

New Jersey Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18A111 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 09/24/2025 |
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| NAME OF PROVIDER OR SUPPLIER SUNRISE OF BRIDGEWATER | STREET ADDRESS, CITY, STATE, ZIP CODE 390 US 22 BRIDGEWATER, NJ 08807 |
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| A 000 | <p>Initial Comments</p> <p>Initial Comments: Type of Survey: Complaint</p> <p>Complaint #: NJ00188731</p> <p>Census: 91</p> <p>Sample Size: 4</p> <p>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.</p> | A 000 | | |
| A 269 | <p>8:36-3.1(a) Administration</p> <p>(a) An administrator shall be appointed and an alternate shall be designated in writing to act in the absence of the administrator. The administrator or a designated alternate shall be available at all times and shall be on-site at the facility on a full-time basis in facilities that have 60 or more licensed beds, and on a half-time basis in facilities that have fewer than 60 licensed beds, in accordance with the definition of "full-time" and "half-time" at N.J.A.C. 8:36-1.3.</p> | A 269 | | |

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

TITLE


(X6) DATE

12/08/25

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| A 269 | <p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00188731</p> <p>Based on interview, observation and record review, it was determined that the facility failed to ensure an alternate Executive Director (ED) was designated in writing in the absence of the ED. This deficient practice was evidenced by the following:</p> <p>On 9/24/25 at 9:00 a.m., the surveyor asked the Receptionist to see the ED upon having entered the facility. The Receptionist stated that the ED and the Business Office Manager (BOM) were not in the facility, and she did not know who was in charge.</p> <p>At 9:11 a.m., the surveyor inquired again with the Receptionist, she stated that the BOM would be arriving in about 20 minutes, after she called her on the phone. When asked if the BOM was in charge, the Receptionist stated that she was usually in charge when the ED was not present in the facility.</p> <p>At 9:15 a.m., the Receptionist, she stated that she contacted the ED via telephone. At that time, the surveyor spoke with the ED, who stated that he was on his way to another facility but redirected and would be at the facility in approximately 30 minutes.</p> <p>At 10:02 a.m., the surveyor interviewed the ED when he arrived at the facility, he stated that the BOM was the alternate ED, and she had a  license. The ED also stated that the facility did not have any written documentation which</p> | A 269 | | |

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| A 269 | Continued From page 2 identified who was the alternate ED. When asked when he was away from the facility, how would the staff know who was in charge, the ED stated that there was an "internal communication board" within the electronic charting system utilized by the facility as well as posting the information on a bulletin board in the facility "team room". At 11:19 a.m., the surveyor reviewed the policy and procedures manual, which revealed there was no policy for the designation of an alternate ED for the facility. | A 269 | | |
| 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; This REQUIREMENT is not met as evidenced by: Complaint #: NJ00188731 Based on interview and record review, it was | A 310 | | |

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| A 310 | <p>Continued From page 3</p> <p>determined that the facility failed to ensure the enforcement of the facility policy titled, "Incident and Event Reporting", dated 11/1998, last revised 4/2025, for 1 of 4 residents reviewed, Resident #2. This deficient practice was evidenced by the following:</p> <p>On 9/9/25 at 4:20 p.m., the New Jersey Department of Health (DOH) received a Facility Reportable Event (FRE) (a form utilized by health care facilities to report incidents), which revealed Resident #2 did not receive his/her [redacted] medications which resulted in the resident [redacted] and hospitalized on [redacted].</p> <p>On 9/24/25 at 10:02 a.m., the surveyor interviewed the Executive Director (ED) regarding who reported the incident with Resident #2's medications, he stated that the Resident Care Director (RCD) reported the incident to him on [redacted] after Resident # 2 returned from the hospital.</p> <p>At 11:19 a.m., the surveyor reviewed the 4/24/25 facility policy titled, "Incident and Event Reporting" which revealed "Policy Statement: It is the policy of the community to ensure that [facility] team members promptly and accurately report ... Procedure: ... 14. For resident events, the Resident Care Director (RCD)/designee will ... e. Coordinate with the ED regarding notification of appropriate parties in accordance with state/federal/provincial law or regulation: Regulatory Agency, ..."</p> | A 310 | | |
| A 531 | <p>8:36-5.6(c) General Requirements</p> <p>(c) The staffing level in this chapter is minimum only and the assisted living residence,</p> | A 531 | | |

