

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25425	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD HOMES AT KRESSON		STREET ADDRESS, CITY, STATE, ZIP CODE 1005 KRESSON ROAD CHERRY HILL, NJ 08003		
(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
R 000	Initial Comments Type of Survey: Initial. Census: 0 Applying for 14 beds Sample Size: 0 The facility was not in substantial compliance with all of the standards in the New Jersey Administrative Code, Chapter 8:43F, Standards for Licensure of Adult Day Health Services. 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 New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	R 000		
R 095	8:37-2.2(c) Newly constructed, renovated, or expanded DCH Newly constructed, renovated, and expanded dementia care homes shall conform with the New Jersey Uniform Construction Code, N.J.A.C. 5:23-3, Use Group I-2 of the subcode. This STANDARD is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to hard wire the sprinkler systems Post Indicator Valve (PIV) into the Fire Alarm and Detection system as required by National Fire Protection Association (NFPA) 13. The deficient practice was evidenced by the following: On 11/05/25 at 10:22 a.m., in the presence of the facility's Owner and Administrator, the surveyor	R 095		

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

TITLE

(X6) DATE

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R 095	Continued From page 1 requested the Owner and Administrator to provide a copy of the facility lay-out which identified the various rooms and the Department of Community Affairs (DCA) approved architectural plans for review. At 11:14 a.m., in the presence of the Owner and Admin. a tour of the building was conducted. At 11:27 a.m., during the an inspection outside of the building where the PIV was located, the surveyor observed no evidence that the Sprinkler PIV was hard wired to the Fire Alarm Panel. A review of the DCA approved plan FP-1 reads in part, "PIV must be monitored tamper and wiring provided by others." During interview, both the Owner and Administrator acknowledged the above concern. The facility failed to monitor the Sprinkler system PIV as required by NFPA 13. NJAC 8:37 -2.2 (c).	R 095		
R 720	8:37-5.4(a)(2)(i-ii) Personal Care-Training & Staffing Requirement All staff who are employed by the facility who have regular direct contact with residents and are not licensed healthcare professionals shall successfully complete the following: 2.A five-day course given by a registered nurse or other healthcare professional, which shall include: i. Orientation to the facility; ii. Specific training regarding Alzheimer's disease; and	R 720		

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R 720	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure that employees received orientation and mandatory training upon hire for 12 of 12 employees reviewed, Employee #'s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, and 12. This deficient practice was evidenced by the following: On 11/20/25 at 9:11 a.m., the surveyor requested personnel files and training records from the Administrator for review. At 9:20 a.m., the Administrator provided the surveyor with the personnel files for review. In addition, the Owner provided the surveyor with a training binder. During review of personnel files and training, the surveyor observed that there was no documented evidence of orientation and training upon hire for the following employees: 1. The surveyor reviewed Employee #1's personnel file, which revealed a hire date of [REDACTED] as a Certified Nursing Aide (CNA). During review, the survey observed that there was no documented evidence that reflected orientation and required training was completed upon hire. 2. The surveyor reviewed Employee #2's personnel file, which revealed a hire date of [REDACTED] as a CNA. During review, the survey observed that there was no documented evidence that reflected orientation and required training was completed upon hire.	R 720		

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R 720	Continued From page 3 3. The surveyor reviewed Employee #3's personnel file, which revealed a hire date of [REDACTED] as a Certified Home Health Aide (CHHA). During review, the survey observed that there was no documented evidence that reflected orientation and required training was completed upon hire. 4. The surveyor reviewed Employee #4's personnel file, which revealed a hire date of [REDACTED] as a Certified Medication Aide (CMA) and Activities Director. During review, the survey observed that there was no documented evidence that reflected orientation and required training was completed upon hire. 5. The surveyor reviewed Employee #5's personnel file, which revealed a hire date of [REDACTED] as a Certified Medication Aide (CMA). During review, the survey observed that there was no documented evidence that reflected orientation and required training was completed upon hire. 6. The surveyor reviewed Employee #6's personnel file, which revealed a hire date of [REDACTED] as a Chef. During review, the survey observed that there was no documented evidence that reflected orientation and required training was completed upon hire. 7. The surveyor reviewed Employee #7's personnel file, which revealed a hire date of [REDACTED] as a CMA. During review, the survey observed that there was no documented evidence that reflected orientation and required training was completed upon hire. 8. The surveyor reviewed Employee #8's	R 720		

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R 720	Continued From page 4 personnel file, which revealed a hire date of [REDACTED] as a Chef. During review, the survey observed that there was no documented evidence that reflected orientation and required training was completed upon hire. 9. The surveyor reviewed Employee #9's personnel file, which revealed a hire date of [REDACTED] as a CMA. During review, the survey observed that there was no documented evidence that reflected orientation and required training was completed upon hire. 10. The surveyor reviewed Employee #10's personnel file, which revealed a hire date of [REDACTED] as a CHHA. During review, the survey observed that there was no documented evidence that reflected orientation and required training was completed upon hire. 11. The surveyor reviewed Employee #11's personnel file, which revealed a hire date of [REDACTED] as a CMA. During review, the survey observed that there was no documented evidence that reflected orientation and required training was completed upon hire. 12. The surveyor reviewed Employee #12's personnel file, which revealed a hire date of [REDACTED] as a CMA. During review, the survey observed that there was no documented evidence that reflected orientation and required training was completed upon hire. Following review of the personnel files, the surveyor reviewed the training binder that was provided by the Owner. The surveyor observed that the binder contained CMA training and delegation documents but there was no documented evidence of employee orientation	R 720		

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R 720	Continued From page 5 and training. At 10:50 a.m., the surveyor interviewed the Owner regarding employee orientation and training. The Owner stated that no employee training was completed but would begin on first day of orientation. At 11:18 a.m., the Administrator and Consultant Administrator also acknowledged that no employees were oriented or received training, but the plan was to hold an orientation and training program prior to opening and admitting residents. The surveyor reviewed the policy and procedure titled, "...14.4-Training" that revealed " ... [Facility Name] will ensure staff training, appropriate to staff responsibilities to include at a minimum: ...Initial orientation." In addition, the surveyor reviewed the policy and procedure titled, "Orientation -Staff Education and Training" that revealed "...A Supervised orientation program of at least five working days is mandatory for all new direct care employees."	R 720			
R1160	8:37-7.1(b) Physical Plant-Water Supply Every facility shall have hot water heating systems that are installed and maintained in good and safe working condition, connected to the hot water lines required under the provisions of N.J.A.C. 8:37-7.2(e), and capable of delivering water at a minimum temperature of not less than 105 degrees Fahrenheit and at a maximum temperature of not more than 120 degrees Fahrenheit at all times in accordance with anticipated needs.	R1160			

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R1160	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure that the Domestic Hot Water (DHW), used by residents for bathing and hand washing was maintained between 105 degrees and 120 degrees Fahrenheit (dF) for 5 of 10 Resident bathroom sinks tested. This deficient practice was evidenced by the following: On 11/05/25 at 10:22 a.m., in the presence of the facility's Owner and Administrator, the surveyor asked the Owner and Administrator if the facility monitored the temperature of the DHW and what the temperature range was for the hot water. The Owner stated that the facility monitored the temperature, but not sure what the temperature was. The surveyor also asked the Administrator to bring a facility thermometer along the tour to record DHW temperatures along with the surveyor. The Administrator informed the surveyor that the facility did not have a thermometer. At 11:14 a.m., in the presence of the Owner and Administrator, a tour of the fourteen (14) Resident rooms and common areas was conducted. The surveyor observed and recorded the following DHW temperatures in the following locations: 1. At 12:31 p.m., the surveyor observed and recorded inside Resident room # XXXX bathroom sink which revealed 136 degree Fahrenheit (DF).	R1160		

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R1160	Continued From page 7 2. At 12:34 p.m., the surveyor observed and recorded inside Resident room # bathroom sink which revealed 139.6 dF. 3. At 12:38 p.m., , the surveyor observed and recorded inside Resident room # bathroom sink which revealed 148.7 dF. 4. At 12:41 p.m., the surveyor observed and recorded inside Resident room # bathroom sink which revealed 153.6 dF. 5. At 12:45 p.m., the surveyor observed and recorded inside Resident room # bathroom sink which revealed 149.9 dF. At 1:39 p.m., the surveyor informed the Owner and Administrator of the above high water temperature readings. NJAC 8:37 -7.1	R1160		
R1336	8:37-7.5(a)(1) Physical Plant-Ventilation Means of ventilation by either easily operable windows or by mechanical ventilation shall be provided for in every habitable room and in every bathroom and water closet compartment in accordance with the Uniform Construction Code, N.J.A.C. 5:23. Windows shall have an openable area of no more than six inches. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to limit the opening of windows in the facility to a six (6") opening, for 33 windows observed. This deficient	R1336		

