STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315500	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VOORHEES	**1086 DUMONT CIRCLE , VOORHEES, New Jersey, 08043**

(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
F0000	INITIAL COMMENTS A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations. Complaint #: NJ00168872 NJ00177847, NJ00178267, and NJ00182337 Survey Dates: 07/22/25 – 07/24/25 Survey Census: 109 Sample Size: 27 Supplemental Residents: 8 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 RECERTIFICATION AND COMPLAINT VISIT.	F0000		08/06/2025
F0645 SS = D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,	F0645	F645 Completion Date: 9/15/2025 Immediate Action Social Worker submitted information for Preadmission Screening and Resident Review (PASARR) for a re-evaluation for resident #79 on [redacted]. New PASARR for resident #79 was completed on [redacted] and [redacted] was identified indicating the need for a referral for a[redacted]. Resident At-risk	09/15/2025

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315500	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

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F0645 SS = D	Continued from page 1 (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental	F0645	Continued from page 1 Facility completed an audit of current residents Preadmission Screening and Resident Review (PASARR) to ensure that any resident with a new mental health diagnosis(s) had a PASARR evaluation completed, and any mental health diagnosis(s) were identified on the current PASARR screen. Those residents identified that do not have an accurate PASARR evaluation on file will be reviewed for a new PASARR screening. Systemic Change Administrator provided education to the Social Worker(s) and Admissions Director on the requirements of the Preadmission Screening and Resident Review (PASARR) processing for mental disorders and individuals with intellectual disabilities. Quality Assurance The Social Worker(s) and Admission Director will audit each resident PASARR Screen at the time of admission. Then quarterly thereafter as needed for any significant changes or acute mental changes. Social Work will report the findings of the audits in the Quality Assurance Meetings to ensure compliance for 12 months. The QAA and the QAPI committee will review the effectiveness of the implemented corrective actions and determine if further action is needed for 12 months. If necessary, they will make adjustments to protocols or corrective actions to ensure continued compliance and improvement.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315500	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

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F0645 SS = D	Continued from page 2 disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure that one out of three resident (Resident (R) 79) with a Level I PASARR (Preadmission Screening and Resident Review), who later was identified with NJ Ex Order 26.4(b)(1) , was evaluated through the NJ Ex Order 26.4(b)(1) process in a total sample of 38 residents. This deficient practice resulted in R79 not being evaluated for and/or provided specialized care and treatment for NJ Ex Order 26.4(b)(1) [redacted]. Findings include: Review of a "Resident Face Sheet" found in R79's electronic medical record (EMR) under the "Profile" tab indicated the resident was admitted to the facility on NJ Ex Order 26.4[redacted]. Review of a document titled "New Jersey Department of Human Services . . . Pre- Admission Screening and Resident Review (PASRR) Level 1 Screen. . ." located under the "Misc (Miscellaneous)" tab dated NJ Ex Order 26[redacted] indicated the resident was NJ Ex Order 26.4[redacted] for NJ Ex Order 26.4(b)(1) [redacted]. Review of R79s' EMR tab titled "Med (Medical) Diag (Diagnosis)" indicated the resident was diagnosed with NJ Ex Order 26.4(b)(1) [redacted] on NJ Ex Order 26.4(b[redacted]. Review of the quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ Ex Order 26.4[redacted] indicated R79 had a "Brief Interview for Mental Status (BIMS) score of NJ E[redacted] out of 15, which revealed the resident was NJ Ex Order 26.4(b)(1)[redacted]. Review of R79's EMR titled "NJ Ex Order 26.4(b)(1) [redacted]" dated NJ Ex Order 26.4(b[redacted] revealed the resident was diagnosed with NJ Ex Order 26.4(b)(1) [redacted].	F0645		

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F0645 SS = D	Continued from page 3 Review of R79's EMR failed to contain a referral for [NJ Ex Order 2] PASARR. During an interview conducted on 07/24/25 at 9:00 AM, the [U.S. FOIA (b) (6)]) stated if there was a new [NJ Ex Order 26.4(b)(1)] diagnosis that [NJ Ex Order 26.4(] referral would be made to ensure that the resident received appropriate services. During an interview conducted on 07/24/25 at 10:56 AM the [U.S. FOIA (b) (6)] confirmed she was not aware of R79's new diagnosis of [NJ Ex Order 26.4(b)(1)] and a referral for a [NJ Ex Order 2] should have been done and confirmed the referral was not completed. NJAC 8:39-5.1(a)	F0645		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 158336	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VOORHEES	1086 DUMONT CIRCLE , VOORHEES, New Jersey, 08043

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S0000	Initial Comments 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.	S0000		08/06/2025
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. 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 Certified Nurse Aide (CNA) to every eight residents for the day shift.	S0560	S-560 Completion Date: 9/6/2025 CORRECTIVE ACTION: Efforts to hire facility staff will continue until there is adequate staff to serve all residents. Until that time, the facility will utilize staffing agencies to fill any open spots in the schedule. IDENTIFICATION OF THE RESIDENTS AT RISK: All residents have the potential to be at risk for deficient practice. SYSTEMIC CHANGE: The facility Administrator has put in place a bonus structure as to help increase the levels of staffing according to census. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, online job listings, job fairs, shift differentials and referral bonuses are being utilized to become more competitive in the marketplace. In addition, the director of nursing or designee will meet daily with the staffing coordinator to ensure appropriate staffing. QUALITY ASSURANCE: The Director of Nursing or designee will review staffing schedules daily to ensure adequate staffing for all shifts. Findings from the review will be reported to the Administrator. Any issue from the findings will be addressed immediately. The results of the staffing review will be submitted to the QA quarterly until compliance is met.	09/06/2025

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 158336	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

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S0560	Continued from page 1 One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA 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 09/02/2024 to 09/28/2024, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -09/02/24 had 11.5 CNAs for 114 residents on the day shift, required at least 14 CNAs. For the week of Complaint staffing from 10/13/2024 to 10/19/2024, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -10/13/24 had 10 CNAs for 114 residents on the day shift, required at least 14 CNAs.	S0560		

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 9/17/2025 in relation to the 7/24/2025 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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 reverse for further 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.