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| A 531 | <p>Continued From page 4</p> <p>comprehensive personal care, or assisted living program shall employ staff in sufficient number and with sufficient ability and training to provide the basic resident care, assistance, and supervision required, based on an assessment of the acuity of residents' needs.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00188731</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to ensure that staff who had the ability and training to provide medication administration was scheduled for 1 of 4 residents reviewed, Resident #2.</p> <p>On 9/24/25 at 10:02 a.m., the surveyor interviewed the Executive Director (ED) regarding the process of medication preparation. The ED stated that if the resident utilized the facility's pharmacy, the resident's prescriptions would be sent to the pharmacy via fax machine. Once prepared in individual dose packaging, the pharmacy notified the facility that the medications were ready and send to the facility. Once received, the medication was approved in the computer system by the Resident Care Director (RCD) and ready to be administered to the resident. The ED also stated that if the resident's medication was not packaged in individual doses, the Medication Care Manager (MCM) cannot administer it to the resident.</p> <p>In the same interview, the ED stated that a licensed nurse, such as a Licensed Practical Nurse or the RCD, administered the medication. The Executive Director continued to state that</p> | A 531 | | |

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| A 531 | <p>Continued From page 5</p> <p>only Licensed Practical Nurses and Registered Nurses administered the medications as they were packaged from home.</p> <p>On 9/24/25 at 10:40 a.m., the surveyor reviewed Resident #2's medical record (MR) which revealed that the resident moved into the facility in [redacted] with a diagnoses of [redacted] and [redacted].</p> <p>Further review of the PNN revealed that on [redacted] the resident [Resident #2] was at [the] dinner table and CM noted [he/she] wasn't [redacted] ... having [redacted] ...". The PNN also revealed that "... a review of [the] medication administration showed that the following medications [were] pending delivery since move-in ([redacted]) tab ([redacted]) tab (tablet) BID (twice a day) and [redacted] 1 tablet BID..."</p> <p>Surveyor review of Resident #2's Medication Administration Record (MAR) revealed during the time period of [redacted] to [redacted], Resident #2 missed 6 doses of [redacted] twice daily on the following dates: [redacted] (missed 1 dose), [redacted] (missed 2 doses), [redacted] missed 2 doses, and [redacted] (missed 1 dose), and 4 doses of [redacted] twice daily on the following dates: [redacted] (missed 1 dose), [redacted] (missed 1 dose), [redacted] (missed 1 dose), and [redacted] (missed 1 dose).</p> <p>The surveyor review of the [facility] "Community" schedule for Friday [redacted] through Monday [redacted], revealed Medication Care Managers (MCMs) were scheduled to work during the times the medications were to be administered for</p> | A 531 | | |

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| A 531 | <p>Continued From page 6</p> <p>Resident #2.</p> <p>At 12:40 p.m., the surveyor interviewed the Medication Care Manager (MCM #1), she stated that she worked on [redacted] and [redacted] from 6:00 a.m. to 2:00 p.m. each day. MCM #1 also stated that Resident #2 had taken his/her morning [redacted] medication earlier during his/her admission day. MCM #1 continued to state that the facility was waiting for Resident #2's [redacted] medications from the pharmacy on both days. In the same interview, MCM #1 stated that she notified the RCD that the pharmacy had not sent Resident #2's [redacted] medications.</p> <p>At 12:58 p.m., the surveyor interviewed MCM #2, she stated that she worked from 6:00 a.m. to 2:00 p.m. on [redacted] and 6:00 a.m. to 10:00 p.m. on [redacted]. MCM #2 stated that she had verbally notified the RCD regarding Resident #2's missing [redacted] medications. MCM #2 also stated that Resident #2 did not receive any of his/her nighttime medications on [redacted] as the resident [redacted] and sent to the hospital.</p> <p>The surveyor reviewed a "Progress Note New (PNN)" dated [redacted] at 7:01 p.m. written by the Resident Care Director (RCD) that revealed Resident #2 had [redacted] on [redacted] and admitted to the hospital.</p> <p>Surveyor review of a 12/14/20 facility policy titled, "Staffing" revealed "... Definitions: Action Steps: 1. The Executive Director (ED) will ensure the community employs both professional and unlicensed staff in sufficient number and with sufficient ability and training to provide the basic resident care, assistance... based on an assessment of the residents' needs ..."</p> | A 531 | | |

