STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15c001	A. BUILDING: _____ B. WING _____	C 02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT COLLI	460 HADDON AVENUE COLLINGSWOOD, NJ 08108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ00131702, NJ00158881 CENSUS: 94 SAMPLE SIZE: 8 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;	A 310		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 310	Continued From page 1	A 310		

This REQUIREMENT is not met as evidenced by:
NJ00131702, NJ00158881

Based on staff interview and review of medical and facility records, it was determined the facility failed to ensure it's policy and procedure titled, " Medication Management Program Guidelines (RS-10)" was implemented for 1 of 8 residents, Resident #2. This deficient practice was evident by the following:

On 2/1/24 at 10:55 a.m., the surveyor reviewed Resident #2's Medication Administration Record (MAR) titled "NON-PRN MEDICATION NOTES" dated Ex Order 26.4B1 and identified the Ex Order 26.4B1 to be administered every morning was signed out in the MAR as "Not Administered (Medication Not Available)" for 10 days on Ex Order 26.4B1 through and including Ex Order 26.4B1 The surveyor also identified the medication was signed out as "Not Administered (Resident Out Of Facility) on Ex Order 26.4B1 totaling [redacted] days.

During the medical record (MR) review at 10:55 a.m., the surveyor did not identify documented evidence the U.S. FOIA (b)(6) or the nursing staff contacted the residents physician regarding the unavailable medication.

At 4:10 p.m., the surveyor interviewed the Licensed Practical Nurse (LPN) regarding the residents Ex Order 26.4B1 medication being unavailable from Ex Order 26.4B1 and including Ex Order 26.4B1 The LPN stated as she can recall the Ex Order 26.4B1 medication required a

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UNITED METHODIST COMMUNITIES AT COLLI	460 HADDON AVENUE COLLINGSWOOD, NJ 08108

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A 310	Continued From page 2 refill and the Registered Nurse made phone calls to the resident's Physician. On 2/2/24 at 2:00 p.m., the survey reviewed the RN's employee file and identified a hire date of Ex Order 26.4B1 and a termination letter dated Ex Order 26.4B1 which revealed "[Resident #2] went without Ex Order 26.4B1 medication for a period of Ex Or days. There was no documentation in the medical record that any contact was made to the physician to refill the medication ..." The surveyor then interviewed the Executive Director and the Regional Corportate Nurse regarding documentation of the unavailable Ex Order 26.4B Ex Order 26.4B1 medication related to the reportable event on Ex Order 26.4B1 for medication error and both stated they were unable to locate any documented records. At 3:00 p.m., the surveyor reviewed the facility policy and procedure titled, "Medication Management Program Guidelines (RS-10)" which listed ... All staff shall follow general guidelines for safe and appropriate handling of medications. Medications will be administered to residents in a safe effective manner in accordance with physician orders or protocols and prescribed principles and procedures. POLICY PURPOSE To [e]nsure safe and timely delivery of medication and care to those under the [Facility's] staff, and to communicate effectiveness of medication to other members of the health care team through appropriate, accurate and timely documentation. ...Physician Orders/Prescriptions ...page 3 ...The attending physician shall be contacted by nursing for direction when delivery of a medication will be delayed or the medication is not or will not be available. ..."	A 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 310	Continued From page 3 The facility was unable to provide documented records to confirm the RN notified the residents physician for the blood pressure medication refill according to its "Medication Management Program Guidelines (RS-19)" policy and procedure. Reference: 8:36-11.4(b)	A 310		
A 355	8:36-4.1(a)(1) Resident Rights comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, 1. The right to receive personalized services and care in accordance with the resident's individualized general service and/or health service plan; This REQUIREMENT is not met as evidenced by: NJ00131702, NJ00158881 Based on interview, record review and review of pertinent facility documents it was determined that the facility failed to provide care and services to 1 of 8 residents, Resident #2, in accordance with physician's orders for medication administration. This deficient practice was	A 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 355	Continued From page 4 evidenced by the following: On 2/1/24 at 10:55 a.m., the surveyor reviewed the closed medical record (MR) of Resident #2 which revealed the resident was admitted on Ex Order 26.4B1 and died on Ex Order 26.4B1 with multiple diagnoses, one being Ex Order 26.4B1. According to the "Physician Order Sheet" dated Ex Order 26.4B1 the resident was to be administered Ex Order 26.4B1 (controlled delivery) Ex Order 26.4B1 Ex Order 26.4B1 (Ex Order 26.4B1 " for Ex Order 26.4B1 management. Further review of the MR, revealed the staff documented in the "NON-PRN MEDICATION NOTES" Resident #2's Ex Order 26.4B1 medication had not been available to administer for Ex Order days Ex Order 26.4B1 through and including Ex Order 26.4B1. Additionally, the surveyor identified on Ex Order 26.4B1 the Licensed Practical Nurse (LPN) documented the Ex Order 26.4B1 medication was not administered due to the resident being transferred out of the facility, totaling Ex Order days. At 4:26 p.m., the surveyor interviewed the (LPN) regarding the availability of the residents Ex Order 26.4 Ex Order 26.4B1 medication. The LPN stated the medication required a refill and the Registered Nurse (RN) placed calls to the physician. On 2/2/24 at 11:00 a.m., the surveyor interviewed the facility Corporate RN (CRN) regarding the resident's Ex Order 26.4B1 medication not being available for administration. The CRN stated she heard about the Ex Order 26.4B1 medication, but the U.S. FO who worked at the time Ex Order 26.4B1 was no longer on staff at the facility. At 2:00 p.m., the survey reviewed the RN's employee file and identified a hire date of Ex Order 26.4B1	A 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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UNITED METHODIST COMMUNITIES AT COLLI	460 HADDON AVENUE COLLINGSWOOD, NJ 08108