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New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 158336	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2025

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 9/17/2025 in relation to the 7/24/2025 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities	S0000		

Office of Primary Care and Health Systems Management

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315500	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING **01 - MANOR CARE AT V...** B. WING	**07/24/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 07/23/25 and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Autumn Lake Healthcare at Voorhees is a two-story building built in 2000. It is composed of Type II protected construction. The facility is divided into six - smoke zones. The generator powers 100% of the building per the Maintenance Director. The current occupied beds are 105 of 127.	K0000		08/06/2025
K0271 SS = F	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure stairs located outside the exit door were equipped with a handrail in accordance with NFPA 101 Life Safety Code (2012 Edition) section 7.2.2.4.1.1. and 7.2.2.4.1.6. This deficient practice had the potential to affect all 60 residents who resided in that wing of the facility and was evidenced by the following: An observation on 07/24/25 at 12:58 PM revealed that	K0271	Observation / Deficiency Statement K0271 – Discharge from Exits Based on observation and staff interview, the facility failed to maintain the exit discharge in a safe and code-compliant condition. On 07/24/2025 at 12:58 PM, surveyors observed that the exterior stairs serving Stairway 1D were not provided with a circular, graspable handrail along the stair run. This condition does not comply with NFPA 101 (2012), 7.7 and 7.1.7 for safe exit discharge and maintenance of level, unobstructed egress surfaces, and applicable state requirements at NJAC 8:39-31.2(e). During a concurrent interview, the Maintenance Director and the Regional Administrator confirmed that the exterior stairs at Stairway 1D did not have a handrail. Potential impact: This deficient practice could affect all residents, staff, and visitors who may use this exit during routine movement or an emergency. 1) Corrective action for the affected area:	09/06/2025

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315500	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING **01 - MANOR CARE AT V...** B. WING	**07/24/2025**

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K0271 SS = F	Continued from page 1 the stairs outside stairway 1D were not provided with a circular, graspable handrail. During an interview at the time of observation, the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) confirmed that the stairs did not have a handrail. NJAC 8:39-31.2(e)	K0271	Continued from page 1 By 9/6/25: Engage to install a continuous, graspable, circular handrail with secure returns at terminations and proper mounting height, in accordance with NFPA 101 handrail provisions applicable to stairs serving the exit discharge. After installation, maintenance will verify secure anchorage and continuity and document with photographs. 2) Systemic changes to prevent recurrence: Updated the Preventive Maintenance (PM) schedule to include quarterly inspections of all exit discharges (stairs, ramps, handrails, guards, walking surfaces) and after any severe weather events. 3) Monitoring / quality assurance: Maintenance Director (or designee) will perform monthly audits of all exit discharge points using the Exit Discharge Checklist for 3 months, then quarterly for 12 months. Audit results will be reported to QA committee monthly for 3 months and then quarterly, with corrective actions tracked to closure.	
K0741 SS = F Bldg. 01	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible	K0741	Completion Date: 8/1/2025 K 741 Corrective Action Metal containers with self-closing lids were immediately placed in all areas where residents or staff smoking is permitted. The non-compliant trash bins used for cigarette disposal were removed and replaced. The outdoor designated smoking area was cleared of combustible debris (e.g., dried grass, leaves, and cigarette butts). Cigarette butts and ash were immediately removed from any general-purpose trash cans and relocated to designated metal containers. Identification of At-Risk Resident All residents have the potential to be affected by this	08/01/2025

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K0741 SS = F Bldg. 01	Continued from page 2 shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to provide metal canisters with self-closing lids at smoking area in accordance with NFPA 101 Life Safety Code (2012 Edition) section 19.7.4 (6). This deficient practice had the potential to affect 105 residents and was evidenced by the following: Observation on 07/23/25 at 2:06 PM of the smoking area outside the main dining room on the first floor, revealed that no metal container with a self-closing lid was present in the smoking area. outside the main dining room on the first floor. During an interview at the time of observation, the U.S. FOIA (b) (6) confirmed that no metal canister with a self-closing lid was present in the smoking area. NJAC 8:39-31.2(e)	K0741	Continued from page 2 deficient practice Systemic Change Implemented Q shift inspection and cleaning of designated smoking areas by maintenance. Staff were in-serviced by the maintenance director to report any unsafe conditions or misuse of smoking areas to the Maintenance or Nursing Supervisor immediately. The Maintenance Director or designee will conduct weekly inspections of all designated smoking areas for presence and condition of compliant metal containers and accumulation of debris or improperly disposed cigarette butts. Quality Assurance The maintenance director will report the findings of the weekly inspections of the smoking area audits to the administrator monthly for 6 months and quarterly to QA 12 months. The QA will review the effectiveness of the implemented corrective actions and determine if further action is needed. If necessary, adjustments to protocols or corrective actions to assure continued compliance and improvement.	

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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) COMPLETION DATE
E0000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 07/23/25. The facility was found to be in compliance with 42 CFR 483.73.	E0000		08/06/2025

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315500	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING **01 - MANOR CARE AT V...** B. WING	**09/17/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT VOORHEES	**1086 DUMONT CIRCLE , VOORHEES, New Jersey, 08043**

(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
K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 9/17/2025 in relation to the 7/24/2025 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.	K0000		

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 reverse for further 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.

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