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| A 765 | Continued From page 7 | A 765 | | |
| A 765 | <p>8:36-7.4(c)(1) Resident Assessments and Care Plans</p> <p>(c) Written policies and procedures shall be developed and implemented to ensure, but not be limited to, the following:</p> <p>1. Assessment of all residents with a general service plan at least semi-annually, and those residents who have a health service plan shall be reassessed at least quarterly and more often on an as needed basis, including and upon the resident's return to the facility from the hospital;</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00188731</p> <p>Based on interview and record review, it was determined that the facility failed to assess a resident after returning from the hospital for 1 of 4 residents reviewed, Resident #2. This deficient practice was evidenced by the following:</p> <p>On 9/9/25 at 4:20 p.m., the New Jersey Department of Health (DOH) received a Facility Reportable Event (FRE) (a form utilized by health care facilities to report incidents), which revealed a resident was (Resident #2) did not receive his/her [redacted] medications resulting in the resident [redacted] and was hospitalized on [redacted]</p> <p>On 9/24/25 at 10:40 a.m., the surveyor reviewed Resident #2's medical record (MR) which</p> | A 765 | | |

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| A 765 | <p>Continued From page 8</p> <p>revealed that the resident moved into the facility in [redacted] with diagnoses of [redacted] and [redacted]. The surveyor reviewed a "Progress Note New (PNN)" dated [redacted] at 7:01 p.m. written by the Resident Care Director (RCD) that revealed Resident #2 [redacted] on [redacted] and was admitted to the hospital. Further review of the PNN revealed that on [redacted] the resident [Resident #2] was at [the] dinner table and CM noted [he/she] [redacted] to server ... having [redacted]..."</p> <p>The PNN also revealed that "... a review of [the] medication administration showed that the following medications [were] pending delivery since move-in date [redacted] [redacted] tab (tablet) BID (twice a day) (NJ Ex Order 26.4(b)(1) [redacted]) and [redacted] [redacted] [redacted] [redacted] 1 tablet BID" [redacted] [redacted]).</p> <p>Continued surveyor review of the PNN dated [redacted] at 5:55 p.m. written by the RCD revealed Resident #2 returned from the hospital on [redacted] at 5:32 p.m.</p> <p>Surveyor review of Resident #2's Medication Administration Record (MAR) revealed during the time period of [redacted] to [redacted], Resident #2 missed 6 doses of [redacted] [redacted] twice daily and 4 doses of [redacted] [redacted] twice daily.</p> <p>At 11:19 a.m., the surveyor reviewed the 5/15/25 facility policy titled, "Assessing and Evaluating Residents" which revealed "Policy Statement: It is the policy of the community to assess/evaluate residents to determine care and service needs, preferences, to determine the community can</p> | A 765 | | |
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| A 765 | <p>Continued From page 9</p> <p>meet the resident's care, to establish an individualized service plan ... Procedure: ... 3. A Licensed Nurse (LN)/designee...shall complete a comprehensive assessment or evaluation of residents at the following times or in accordance with requirements and timeframes fo state/province regulations: ... d. Upon a significant change in condition ..."</p> <p>At 12:20 p.m., the surveyor interviewed the Regional Director of Resident Care (RDRC) about Resident #2's assessment after returning from the hospital, she stated that the resident did not need to be re-assessed because the resident did not have a NJ Exec Order 26.4b1, so the care plan only was updated. The surveyor asked her about Resident #2's NJ Exec Order 26.4b1 from being NJ Exec O and then had a NJ Exec Order 26.4b1 the RDRC stated that it was not a NJ Exec Order 26.4b1.</p> | A 765 | | |
| A 935 | <p>8:36-11.4(b) Pharmaceutical Services</p> <p>(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.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00188731</p> | A 935 | | |