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R1336	Continued From page 8 practice had the potential to affect 14 Residents and was evidenced by the following: On 11/5/25 at 10:22 a.m., a request was made to the Owner and Administrator to provide a copy of the facility lay-out which identified the various rooms and the Department of Community Affairs (DCA) approved architectural plans for review. At 11:14 a.m., in the presence of the Owner and Administrator. a tour of the building was conducted. During the tour the surveyor observed, measure and recorded 33 windows that could be opened from 19 inches up to 32 inches. The surveyor did not observe stoppers to limit the window from opening of the windows to no more then 6 inches. At 1:39 p.m., during interview, the surveyor informed the Owner and Administrator of the above windows concerns. NJAC 8:37 -7.10 Resident safety hazards	R1336			
R1680	8:37-7.10(a)(2)(i-vi) Physical Plant-Building Safety Requirements All facilities shall have the following: Physical security features in compliance with the following: i. The entrance to the front yard shall be controlled with a non-scalable fence of at least four feet and a gate. ii.	R1680			

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R1680	Continued From page 9 The gate will have self-closing and self-latching hardware and be equipped with a doorbell or intercom that controls access into the building and the licensee or an employee of the licensee shall, at all times, be responsible for responding to the doorbell or intercom. iii. Exterior doors shall be locked at all times and access by the residents and visitors will only be permitted with the assistance of a staff member. iv. All doors to a common cellar or storage area shall remain locked at all times, except for ingress or egress in the presence of a staff member. v. The gate or main entrance of the residence shall be monitored by a closed circuit monitor. vi. Windows and doors will be equipped with audible alarms that will ring if a door or window is opened. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to have windows equipped with audible alarms that would ring if the window was opened. This deficient practice was evidenced by the following: On 11/5/25 at 10:22 a.m., a request was made to the Owner and Administrator to provide a copy of the facility lay-out which identified the various rooms for review. At 11:14 a.m., in the presence of the Owner and Administrator, a tour of the building was	R1680		

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R1680	Continued From page 10 conducted. During the tour the surveyor observed 33 windows that could be opened which had no audio alarms that could ring if the window is opened. At 1:39 p.m., the surveyor informed the Owner and Administrator of the above windows without audio alarms. NJAC 8:37 -7.10 Resident safety hazards	R1680			



POC#1
Rec'd 12/11/25
accepted 12/12/25

POC
REVIEWED AND
ACCEPTED 12/12/25

NJ Exec Order 26.4b1

Plan of Correction R-095 Post Indicator Valve (PIV)

Immediate corrective action for residents affected by this deficient practice:

- No residents have been affected by this deficient practice.
- Facility owner immediately contacted the facilities Fire sprinkler vendor who arrived onsite on 11/17/25 and hardwired the Post Indicator Valve (PIV) from the tamper switch to the fire panel.

Identify those individuals who could be affected by this deficient practice:

- The facility has not been opened yet; therefore, no residents had the potential to be affected by this deficient practice.

Measures put in place to ensure the deficient practice will not occur for those residents affected:

- On 11/10/2025 the Administrator and Facility owner both reviewed NJAC 8:37-2.2 (c) and NFPA 13 and are both now fully aware and knowledgeable of the requirement to have the Post Indicator Valve (PIV) hardwired from the tamper switch to the Fire alarm panel.
- The Administrator and/or designee will audit the fire alarm panel once per week to ensure that there are no errors indicated on the fire alarm panel related to the Post indicator valve (PIV).

Monitoring of measures or systemic changes to ensure that the deficiencies will not recur:

- Audits of the Fire alarm panel will be completed weekly x 4 weeks and then monthly x 3 months or until compliance is met to ensure that the Post indicator valve is properly hardwired to the Fire alarm panel.
- Results of the audits will be reported to the owner of the facility on a quarterly basis at the scheduled quarterly operations meeting.

Date of Completion: 11/29/2025

NJ Exec Order 26.4b1



**Havenwood Homes
at Kresson**
MEMORY CARE

accepted
12/8/25
NJ Ex Order 26.4(b)(1)

Plan of Correction R-720 – Staff Orientation

Immediate corrective action for residents affected by this deficient practice:

- No residents have been affected by this deficient practice.
- Employees #1, #2, #3, #4, #5, #6, #7, #9, #10, #11 and #12 all received orientation in accordance with NJAC 8:37-5.4. Orientation commenced on Sunday 11/23/25 and continued on Monday 11/24/25, Tuesday 11/25/25, Wednesday 11/26/25 and Friday 11/28/25.
- Employee #8 is no longer employed by the facility, therefore employee #8 has not received the orientation. An additional employee has been hired on 11/21/25 to replace Employee #8. This new employee received all orientation commencing on Sunday, 11/23/25, as per NJAC 8:37-5.4. together with employees #1, #2, #3, #4, #5, #6, #7, #9, #10, #11 and #12.

Identify those individuals who could be affected by this deficient practice:

- The facility has not been opened yet; therefore, no residents had the potential to be affected by this deficient practice.

Measures put in place to ensure the deficient practice will not occur for those residents affected:

- The Administrator and/or designee will audit all new employee files to ensure that orientation is provided for all new employees prior to their first day on the schedule, in accordance with NJAC 8:37-5.4.
- On 11/24/2025 the Administrator and Facility owner both reviewed NJAC 8:37-5.4 and its policy/ and procedure related to facility staff orientation and are now fully aware and/ knowledgeable of the new staff orientation regulation and requirements.

Monitoring of measures or systemic changes to ensure that the deficiencies will not recur:

- Audits will be completed for every newly hired employee by the Administrator and/or designee to assure that orientation is successfully completed prior to the employee's first day on the schedule.
- Results of the audits will be reported to the owner of the facility on a quarterly basis or until compliance is met at the scheduled quarterly operations meeting.



Havenwood Homes
at Kresson
MEMORY CARE

Poc R-720

Date of Completion: 11/29/2025

NJ Exec Order 26.4b1



POC
Reviewed AND
Accepted
11/10/2025

NJ Exec Order 26.4b1

Plan of Correction R-1160 Water Supply

Immediate corrective action for residents affected by this deficient practice

- No residents have been affected by this deficient practice.
- As of 11/10/2024, The facility owner adjusted the temperature on the hot water boiler to be maintained between 105- and 120-degrees Fahrenheit.
- As of 11/10/2024, Room # [redacted] sink now shows a temperature of 107 Degrees Fahrenheit
- As of 11/10/2024, Room # [redacted] bathroom sink now shows a temperature of 107 Degrees Fahrenheit
- As of 11/10/2024, Room # [redacted] bathroom sink now shows a temperature of 108 Degrees Fahrenheit
- As of 11/10/2024, Room # [redacted] bathroom sink now shows a temperature of 110 Degrees Fahrenheit
- As of 11/10/2024, Room # [redacted] bathroom sink now shows a temperature of 109 Degrees Fahrenheit

Identify those individuals who could be affected by this deficient practice:

- The facility has not been opened yet and therefore no residents had the potential of being affected by this deficient practice.
- On 11/10/2025 the Facility Administrator and Facility Owner inspected all hot water temperatures throughout the facility. All hot water temperatures tested at the required range between 105- and 120-degrees Fahrenheit

Measures put in place to ensure the deficient practice will not occur for those residents affected:

- On 11/10/2025 the facility owner and Administrator both reviewed NJAC 8:37-7.2 (e) to understand the regulation and its practical applications. Both are now fully aware and knowledgeable of the hot water temperature regulation and requirements.



Havenwood Homes
at Kresson
MEMORY CARE

POC- R-1160

- The Administrator and/or designee will complete weekly Audits of the hot water temperature to ensure that the hot water is tested at the required range. For each audit, 3 different Resident room sinks will be selected.

Monitoring of measures or systemic changes to ensure that the deficiencies will not recur:

- The facility Administrator and/or designee will complete audits weekly x 4 weeks and then monthly times 3 months or until compliance is met.
- The results of the audits will be reported to the Facility owner during the facilities scheduled quarterly operations meeting.

Date of completion: 11/29/2025

NJ Exec Order 26.4b1



POC
Reviewed with
Admin
12/08/2025
NJ Ex Order 26.4(b)(1)

POC R-1336 Physical Plant – Ventilation

Immediate corrective action for residents affected by this deficient practice:

- No residents have been affected by this deficient practice.
- On 11/10/2025 the facility staff installed window stoppers to prevent all windows from opening more than 6 inches. All windows in the facility have been corrected and now do not open more than 6 inches.

Identify those individuals who could be affected by this deficient practice:

- The facility has not been opened yet and therefore no residents have been affected by this deficient practice.
- On 11/10/2025 all windows in the facility have been inspected by the administrator, and window stoppers have been installed to ensure that all windows are limited to a 6-inch opening.

Measures put in place to ensure the deficient practice will not occur for those residents affected:

- On 11/10/2025 the facility owner and Administrator both reviewed NJAC 5:23. the regulation and its practical applications. Both are now fully aware and knowledgeable of the window regulation and requirements.
- The Administrator and/or designee will inspect and complete weekly audits of all facility windows to ensure that windows are limited to a 6-inch opening. For each audit, 3 different windows will be selected.

Monitoring of measures or systemic changes to ensure that the deficiencies will not recur:

- Audits will be completed by the Administrator and/or designee weekly x 4 weeks and then monthly times 3 months or until compliance is met.
- The results of the audits will be reported to the Facility owner during the facilities scheduled quarterly operations meeting.

Date of Completion: 11/29/2025

NJ Exec Order 26.4b1



POC
AND
REVIEWED
ACCEPTED
12/9/2025

NJ Exec Order 26.4b1

POC R -1680 Audible Alarms

Immediate corrective action for residents affected by this deficient practice:

- No residents have been affected by this deficient practice.
- On 11/10/2025 Facility owner installed audio alarms for all windows of the facility that now ring if any window is opened.

Identify those individuals who could be affected by this deficient practice:

- The facility has not been opened yet and therefore no residents had the potential of being affected by this deficient practice.
- As of 11/10/2025 all windows in the facility have been inspected by the administrator to ensure that each window now has an audio alarm installed which rings when opened.

Measures put in place to ensure the deficient practice will not occur for those residents affected:

- On 11/10/2025 the facility owner and Administrator both reviewed NJAC 8:37.10 (a)(2) (i-vi) to understand the regulation and its practical applications. Both are now fully aware and knowledgeable of the window audio alarm regulation and requirements.
- The Administrator and/or designee will inspect and complete audits of the facility windows to ensure that windows have audio alarms installed and the alarm rings when windows are opened. For each audit, 3 alternating windows will be selected.
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Monitoring of measures or systemic changes to ensure that the deficiencies will not recur:

- Audits of three alternating windows will be completed weekly x 4 weeks and then monthly times 3 months or until compliance is met by the facility Administrator and/or designee.
- The results of the audits will be reported to the Facility owner during the facilities scheduled quarterly operations meeting.

Date of Completion: 11/29/2025

NJ Exec Order 26.4b1

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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25425	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 11/20/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD HOMES AT KRESSON			STREET ADDRESS, CITY, STATE, ZIP CODE 1005 KRESSON ROAD CHERRY HILL, NJ 08003		
(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	
{R 000}	Initial Comments Type of Survey: Initial. Census: 0 Applying for 14 beds Sample Size: 0 The facility was not in substantial compliance with all of the standards in the New Jersey Administrative Code, Chapter 8:43F, Standards for Licensure of Adult Day Health Services. 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 New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	{R 000}			

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

TITLE

(X6) DATE

11/29/25

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 25425	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 11/20/2025
NAME OF FACILITY HAVENWOOD HOMES AT KRESSON		STREET ADDRESS, CITY, STATE, ZIP CODE 1005 KRESSON ROAD CHERRY HILL, NJ 08003

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 R0095	Correction	ID Prefix R0720	Correction	ID Prefix R1160	Correction
Reg. # 8:37-2.2(c)	Completed	Reg. # 8:37-5.4(a)(2)(i-ii)	Completed	Reg. # 8:37-7.1(b)	Completed
LSC	11/29/2025	LSC	11/29/2025	LSC	11/29/2025
ID Prefix R1336	Correction	ID Prefix R1680	Correction	ID Prefix	Correction
Reg. # 8:37-7.5(a)(1)	Completed	Reg. # 8:37-7.10(a)(2)(i-vi)	Completed	Reg. #	Completed
LSC	11/29/2025	LSC	11/29/2025	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	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 11/20/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
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