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A 355	Continued From page 5 and a termination letter dated Ex Order 26.4B1 which revealed "[Resident #2] went without Ex Order 26.4B1 medication for a period of Ex Order days. There was no documentation in the medical record that any contact was made to the physician to refill the medication ..." Additional review of the MR, revealed no documented evidence to verify Resident #2's physician was notified of the Ex Order 26.4B1 medication not being available for administration as prescribed. The facility failed to ensure Resident #2 received medication care services in accordance with physician orders for maintenance of Ex Order 26.4B1 Ex Order 26.4B1.	A 355		
A 563	8:36-5.10(a)(2) General Requirements (a) The facility shall notify the Division of Health Facility Survey and Field Operations immediately by telephone at (609) 633-9034 (609) 392-2020 if after business hours, followed within 72 hours by written confirmation, of the following: 2. Any major occurrence or incident of an unusual nature, including, but not limited to, all fires, disasters, any elopements; and all deaths resulting from accidents or incidents in the facility or related to facility services. Reports of such incidents shall contain information about injuries to residents and/or personnel, disruption of services, and extent of damages;	A 563		

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A 563	Continued From page 6	A 563		

This REQUIREMENT is not met as evidenced by:
NJ00131702, NJ00158881

Based on interview and record review, it was determined that the facility failed to Immediately report a medication error to the Department of Health (DOH) which resulted in a change in medical condition and hospitalization for 1 of 8 residents reviewed, Resident #2. This deficient practice was evidenced by the following:

On 2/1/24 and 2/2/24 the Department of Health (DOH) conducted a survey regarding a Facility Reportable Event (FRE) received on Ex Order 26.4B1 which identified a resident medication error. According to the FRE, the medication error was discovered on Ex Order 26.4B1, and not reported to DOH due to auditing, and staff in-services.

On 2/1/24 at 9:50 a.m., the surveyor interviewed the Executive Director (ED) regarding the FRE for the medication error. The ED stated she worked at the facility for NJ Ex Order 26.4B1 and was not familiar with the details of the investigation but would check the facility records.