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| A 935 | <p>Continued From page 10</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to ensure that medications were administered in accordance with the prescriber's orders for 1 of 4 residents reviewed, Resident #2. This deficient practice was evidenced by the following:</p> <p>On 9/9/25 at 4:20 p.m., the New Jersey Department of Health (DOH) received a Facility Reportable Event (FRE-a form utilized by health care facilities to report incidents), which revealed a resident was (Resident #2) did not receive his/her [redacted] medications resulting in the resident [redacted] and was hospitalized on [redacted].</p> <p>On 9/24/25 at 10:02 a.m., the surveyor interviewed the Executive Director (ED) regarding the process of medication preparation. The ED stated that if the resident utilized the facility's pharmacy, the resident's prescriptions were sent to the pharmacy via fax machine. Once prepared in individual dose packaging, the pharmacy notified the facility that the medications were ready and sent to the facility. Once received, the medication was approved in the computer system by the Resident Care Director (RCD) and ready to be administered to the resident.</p> <p>The ED also stated that if the resident's medication was not packaged in individual doses, the Medication Care Manager (MCM) cannot administer it to the resident. The ED further stated that a licensed nurse, such as a Licensed Practical Nurse or the RCD, administered the medication. Additionally, the ED stated that Resident # 2's family had delivered one of the resident's [redacted] medications [redacted] but was not in unit dose packaging.</p> | A 935 | | |

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| A 935 | <p>Continued From page 11</p> <p>At 10:40 a.m., the surveyor reviewed Resident #2's medical record (MR) which revealed that the resident moved into the facility in [redacted] with diagnoses of [redacted] and [redacted]. Further review of the MR, revealed an Advanced Practitioner Nurse's (APN) prescription order dated [redacted], for [redacted] tablet, take 1 tablet by mouth every 12 hours as well as [redacted] tablet, take 1 tablet every 12 hours.</p> <p>The surveyor reviewed Resident #2's Electronic Medication Administration Record (EMAR) dated [redacted] to [redacted]. The MAR revealed that Resident #2 was prescribed [redacted] tablet, take 1 tablet by mouth in the morning and at bedtime. The surveyor observed that the documented times for the [redacted] was between 7:00 a.m. to 9:00 a.m. and 7:00 p.m. to 9:00 p.m., totaling two (2) doses each day. In addition, the surveyor observed the same order on Resident #2's MAR for [redacted] to [redacted].</p> <p>Continued review of Resident #2's MAR dated [redacted] to [redacted] and the MAR dated [redacted] to [redacted] indicated that Resident # 2 was prescribed [redacted] tablet, take 1 tablet in the morning and at bedtime. The surveyor observed that the documented times on both MARs for the [redacted] were to be administered was 7:00 a.m. to 9:00 a.m. and 7:00 p.m. to 9:00 p.m., totaling two (2) times each day.</p> <p>Further surveyor review of Resident #2's MAR dated from [redacted] to [redacted] revealed that the resident did not receive the ordered dose of the [redacted] tablet every 12 hours from [redacted] to [redacted], which totaled six (6) missed doses. Resident #2's MAR also revealed</p> | A 935 | | |
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New Jersey Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18A111 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 09/24/2025 |
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| NAME OF PROVIDER OR SUPPLIER SUNRISE OF BRIDGEWATER | STREET ADDRESS, CITY, STATE, ZIP CODE 390 US 22 BRIDGEWATER, NJ 08807 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|--------------------|--|---------------|---|--------------------|
| A 935 | <p>Continued From page 12</p> <p>that the resident only received the [redacted] NJ Ex Order 26.4(b)(1) tablet every 12 hours on [redacted] NJ Ex Order 26.4(b) evening and [redacted] NJ Ex Order 26.4(b) evening, which totaled four (4) missed doses.</p> <p>At 12:40 p.m., the surveyor interviewed the Medication Care Manager (MCM #1), she stated that she worked on [redacted] NJ Ex Order 26.4(b) and [redacted] NJ Ex Order 26.4(b) from 6:00 a.m. to 2:00 p.m. each day. MCM #1 also stated that Resident #2 had taken his/her morning [redacted] NJ Ex Order 26.4(b) medication earlier during his/her admission day. MCM #1 continued to state that the facility was waiting for Resident #2's [redacted] NJ Ex Order 26.4(b) medications from the pharmacy on both days. In the same interview, MCM #1 stated that she notified the RCD that the pharmacy had not sent Resident #2's [redacted] NJ Ex Order 26.4(b) medications.</p> <p>At 12:58 p.m., the surveyor interviewed MCM #2, she stated that she worked from 6:00 a.m. to 2:00 p.m. on [redacted] NJ Ex Order 26.4(b) and 6:00 a.m. to 10:00 p.m. on [redacted] NJ Ex Order 26.4(b). MCM #2 stated that she had verbally notified the RCD regarding Resident #2's missing [redacted] NJ Ex Order 26.4(b) medications. MCM #2 also stated that Resident #2 did not receive any of his/her nighttime medications or [redacted] NJ Ex Order 26.4(b) as the resident [redacted] NJ Ex Order 26.4(b)(1) and was sent to the hospital.</p> <p>At 1:05 p.m., the surveyor interviewed the ED who revealed that the RCD did not report the incident to him until [redacted] NJ Ex Order 26.4(b)(1) days after the resident returned from the hospital or [redacted] NJ Ex Order 26.4(b). The ED also stated that the RCD did not notify the New Jersey Department of Health.</p> <p>At 2:26 p.m., the surveyor interviewed the Licensed Practical Nurse/Medication Care Manager (LPN/MCM) via phone, she stated that she worked during the 2:00 p.m. to 10:00 p.m. shift on [redacted] NJ Ex Order 26.4(b) and [redacted] NJ Ex Order 26.4(b). The LPN/MCM</p> | A 935 | | |

New Jersey Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18A111 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 09/24/2025 |
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| NAME OF PROVIDER OR SUPPLIER SUNRISE OF BRIDGEWATER | STREET ADDRESS, CITY, STATE, ZIP CODE 390 US 22 BRIDGEWATER, NJ 08807 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|--------------------|--|---------------|---|--------------------|
| A 935 | <p>Continued From page 13</p> <p>stated that she administered Resident #2's (NJ Ex Order 26.4b) medication (NJ Ex Order 26.4b) that was located in the medication box that the resident's family brought in during the resident's admission.</p> <p>The surveyor reviewed a "Progress Note New (PNN)" dated (NJ Ex Order 26) at 7:01 p.m. written by the Resident Care Director (RCD) that revealed Resident #2 (NJ Ex Order 26.4(b)(1)) on (NJ Ex Order 26) and was admitted to the hospital. The PNN also stated that a "...review of [the] medication administration showed that the following medications [were] pending delivery since move-in (NJ Ex Order 26.4(b)(1)) () tab (tablet) BID (twice a day) and (NJ Ex Order 26.4(b)(1)) tablet [,] 1 tablet BID. Pharmacy profile reviewed and indicated the following medications were "Profile Only": (NJ Ex Order 26.4(b)(1)) 1 tab twice daily (NJ Ex Order 26.4(b)(1)) 1 tablet twice daily..."</p> <p>The surveyor reviewed another PNN dated 9/1/25 at 9:42 p.m. written by the RCD indicated that the "RCD confirmed with both (NJ Exec Order 26.4b) and (NJ Exec Order 26.4b) resident medications in (NJ Exec Order 26.4b) pill-pack on hand and given by LPN on duty both Sat/Sun 2-10 p.m. shift, but (NJ Ex Order 26.4(b)(1)) () not included in pill pack nor delivered by (facility pharmacy) as it was sent in a separate bottle to resident address..."</p> | A 935 | | |

STATE FORM: REVISIT REPORT

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| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 18A111 | MULTIPLE CONSTRUCTION A. Building B. Wing | DATE OF REVISIT 12/10/2025 |
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| NAME OF FACILITY SUNRISE OF BRIDGEWATER | STREET ADDRESS, CITY, STATE, ZIP CODE 390 US 22 BRIDGEWATER, NJ 08807 |
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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 A0269 | Correction | ID Prefix A0310 | Correction | ID Prefix A0531 | Correction |
| Reg. # 8:36-3.1(a) | Completed | Reg. # 8:36-3.4(a)(1) | Completed | Reg. # 8:36-5.6(c) | Completed |
| LSC | 09/25/2025 | LSC | 12/10/2025 | LSC | 12/10/2025 |
| ID Prefix A0765 | Correction | ID Prefix A0935 | Correction | ID Prefix | Correction |
| Reg. # 8:36-7.4(c)(1) | Completed | Reg. # 8:36-11.4(b) | Completed | Reg. # | Completed |
| LSC | 12/10/2025 | LSC | 12/10/2025 | 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 |
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| REVIEWED BY STATE AGENCY <input type="checkbox"/> | REVIEWED BY (INITIALS) | DATE | SIGNATURE OF SURVEYOR | DATE |
| REVIEWED BY CMS RO <input type="checkbox"/> | REVIEWED BY (INITIALS) | DATE | TITLE | DATE |
| FOLLOWUP TO SURVEY COMPLETED ON 9/24/2025 | | <input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO | | |