephone interview on 08/26/2025 at 10:45 AM, the Nurse Supervisor stated she supervised the skilled nursing unit, the assisted living unit, and the [redacted] NJ Exec Order 26.4b1 unit at night. The Nurse Supervisor stated SG #9 called her the night Resident #1 [redacted] NJ Exec Order 26.4b1 unit, and when she arrived at the [redacted] NJ Exec Order 26.4b1 apartment, Resident #1 was seated at the kitchen table. The Nurse Supervisor stated she did not know what time Resident #1 [redacted] NJ Exec Order 26.4b1 care unit. Per the Nurse Supervisor, HHA #7 reported that she had not seen the resident since 11:00 PM.</p> <p>During an interview on 08/26/2025 at 1:20 PM, the Wellness Director (WD) stated he expected all residents to be kept safe at all times.</p> <p>During an interview on 08/26/2025 at 1:28 PM, the Executive Director (ED) stated she expected</p>	A 389		

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A 389	Continued From page 7  residents to be kept safe and secure, and staff were responsible for ensuring that safety.	A 389		
A 751	<p>8:36-7.3(b) Resident Assessments and Care Plans</p> <p>(b) The resident health service plan shall be reviewed, and if necessary, revised quarterly, and as needed, based upon the resident's response to the care provided and any changes in the resident's physical or cognitive status.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure timely review and revision of the service plan for 1 (Resident #1) of 3 sampled residents reviewed for service plans.</p> <p>Findings included:</p> <p>A facility policy titled, "Resident Assessments &amp; Service Plans," dated 08/2021, indicated, "3. The general service plan will be reviewed and, if necessary, revised at least semi-annually, and more frequently as needed based upon the resident's response to the care provided and changes in the resident's physical and/or cognitive status."</p> <p>An "Admission Record" indicated the facility admitted Resident #1 on <span style="background-color: black; color: purple;">NJ Exec Order 26.4b1</span>. According to the Admission Record, Resident #1 had a medical history that included diagnoses of <span style="background-color: black; color: purple;">NJ Exec Order 26.4b1</span> and</p>	A 751		

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A 751	<p>Continued From page 8</p> <p>NJ Exec Order 26.4b1</p> <p>A "Health and Service Evaluation <sup>NJ Exec Order 26.4b1</sup> Care" record, effective <sup>NJ Exec Order 26.4b1</sup> at 9:36 AM, indicated Resident #1 had <sup>NJ Exec Order 26.4b1</sup>, even in familiar surroundings, and required <sup>NJ Exec Order 26.4b1</sup> and <sup>NJ Exec Order 26.4b1</sup> for safety. The evaluation also indicated Resident #1 had <sup>NJ Exec Order 26.4b1</sup> and required "NJ Exec Order 26.4b1," because the resident made "NJ Exec Order 26.4b1." The evaluation further indicated Resident #1 <sup>NJ Exec Order 26.4b1</sup> with the use of a walker; required <sup>NJ Exec Order 26.4b1</sup> with <sup>NJ Exec Order 26.4b1</sup> including <sup>NJ Exec Order 26.4b1</sup> to complete the task; and required <sup>NJ Exec Order 26.4b1</sup> with <sup>NJ Exec Order 26.4b1</sup> including <sup>NJ Exec Order 26.4b1</sup> to <sup>NJ Exec Order 26.4b1</sup> the residence or to request emergency assistance.</p> <p>A <sup>NJ Exec Order 26.4b1</sup> - Level of Care Assessment," dated <sup>NJ Exec Order 26.4b1</sup> indicated Resident #1's <sup>NJ Exec Order 26.4b1</sup>. The assessment indicated Resident #1 required <sup>NJ Exec Order 26.4b1</sup> <sup>NJ Exec Order 26.4b1</sup> did not <sup>NJ Exec Order 26.4b1</sup>, required <sup>NJ Exec Order 26.4b1</sup> in <sup>NJ Exec Order 26.4b1</sup>, and frequently <sup>NJ Exec Order 26.4b1</sup> and was at times, "NJ Exec Order 26.4b1." The assessment further indicated that Resident #1 <sup>NJ Exec Order 26.4b1</sup> in and out of other residents' <sup>NJ Exec Order 26.4b1</sup> and required <sup>NJ Exec Order 26.4b1</sup></p> <p>Resident #1's "Service Plan Report" included the following focus areas and interventions: - a focus area, initiated <sup>NJ Exec Order 26.4b1</sup> that indicated the resident required <sup>NJ Exec Order 26.4b1</sup> during <sup>NJ Exec Order 26.4b1</sup> and <sup>NJ Exec Order 26.4b1</sup> interventions initiated on <sup>NJ Exec Order 26.4b1</sup> indicated the resident</p>	A 751		

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A 751	<p>Continued From page 9</p> <p>required <b>NJ Exec Order 26.4b1</b> and occasional reminding on how to use the emergency response system and <b>NJ Exec Order 26.4b1</b> and/or <b>NJ Exec Order 26.4b1</b>. The focus area was not updated to reflect the need for <b>NJ Exec Order 26.4b1</b> including <b>NJ Exec Order 26.4b1</b> assistance, as reflected on the resident's <b>NJ Exec Order 26.4b1</b> Health and Service Evaluation;</p> <p>- a focus area, initiated <b>NJ Exec Order 26.4b1</b> that indicated the resident was at risk of <b>NJ Exec Order 26.4b1</b> "and/or" <b>NJ Exec Order 26.4b1</b>. An interventions dated <b>NJ Exec Order 26.4b1</b> indicated the resident, "May have <b>NJ Exec Order 26.4b1</b> management plan in place." No specific interventions addressing the resident's risk of <b>NJ Exec Order 26.4b1</b> were added until <b>NJ Exec Order 26.4b1</b> when the service plan was updated with interventions that directed staff to ensure all <b>NJ Exec Order 26.4b1</b> were properly functioning, provide frequent safety checks per the facility's protocol, maintain a safe and secure environment with doors locked and <b>NJ Exec Order 26.4b1</b>, and to use visual <b>NJ Exec Order 26.4b1</b> such as <b>NJ Exec Order 26.4b1</b>;</p> <p>- a focus area, initiated <b>NJ Exec Order 26.4b1</b> that indicated the resident had <b>NJ Exec Order 26.4b1</b> that did not interfere with <b>NJ Exec Order 26.4b1</b> in <b>NJ Exec Order 26.4b1</b>. An intervention dated <b>NJ Exec Order 26.4b1</b> indicated that the resident <b>NJ Exec Order 26.4b1</b>." The focus area was not updated to reflect the need for <b>NJ Exec Order 26.4b1</b> "or the resident's inability <b>NJ Exec Order 26.4b1</b> as reflected on the resident's <b>NJ Exec Order 26.4b1</b> Level of Care Assessment; and</p> <p>- a focus area, initiated <b>NJ Exec Order 26.4b1</b> that indicated the resident required assistance with <b>NJ Exec Order 26.4b1</b>. An intervention initiated on <b>NJ Exec Order 26.4b1</b> indicated the resident required <b>NJ Exec Order 26.4b1</b> with <b>NJ Exec Order 26.4b1</b> could <b>NJ Exec Order 26.4b1</b> themselves without <b>NJ Exec Order 26.4b1</b> assistance, but may require reminding or <b>NJ Exec Order 26.4b1</b></p>	A 751		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>02C003</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/26/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MASONIC VILLAGE AT BURLINGTON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>902 JACKSONVILLE ROAD BURLINGTON, NJ 08016</b>
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(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 751	<p>Continued From page 10</p> <p>assistance. The focus area was not updated to reflect the need for <b>NJ Exec Order 26.4b1</b> with <b>NJ Exec Order 26.4</b> as reflected on the resident's <b>NJ Exec Order 26.4b1</b> Health and Service Evaluation.</p> <p>During an interview on 08/26/2025 at 1:20 PM, the Wellness Director (WD) stated he was responsible for updating health service plans. The WD stated the service plans were typically updated every six months or as needed if there was a change in condition. The WD stated he was uncertain when Resident #1's service plan had been updated. The WD stated his expectation was that the service plans be updated at least every six months, and anything new that was needed would be added to the service plan.</p> <p>During an interview on 08/26/2025 at 1:28 PM, the Executive Director (ED) stated her expectation was that service plans were completed within 14 days of admission. The ED stated service plans should then be updated every six months or whenever the resident's needs changed.</p>	A 751		

**STATE FORM: REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 02C003 <span style="float:right">Y1</span>	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 12/31/2025 <span style="float:right">Y3</span>
NAME OF FACILITY MASONIC VILLAGE AT BURLINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 902 JACKSONVILLE ROAD BURLINGTON, NJ 08016	

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 A0751	Correction	ID Prefix	Correction
Reg. # 8:36-4.1(a)(16)	Completed	Reg. # 8:36-7.3(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 8/26/2025		<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		