STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315460	A. BUILDING _____ B. WING _____	C 03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PROSPECT HEIGHTS LLC	336 PROSPECT AVE HACKENSACK, NJ 07601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS COMPLAINT: # NJ00183692 and NJ00183376 CENSUS: 103 SAMPLE: 10 THE FACILITY IS NOT IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES, BASED ON THIS COMPLAINT VISIT.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policies, it was determined that the facility failed to follow acceptable standards of clinical practice related to assessing residents' [NJ Ex Order 26.4(b)] and accurate implementation of Physician's orders. This deficient practice was identified for 3 of 4 residents reviewed for [NJ Ex Order 26.4(b)] (Resident #2, Resident #3 and Resident #6). 1. According to the "Admission Record (AR)," Resident #2 was admitted to the facility in [NJ Ex Order 26.4(b)(1)], with diagnoses which included but were not limited to: NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and [NJ Ex Order 26.4(b)(1)] ([redacted]).	F 658	Residents affected by deficient practice: " The facility nursing staff (Certified Nursing Assistants and Nurses) failed to have the admission [NJ Ex Order 26.4(b)] on date of admission and once a week for four weeks on Three (3) of the Ten (10) residents in the survey sample (Residents (R) 1, 3, 6). Identify those individuals who could be affected by the deficient practice: " All residents have the potential to be affected by the deficient practice. What corrective action will be accomplished for those residents affected	3/6/25

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

Electronically Signed | 03/31/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315460	A. BUILDING _____ B. WING _____	C 03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PROSPECT HEIGHTS LLC	336 PROSPECT AVE HACKENSACK, NJ 07601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 1 According to the "Minimum Data Set (MDS)," an assessment tool dated NJ Ex Order 26.4(b)(1), Resident #2 had a Brief Interview for Mental Status (BIMS) score of NJ Ex indicating the Resident was NJ Ex Order 26.4(b)(1). The MDS also indicated that Resident #2 required assistance with NJ Ex Order 26.4(b)(1). According to the "Order Summary Report (OSR)," an order dated NJ Ex Order 26.4(b)(1), revealed Resident #'s weights were to be collected on admission, then every Monday for 4 weeks. According to the 'NJ Ex Order 26.4(b)(1)," there was one documented NJ Ex Order 26. that was collected on NJ Ex Order 26.4(b)(1) No documentation in the Progress Notes (PN) on why weights were not collected. 2. According to the AR," Resident #3 was admitted to the facility in NJ Ex Order 26.4(b)(1), with diagnoses which included but were not limited to: NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) According to the MDS dated NJ Ex Order 26.4(b)(1), Resident #3 had a BIMS score of NJ Ex indicating the Resident had NJ Ex Order 26.4(b)(1). The MDS also indicated that Resident #3 required assistance with NJ Ex Order 26 According to the OSR, an order dated NJ Ex Order 26.4(b)(1), revealed Resident #3's NJ Ex Order 26.4(b) were to be collected on admission, then every Monday for 4 weeks. According to the WVS, there were no NJ Ex Order 26.4(b) collected after Resident #3's re-admission.	F 658	by the deficient practice: " The registered dietician will review all new resident admissions to ensure that weights are taken and recorded in PCC within 72 hours of admission. " All nursing staff re-educated on importance of following orders and if there is a refusal, the nurse would document the refusal and notify the registered dietician. " Responsibility of monitoring weights was re-emphasized with registered dietician and making recommendations as appropriate. Measures or systemic changes to ensure that the deficiency will not recur: " The registered dietician will review weekly all new admission weights for compliance. " Audits will be completed weekly X 4 weeks. Results of audit process will be reviewed at the Quarterly QAPI Meeting to ensure compliance and reassessed for further action. Date of Completion: 3/6/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315460	A. BUILDING _____ B. WING _____	C 03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PROSPECT HEIGHTS LLC	336 PROSPECT AVE HACKENSACK, NJ 07601

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F 658	Continued From page 2	F 658		

There was no documentation in the PN on why [NJ Exec Order 26.4] were not collected.

3. According to the AR," Resident #6 was admitted to the facility in [NJ Ex Order 26.4(b)(1)], with diagnoses which included but were not limited to: [NJ Exec Order 26.4b1].

According to the MDS dated [NJ Ex Order 26.4(b)(1)], Resident #6 had a BIMS score of [NJ Ex O] indicating the Resident was [NJ Ex Order 26.4(b)(1)]. The MDS also indicated that Resident #6 required [NJ Exec Order 26.4b1] with [NJ Ex Order 26].