At 10:55 a.m., the surveyor reviewed the closed medical record (MR) of Resident #2 which was admitted on Ex Order 26.4B and died on Ex Order 26.4B1 with Ex Order 26.4B1 diagnoses, one being Ex Order 26.4B1

Additionally, the surveyor reviewed Resident #2's

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A 563	Continued From page 7 Medication Administration Record (MAR) titled, "NON-PRN MEDICATION NOTES" dated NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1, and identified Ex Order 26.4B1 Ex Order 26.4B1) to be administered every morning for Ex Order 26.4B1 was signed out in the MAR as "Not Administered (Medication Not Available)" for Ex Orl days on Ex Order 26.4B1 through and including Ex Order 26.4B1. The surveyor also identified the medication was signed out as "Not Administered (Resident Out Of Facility) on Ex Order 26.4B1, totaling Ex Orl days. At 2:28 p.m., the surveyor interviewed the Corporate Registered Nurse who stated the facility was unable to locate the incident investigation documentation for the FRE. The ED also confirmed the documentation for the FRE was not available. The facility reported the medication error on Ex Order 26.4B1 which was fourteen days after discovery on Ex Order 26.4B1 Reference: A-0935, 8:36-11.4(b)	A 563		
A 935	8:36-11.4(b) Pharmaceutical Services (b) All medications shall be administered by qualified personnel in accordance with prescriber orders, facility or program policy, manufacturer's requirements, cautionary or accessory warnings, and all Federal and State laws and regulations.	A 935		

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A 935	Continued From page 8 This REQUIREMENT is not met as evidenced by: NJ00131702, NJ00158881 Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure medication was administered according to the Physicians orders and facility policy for 1 of 8 residents, Resident #2. This deficient practice was evidenced by the following: On 2/1/24 and 2/2/24 the Department of Health (DOH) conducted a survey regarding a Facility Reportable Event (FRE) received on [redacted] which identified a resident medication error. On 2/1/24 at 9:50 a.m., the surveyor interviewed the Executive Director (ED) regarding the FRE for the medication error. The ED stated she worked at the facility for [redacted] and was not familiar with the details of the investigation but would check the facility records. At 10:55 a.m., the surveyor reviewed the closed medical record (MR) of Resident #2 which was admitted on [redacted] and died on [redacted] with [redacted] diagnoses, one being [redacted] According to the [redacted] "Physician Order Sheet," the resident was ordered '[redacted]. Additionally, the surveyor reviewed Resident #2's Medication Administration Record (MAR) titled "NON-PRN MEDICATION NOTES" dated [redacted] and identified the	A 935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 935	Continued From page 9	A 935		

Ex Order 26.4B1) to be administered every morning was signed out in the MAR as "Not Administered (Medication Not Available)" for Ex Ord days on Ex Order 26.4B1 through and including Ex Order 26.4B1 The surveyor also identified the medication was signed out as "Not Administered (Resident Out Of Facility) on Ex Order 26.4B1 " totaling Ex Ord days.

Further review of the MR, revealed on 11/26/19 the Licensed Practical Nurse (LPN) documented in the "Clinical Notes Report" the resident was found in bed during morning medication pass with Ex Order 26.4B1 . ... [with] Ex Order 26.4B1 [and the residents] Ex Order 2 Ex Order 26.4 (clinical measurements that indicates the state of a persons body functions) were obtained Ex Order 26.4B1 , Ex Order 26.4B1 . [Emergency Services] 911 was called and [Resident #2] was transferred to the Hospital. ... [The resident was] admitted to Ex Order 26.4B1

At 12:46 p.m., during medication administration observation, the surveyor interviewed the Certified Medication Aide (CMA #1) regarding Resident #2's Ex Order 26.4B1 medication, she signed out in the MAR as not administered, unavailable on Ex Order 26.4B1 and Ex Order 26.4B1 The CMA #1 stated as she can recall Resident #2's Ex Order 26.4 Ex Order 26.4B1 medication needed to be refilled and she verbally notified the Registered Nurse (RN) on duty. Additionally, CMA #1 stated she did not remember what happened after she reported the need for the Ex Order 26.4B1 medication to the RN.

At 4:15 p.m., the surveyor conducted a telephone interview with the LPN regarding Resident #2's Ex Order 26.4B1 medication, she signed out in the MAR as "Not Administered (Resident Out of

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A 935	Continued From page 10	A 935		

Facility)" on [redacted]. The LPN stated on Ex Order 26.4B1 a CMA alerted her that Resident #2 was Ex Order 26.4B1. Additionally, the LPN stated she observed Resident #2 had Ex Order 26.4B1 and the resident was transferred out to the hospital via Emergency Services. The LPN stated as she can remember, the residents Ex Order 26.4B1 medication needed a refill and the RN made calls to the Physician.

At 4:20 p.m., the surveyor interviewed CMA #2 via telephone regarding the participant's Ex Order 26.4 Ex Order 26.4B1 medication, she signed out in the MAR as not administered, unavailable on Ex Order 26.4B1 Ex Order 26.4B1. The CMA #2 stated if a medication was not available she would verbally report it to the nurse.

On 2/2/24 at 11:00 a.m., the surveyor interviewed the facility Corporate RN (CRN) regarding the resident's Ex Order 26.4B1 medication not being available for administration. The CRN stated she heard about the resident's Ex Order 26.4B1 medication, but the RN who worked at the time NJ Exec Order 26.4b was no longer on staff at the facility. Additionally, the CRN stated the resident returned to the facility Ex Order 26.4B1 and was admitted to skilled care on Ex Order 26.4B1.

At 12:10 p.m., the surveyor interviewed CMA #3 regarding the resident's Ex Order 26.4B1 medication she signed out as not administered, unavailable on Ex Order 26.4B1, and Ex Order 26.4B1. The CMA #3 stated the medication packaging was empty and she notified the nurse.

At 2:00 p.m., the survey reviewed the RN's employee file and identified a hire date of Ex Order 26.4B1 and a termination letter dated Ex Order 26.4B1 which revealed "[Resident #2] went without Ex Order 26.4B1

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A 935	Continued From page 11 medication for a period of [redacted] days. There was no documentation in the medical record that any contact was made to the physician to refill the medication ..." At 3:00 p.m., the surveyor reviewed the facility policy and procedure titled, "Medication Management Program Guidelines (RS-10)" which listed ... All staff shall follow general guidelines for safe and appropriate handling of medications. Medications will be administered to residents in a safe effective manner in accordance with physician orders or protocols and prescribed principles and procedures. POLICY PURPOSE To insure safe and timely delivery of medication and care to those under the [Facility's] staff, and to communicate effectiveness of medication to other members of the health care team through appropriate, accurate and timely documentation. ...Physician Orders/Prescriptions ... page 3 ... The attending physician shall be contacted by nursing for direction when delivery of a medication will be delayed or the medication is not or will not be available. ..."	A 935		

United Methodist Communities
Abundant Life for Seniors

Collingswood
460 Haddon Ave.
Collingswood, NJ 08108

856-854-4331 p
856-854-0879 f
UMCommunities.org

United Methodist Communities at Collingswood – Plan of Correction for Survey 2/2/2024

Deficiencies received 3/8/2024

A310 - Administration

Corrective action for affected resident(s)

The resident is no longer in the community therefore there is no corrective action for this specific resident.

Identification of other residents having potential to be affected

All residents have the potential to be affected by this practice. A full house audit was performed to ensure all medications are available. Any issues identified were corrected.

Systemic changes to ensure deficient practice will not recur

All Nurses and Certified Medication Aides (CMAs) will be in-serviced by the Educator or Director of Residential Living (also known as the Director of Nursing) on the community's policy on the Medication Management Program Guidelines with emphasis placed on timely notification to the Director of Residential Living of medications not available to ensure prompt follow up with the pharmacy and physician. A daily medication administration audit report will be run by the Director of Resident Living/ or designee to identify missed or unavailable medications to ensure compliance. Any Nurse not receiving the education by 4/15/2024 will not be allowed to work a shift until completed. New licensed Nurses and Certified Medication Aides will be educated during their new-hire orientation.

Monitoring of corrective action

A random chart audit will be completed by the Director of Residential Living for 15 residents weekly for 4 weeks and then bi-weekly x 4weeks and then monthly x 2 months to ensure timely follow up of medications unavailable. Findings will be reviewed with the Executive Director and reported in the quarterly quality assurance improvement meeting. Frequency of the audits will be adjusted according to the outcomes. All findings of concern will be addressed with corrective action up to and including termination of the responsible team member as warranted.

4/4/24 accepted
Rec 3/15/24

Completion date

April 15, 2024

A355 – Resident Rights

Corrective action for affected resident(s)

The resident is no longer in the community therefore there is no corrective action for this specific resident.

Identification of other residents having potential to be affected

All residents have the potential to be affected by this practice.

Systemic changes to ensure deficient practice will not recur

All Nurses and CMAs will be in-serviced by the Educator or Director of Residential Living on the Rights of the Residents to receive personalized services and care in accordance with the resident's individualized general service plan and/or health service plan. This in-service will include the Medication Management Program Guidelines as well.

Monitoring of corrective action

An audit of the medication administration records will be completed for 15 residents weekly for 4 weeks and will be completed for 15 residents monthly for 3 months. The audit will review timeliness of ordering of medication, timeliness of documentation of medication unavailable and timeliness of reporting to Director of Residential Living/or designee and Physician. These finding will be reported to the Quality Assurance Performance Improvement Committee.

Completion Date

April 15, 2024

accepted 4/4/24
Rcd 3/15/24

A 563 - General Requirements

Corrective action for affected resident(s)

The resident is no longer in the community therefore there is no corrective action for this specific resident.

Identification of other residents having potential to be affected

All residents have the potential to be affected by this practice.

Systemic changes to ensure deficient practice will not recur

All Nurses and CMAs will be in serviced by the Educator or Director of Residential Living on the policy of reporting events as per the regulation. The Director of Residential Living/or designee will be in serviced by the Educator or Certified Assisted Living Administrator (CALA) on the timely reporting of events to the Department of Health.

Monitoring of corrective action

The CALA/or designee will review with Director of Residential Living at the Assisted Living clinical meeting any events that have the potential to be Reportable Events.

The CALA/ or designee will audit all Reportable Events for timeliness weekly for 4 weeks and then monthly for 3 months. The results of this audit will be reported at the Quality Assurance Performance Improvement Committee.

Completion Date

April 15, 2024

accepted 4/4/24 3/5/24 Rec'd

A935 - Pharmaceutical Services

Corrective action for affected resident(s)

The resident is no longer in the community therefore there is no corrective action for this specific resident.

Identification of other residents having potential to be affected

All residents have the potential to be affected by this practice.

Systemic changes to ensure deficient practice will not recur

All Nurses and CMAs will be in serviced by the Educator or Director of Residential Living on the administration of medications as per the prescriber's orders, facility policies, manufacturer's requirements, cautionary and accessory warnings and Federal and State laws and regulations.

Monitoring of corrective action

An audit of the medication administration records will be completed for 15 residents weekly for 4 weeks and will be completed for 15 residents monthly for 3 months. The audit will review timeliness of ordering of medication, timeliness of documentation of medication unavailable and timeliness of reporting to Director of Residential Living/or Designee and Physician. These finding will be reported to the Quality Assurance Performance Improvement Committee.

Completion Date

April 15, 2024

Rcd 3/15/24
accepted
DR 4/4/24

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
15c001 Y1	A. Building B. Wing Y2	2/2/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT COLLINGSWOOD	460 HADDON AVENUE COLLINGSWOOD, NJ 08108

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 A0310	Correction	ID Prefix A0355	Correction	ID Prefix A0563	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(1)	Completed	Reg. # 8:36-5.10(a)(2)	Completed
LSC	03/15/2024	LSC	03/15/2024	LSC	03/15/2024
ID Prefix A0935	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-11.4(b)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/15/2024	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?
2/2/2024	☐ YES ☐ NO