STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315508	A. BUILDING _____ B. WING _____	C 11/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN POINTE POST ACUTE NURSING & REHABILITATION	3809 BAYSHORE ROAD NORTH CAPE MAY, NJ 08204

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F 000	INITIAL COMMENTS Complaint #: NJ00169106 Census: 103 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=D	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	F 842		12/8/23

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

Electronically Signed | 12/05/2023

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F 842	Continued From page 1	F 842		

records, except when release is-
(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

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F 842	Continued From page 2 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Complaint #NJ00169106 Based on observation, interview, record review, and review of facility documentation on 11/17/23 and 11/20/23, it was determined that the facility failed to: A.) complete neurological evaluations (neuro checks) for a resident who sustained an unwitnessed fall and B.) consistently document on the "Documentation Survey Report" the Activities of Daily Living (ADL) status and care provided to the residents. In addition, the facility failed to follow the facility's policies titled, "Activities of Daily Living, ADLs," and "Falls Management." The deficient practice was identified for Residents #1 and #2, 2 of 3 residents reviewed for medical records documentation and was evidenced by the following: A.) On 11/17/23 at 11:11 AM, the surveyor observed Resident #1 near the nurse's station lying in a Ex.Order 26.4(b)(1) [redacted]) with their eyes closed. The resident did not respond to the surveyor's greetings. According to the Admission Record (AR), Resident #1 was admitted on [redacted], with medical diagnoses that included but were not limited to Exec Order 26, 4b1 NJAC 8:43E-2.1 [redacted]	F 842	1.) Element One-Corrective Action: a.Resident#1's Ex.Order 26.4(b)(1) [redacted] Evaluation Flow Sheet" was completed. The resident did not show any Exec Order 26, 4b1 NJAC 8:43E-2.1 [redacted]. b. Residents #1 and 2's ADL documentation was updated to reflect the care provided. There were no open spaces left on residents #1 and #2 ADL documentation. 2.) Element Two-Identification of at Risk Residents: a. All residents who require a neurological evaluation have the potential to be affected by the facility not completing a "Neurological Evaluation Flow Sheet." b. All residents have the potential to be affected by the facility not completing the "Documentation Survey Report v2" ADL care documentation in it's entirety. 3.)Element Three-Systemic Change: a. All Nursing staff were re-educated on the importance of initiating a neurological evaluation for a resident who has an unwitnessed fall or a witnessed fall where the resident has hit their head. Education included the importance of accurate and appropriate documentation. Staff were educated on maintaining all the necessary documentation in a secured file to ensure compliance. b. Education was provided to all Certified Nursing Assistants the importance of completing the "Documentation Report	

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F 842	Continued From page 3 The admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] revealed a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident's [redacted] The MDS also indicated the resident had [redacted] in the last two to six months prior to admission and had one [redacted] with [redacted], since being admitted to the facility. Review of Resident #1's care plan revealed a "Focus", initiated on [redacted], that the resident was at risk for [redacted] and/or had actual [redacted] related to [redacted], lack of safety awareness, [redacted], a recent hospital stay, [redacted] Review of Resident #1's [redacted] Incident Report (IR), dated [redacted] at [redacted], revealed the Certified Nursing Assistant (CNA) found Resident #1 on the [redacted] next to their bed. Under the, "Incident Description" section, the IR continued that the resident was [redacted] Under the, "Mental Status" section, the IR also indicated that [redacted]) had been initiated. Under the "Notes" section of the IR, dated [redacted], indicated that the interdisciplinary care team met to review the [redacted] and that [redacted] were initiated. Review of the [redacted] Evaluation Flow Sheet" instructed to, '[redacted]	F 842	v2" form that indicates the ADL tasks that were provided to the resident. The expectation is to continue to provide the ADL care to the residents as well as, appropriately documenting all tasks. 4.) Element Four-Quality Assurance: To maintain compliance and on-going monitoring the DON and/or designee will audit 3 resident charts weekly for both the "Neurological Evaluations Flow Sheet" and the "Documentation Survey Report v2" for 2 months. Needed corrections will be addressed as they are discovered. Findings will be submitted to the QAPI committee for review and action as necessary.	

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Ex.Order 26.4(b)(1) [redacted] ."

The surveyor was unable to locate the corresponding "Ex.Order 26.4(b)(1) al Evaluation Flow Sheet" form for the [redacted] in the resident's medical record.

Review of the resident's Progress Notes (PN) revealed a Ex.Order 26.4(b)(1) Practitioner PN which indicated the resident was Ex.Order 26.4(b)(1) evaluated during the visit.

Further review of the PN failed to reveal any documentation that any additional Ex.Order 26.4(b)(1) were performed on 10/29, 10/30, or 10/31.

Review of Resident #1's IR, dated [redacted] and timed [redacted], indicated that the resident had an [redacted] when their Ex.Order 26.4(b)(1) [redacted] with the resident in it. Under the "Mental Status" section revealed that [redacted] had been initiated.

Review of the corresponding Ex.Order 26.4(b)(1) Evaluation Flow Sheet" form for the [redacted] indicated that Ex.Order 26.4(b)(1) began on [redacted] at [redacted]

Further review of the PN did not reveal any documentation that any additiona Ex.Order 26.4(b)(1) were performed on 11/01.

During an interview with the surveyor on 11/20/23 at 10:16 AM, Licensed Practical Nurse (LPN) #1 stated she remembered the incident where Resident #1 had a [redacted] by his/her bedside. LPN #1

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stated she followed the protocol for an [Exec Order 26, 4b1 NJAC 8:43E-2.1] which included initiating [Ex.Order 26.4]

During an interview with the surveyor on 11/20/23 at 12:31 PM, the Registered Nurse/Unit Manager (RN/UM) stated that Ex.Order 26.4(b)(1) would be initiated after a resident had an [Exec Order 26, 4b1 NJAC 8:43E-2.1] The RN/UM stated she believed that [Ex.Order 26.4] were initiated after Resident #1's [Exec Order 26, 4b1] but that she could not locate them.

During an interview with the surveyor on 11/20/23 at 1:17 PM, the Licensed Nursing Home Administrator (LNHA) stated she knew that the Ex.Order 26.4(b)(1) completed after the [Exec Order 26, 4b1] but that she could not produce the documentation.

During an interview with the surveyor on 11/20/23 at 2:09 PM, the Director of Nursing (DON) stated she expected for Ex.Order 26.4(b)(1) to be in place after an [Exec Order 26, 4b1 NJAC 8:43E-2.1].

During a follow-up interview with the surveyor on 11/20/23 at 2:35 PM, the DON stated the purpose of Ex.Order 26.4(b)(1) was to ensure the resident did not have any Ex.Order 26.4(b)(1) from their baseline. The DON continued that the resident might need to go out to the hospital for evaluation if they had a change in their Ex.Order 26.4(b)(1) status.

B.)

1. The surveyor reviewed the medical record for Resident #1:

Review of the admission MDS dated [Exec Order 26, 4b1]

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F 842	Continued From page 6 indicated the resident was dependent for ADLs. Review of Resident #1's care plan revealed a "Focus" that the resident required assistance and was dependent for ADLs related to [redacted] The care plan was initiated on [redacted] and indicated the resident required two staff members to assist them with bed mobility and transfers. Review of Resident #1's "Documentation Survey Report v2" form (DSR) (a form that documents the ADL care provided by the Certified Nursing Assistants (CNAs)) for November 2023 revealed spaces indicating the tasks were not completed as follows: Behavior Symptoms, Bladder Activity, Bowel Activity, Chair/Bed-to-Chair Transfer, Lower Body Dressing, Lying to Sitting on Side of Bed, Oral Hygiene, Personal Hygiene, Putting on/Taking off Footwear, Roll Left and Right rin Bed, Sit to Stand, Sitting on Side of Bed to Lying, Skin Observation, Toilet Transfer, Toileting Hygiene, Upper Body Dressing, Walk 10 Feet, Wheelchair 150 Feet on 11/06/23, 11/11/23, and 11/16/23 on the day shift, on 11/13/23 on the evening shift, on 11/03/23 and 11/13/23 on the night shift. Eating/Drinking, Meal Percentage on 11/06/23, 11/11/23, and 11/16/23 at 9 AM, on 11/06/23, 11/13/23, and 11/16/23 at 1 PM, on 11/13/23 at 6 PM. Bedtime Snack at 8 PM on 11/13/23. 2. The surveyor reviewed the medical record for Resident #2:	F 842		

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According to the AR, Resident #2 was admitted on [redacted] with medical diagnoses that included but were not limited to [redacted]

The quarterly MDS, dated [redacted] revealed a BIMS score of [redacted] which indicated the resident's cognition was [redacted] The MDS also indicated the resident required [redacted] for ADLs.

Review of Resident #2's care plan revealed a "Focus", initiated on [redacted] that the resident was at risk for [redacted] to perform ADLs in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting related to [redacted]

Review of Resident #2's DSR form for November 2023 revealed blank spaces indicating the tasks were not completed as follows:

Behavior Symptoms, Bladder Activity, Bowel Activity, Chair/Bed-to-Chair Transfer, Lower Body Dressing, Lying to Sitting on Side of Bed, Mood Symptoms, Oral Hygiene, Personal Hygiene, Putting On/Taking Off Footwear, Roll Left and Right in Bed, Sit to Stand, Sitting on Side of Bed to Lying, Skin Observation, Toilet Transfer, Toileting Hygiene, Upper Body Dressing, Walk 10 Feet, Wheelchair 150 Feet on 11/04/23, 11/05/23, 11/10/23, 11/14/23, and 11/17/23 on the night shift.

During an interview with the surveyor on 11/17/23 at 12:18 PM, CNA #1 stated that he provided ADL care to residents according to their care plans. CNA #1 continued that CNAs were expected to

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document the ADL care provided to each resident every day and every shift.

During an interview with the surveyor on 11/17/23 at 1:06 PM, the Licensed Practical Nurse (LPN) stated the CNAs should document the care they provide to the residents multiple times throughout the shift.

During an interview with the surveyor on 11/20/23 at 2:09 PM, the Director of Nursing (DON) stated that she expected Resident #1 and #2's DSRs to be filled out, "100%, every single day and every single shift." The DON added the purpose of the ADL documentation was to show the different types of ADL care provided.

Review of the facility policy, "Activities of Daily Living (ADLs)," with an effective date of [redacted] revealed under the "Practice Standards" section that, "ADL care is documented every shift by the nursing assistant."

Review of the facility policy, "Falls Management," with a reviewed date of 03/01/22, revealed under the "Practice Standards" section to, "Perform Neurological Evaluation for all unwitnessed falls and witnessed falls with injury to the head or face."

NJAC 8:39-35.2 (d)(6).

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S 000	Initial Comments Complaint #: NJ00169106 Census: 103 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: Complaint #: NJ00169106 Based on review of other facility documentation on 11/17/23 and 11/20/23 it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratio for the day shift as mandated by the State of New Jersey. The facility was deficient in Certified Nursing Assistants (CNA) staffing for residents on 21 of 28 day shifts and deficient in total staff for residents on 2 of 28 overnight shifts. This	S 560	1.) Element One- Corrective Action No residents were affected by the facility not maintaining the required minimum direct care staff-to-resident ratio for 21 of 28 -day shifts and for 2 of 28 overnight shifts. 2.) Element Two-Identification of at Risk Residents All residents have the potential to be affected by the facility not maintaining the	12/8/23

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

Electronically Signed | 12/05/23

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S 560	Continued From page 1 deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 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 (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) 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 CNA and shall perform nurse aide duties: and One (1) 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. 1. As per the "Nurse Staffing Report" completed by the facility for the weeks of 10/08/2023 to 10/21/2023, the facility was deficient in CNA staffing for residents on 9 of 14 day shifts and deficient in total staff for residents on 1 of 14 overnight shifts as follows: -10/08/23 had 11 CNAs for 102 residents on the day shift, required at least 13 CNAs.	S 560	required minimum direct care staff-to-resident ratios. 3.) Element Three- Systemic Changes To prevent the potential or reoccurrence of the deficient practice the Administrator, DON, and/or designee and the staff scheduler will review the staffing schedule frequently to ensure appropriate staffing ratio requirements are being met. Revisions to the schedule will be made as needed to ensure compliance. Additional financial incentives are offered in an effort to secure staffing. A job fair will be held for recruitment of additional Certified Nursing Assistants. We will conduct a salary survey to ensure we are offering a competitive salary to recruit additional staff. We are currently offering a generous sign-on bonus. We will continue with our rewards and recognition program to retain our current staff. 4.) Element Four-Quality Assurance To maintain and monitor on-going compliance, the Administrator, DON, and/or designee in conjunction with with the staff scheduler will audit schedules two times a week. This practice will continue indefinitely until appropriate staffing is secured. An open position report is provided weekly to Administration. This report provides guidance as to what is needed for recruitment. Findings will be submitted monthly to the QAPI committee for review and action as necessary.	

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PELICAN POINTE POST ACUTE NURSING & REHABIL	3809 BAYSHORE ROAD NORTH CAPE MAY, NJ 08204

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S 560	Continued From page 2 -10/09/23 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. -10/10/23 had 11 CNAs for 100 residents on the day shift, required at least 12 CNAs. -10/11/23 had 10 CNAs for 99 residents on the day shift, required at least 12 CNAs. -10/12/23 had 11 CNAs for 99 residents on the day shift, required at least 12 CNAs. -10/13/23 had 10 CNAs for 98 residents on the day shift, required at least 12 CNAs. -10/16/23 had 8 CNAs for 98 residents on the day shift, required at least 12 CNAs. -10/16/23 had 6 total staff for 98 residents on the overnight shift, required at least 7 total staff. -10/17/23 had 11 CNAs for 98 residents on the day shift, required at least 12 CNAs. -10/21/23 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs. 2. As per the "Nurse Staffing Report" completed by the facility for the weeks of 10/29/2023 to 11/11/2023, the facility was deficient in CNA staffing for residents on 12 of 14 day shifts and deficient in total staff for residents on 1 of 14 overnight shifts as follows: -10/29/23 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs. -10/30/23 had 11 CNAs for 98 residents on the day shift, required at least 12 CNAs. -10/30/23 had 5 total staff for 98 residents on the overnight shift, required at least 7 total staff. -11/02/23 had 10 CNAs for 98 residents on the day shift, required at least 12 CNAs. -11/03/23 had 12 CNAs for 102 residents on the day shift, required at least 13 CNAs. -11/04/23 had 11 CNAs for 102 residents on the day shift, required at least 13 CNAs. -11/05/23 had 12 CNAs for 102 residents on	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05001	A. BUILDING: _____ B. WING _____	C 11/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN POINTE POST ACUTE NURSING & REHABIL	3809 BAYSHORE ROAD NORTH CAPE MAY, NJ 08204

(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 560	Continued From page 3 the day shift, required at least 13 CNAs. -11/06/23 gad 10 CNAs for 102 residents on the day shift, required at least 13 CNAs. -11/07/23 had 12 CNAs for 102 residents on the day shift, required at least 13 CNAs. -11/08/23 had 10 CNAs for 102 residents on the day shift, required at least 13 CNAs. -11/09/23 had 12 CNAs for 102 residents on the day shift, required at least 13 CNAs. -11/10/23 had 12 CNAs for 102 residents on the day shift, required at least 13 CNAs. -11/11/23 had 11 CNAs for 102 residents on the day shift, required at least 13 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)
315508	A. Building B. Wing	12/20/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN POINTE POST ACUTE NURSING & REHABILITATION	3809 BAYSHORE ROAD NORTH CAPE MAY, NJ 08204

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 12/08/2023	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
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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
11/20/2023

☐ 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
05001 Y1	A. Building B. Wing Y2	12/20/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN POINTE POST ACUTE NURSING & REHABILITATION	3809 BAYSHORE ROAD NORTH CAPE MAY, NJ 08204

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 12/08/2023	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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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 11/20/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ YES ☐ NO