According to the OSR, an order dated [NJ Ex Order 26.4(b)(1)] revealed Resident #6's [NJ Ex Order 26.4(b] were to be collected on admission, then every Monday for 4 weeks.

According to the [NJ Ex Order 2] there was one [NJ Ex Order 26.] collected on [NJ Ex Order 26.4(b)(1)]

There was no documentation in the PN on why [NJ Exec Order 26.] were not collected.

During an interview with the [U.S. FOIA (b) (6)] on [NJ Ex Order 26] at 11:22 AM, he revealed that he was responsible for monitoring [NJ Ex Order 26.4(b)(1)]. He stated that [NJ Ex Order 26.4(b] are to be collected on the date of admission and once a week for 4 weeks, unless they are ordered to be on daily [NJ Ex Order 26.4(b)]. He further stated that if the [NJ Ex Order 26] was not collected, he expected staff to inform him by documenting refusal in the [NJ Ex Order 26.] binder, and he would document on the [NJ Ex Order 26.] refusal in the medical record.

During an interview with the U.S. FOIA (b) (6)) on 3/5/25 at 4:16 PM, she stated the [U.S. FOIA] would provide to the U.S. FOIA (b) (6)

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	315460	A. BUILDING _____ B. WING _____	C 03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PROSPECT HEIGHTS LLC	336 PROSPECT AVE HACKENSACK, NJ 07601

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F 658		F 658		

Continued From page 3

U.S. FOIA (b) (6)) a list of residents who would need to be NJ Ex Order 26.4(b)(1) States that the U.S. FOIA (b) (6) or the nurse documents the NJ Ex Order 26.4(b) If there was a refusal, the nurse would document the refusal and notify the U.S. FOIA (b) (6)

According to the job description for the U.S. FOIA (b) under the heading for Major Duties and Responsibilities, revealed the U.S. FOIA (b) "Assists with NJ Ex Order 26.4(b)(1) residents according to facility policy, and records NJ Ex Order 26 in designated locations. Reports NJ Ex Order 26.4(b)(1) to nurse and supervisor."

According to the job description of the U.S. FOIA (b) (6) under the Major Duties and Responsibilities, revealed the U.S. FOIA "Transcribes physician orders to medical record and carry out orders as written."

According to the job description of the U.S. FOIA (b) (6)), under the Major Duties and Responsibilities, revealed the U.S. FO "Transcribes physician orders to medical record and carry out orders as written."

According to the job description for the U.S. FOIA (b) (6) under the heading for Major Duties and Responsibilities, revealed the U.S. FOIA (b) (6) "Monitors residents for weight changes, nutrition support, and skin breakdown, and makes recommendations as needed."

The undated facility policy titled "Weight Policy," under Compliance Guidelines, 5. "A weight monitoring schedule will be developed upon admission for all residents: a. Newly admitted residents-Weigh on admission and monitor weight weekly for 4 weeks."

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PROSPECT HEIGHTS LLC	**336 PROSPECT AVE HACKENSACK, NJ 07601**

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F 658	Continued From page 4 NJAC 8:39-11.2 (b)	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056300	A. BUILDING: _____ B. WING _____	C 03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PROSPECT HEIGHTS LL	336 PROSPECT AVE HACKENSACK, NJ 07601

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S 000	Initial Comments Complaint #: NJ00183692 The facility was not in compliance with the standards in the New Jersey Administrative code, 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 The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 13 day shifts. The deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated)	S 560	Residents affected by deficient practice: • All Residents are affected by the deficient practice. The following corrective action will be taken for those residents found to be affected: DON/Designee will review staffing needs with staffing coordinator/HR designee regularly and check that staff par levels meet the required ratios. DON/Designee will continue to advertise staffing needs through recruitment agencies. No negative outcomes were observed.	3/6/25

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

Electronically Signed | 03/31/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. For the week of Complaint staffing from 02/09/2025 to 02/22/2025 for the 03/05/2025 Complaint survey, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows: -02/09/25 had 11 CNAs for 110 residents on the day shift, required at least 14 CNAs. -02/10/25 had 11 CNAs for 110 residents on the day shift, required at least 14 CNAs. -02/11/25 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs. -02/12/25 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs. -02/13/25 had 11 CNAs for 110 residents on the day shift, required at least 14 CNAs. -02/14/25 had 12 CNAs for 114 residents on the day shift, required at least 14 CNAs.	S 560	Identify those individuals who could be affected by the deficient practice: • All residents have the potential to be affected by the deficient practice. What corrective action will be accomplished for those residents affected by the deficient practice: • The following measures and systemic changes will be put in place to attempt to prevent the deficient practice from recurring: DON/Designee will review staffing needs with staffing coordinator/HR designee daily on an ongoing basis for progress and to monitor mandatory staffing requirements. HR Designee will continue to maintain a recruitment & hiring log, to track all C.N.A. applicants and outcomes. Facility to continue to post open C.N.A. positions on job sites and job fairs. Current C.N.A. rates are at market rate. Measures or systemic changes to ensure that the deficiency will not recur: • The following programs will be put into place to monitor the continued effectiveness of the systemic changes: HR Designee will discuss staffing recruitment and retention plan monthly. Recommendations will be reviewed submitted quarterly to The Quality Assurance Performance Improvement (QAPI) Committee, chaired by the Administrator. • Audits will be completed weekly X 4 weeks. Results of audit process will be reviewed at the Quarterly QAPI Meeting to ensure compliance and reassessed for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 2 -02/15/25 had 8 CNAs for 110 residents on the day shift, required at least 14 CNAs. -02/16/25 had 9 CNAs for 109 residents on the day shift, required at least 14 CNAs. -02/17/25 had 12 CNAs for 109 residents on the day shift, required at least 14 CNAs. -02/18/25 had 13 CNAs for 109 residents on the day shift, required at least 14 CNAs. -02/19/25 had 12 CNAs for 109 residents on the day shift, required at least 14 CNAs. -02/20/25 had 12 CNAs for 110 residents on the day shift, required at least 14 CNAs. -02/22/2025 had 10 CNAs for 108 residents on the day shift, required at least 13 CNAs.	S 560	further action. Date of Completion: 3/6/2025	
S1680	8:39-25.2(b)(1)&(2) Mandatory Nurse Staffing (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a)) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00	S1680		3/6/25

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S1680	Continued From page 3 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day	S1680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1680	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on review of the AAS-12 staffing from 02/09/2025 to 02/22/2025, for the 03/05/2025 Complaint survey, it was determined that the facility was deficient in staffing for resident required services as follows: For the week of 02/09/25 Required Staffing Hours: 333.25 -02/15/25 had 320 actual staffing hours, for a difference of -13.25 hours. For the week of 02/16/25 Required Staffing Hours: 324.75 -02/16/25 had 312 actual staffing hours, for a difference of -12.75 hours.	S1680	Residents affected by deficient practice: • All Residents are affected by the deficient practice. The following corrective action will be taken for those residents found to be affected: DON/Designee will review staffing needs with staffing coordinator/HR designee regularly and check that staff par levels meet the required ratios. DON/Designee will continue to advertise staffing needs through recruitment agencies. No negative outcomes were observed. Identify those individuals who could be affected by the deficient practice: • All residents have the potential to be affected by the deficient practice. What corrective action will be accomplished for those residents affected by the deficient practice: • The following measures and systemic changes will be put in place to attempt to prevent the deficient practice from recurring: DON/Designee will review staffing needs with staffing coordinator/HR designee daily on an ongoing basis for progress and to monitor mandatory staffing requirements. HR Designee will continue to maintain a recruitment & hiring log, to track all Nurse applicants and outcomes. Facility to continue to post open Nurse positions on job sites and job fairs. Current Nurse rates are at market rate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1680	Continued From page 5	S1680	Measures or systemic changes to ensure that the deficiency will not recur: • The following programs will be put into place to monitor the continued effectiveness of the systemic changes: HR Designee will discuss staffing recruitment and retention plan monthly. Recommendations will be reviewed submitted quarterly to The Quality Assurance Performance Improvement (QAPI) Committee, chaired by the Administrator. • Audits will be completed weekly X 4 weeks. Results of audit process will be reviewed at the Quarterly QAPI Meeting to ensure compliance and reassessed for further action. Date of Completion: 3/6/2025	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315460 Y1	A. Building B. Wing Y2	5/27/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PROSPECT HEIGHTS LLC	336 PROSPECT AVE HACKENSACK, NJ 07601

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 F0658	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/06/2025	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	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/5/2025	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
056300 Y1	A. Building B. Wing Y2	5/27/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PROSPECT HEIGHTS LLC	336 PROSPECT AVE HACKENSACK, NJ 07601

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	Correction	ID Prefix S1680	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-25.2(b)(1)&(2)	Completed	Reg. #	Completed
LSC	03/06/2025	LSC	03/06/2025	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 ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/5/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO