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	315077	A. BUILDING _____ B. WING _____	10/27/2022

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WILLOWBROOKE COURT SKILLED CARE AT EVERGREENS	309 BRIDGEBORO RD MOORESTOWN, NJ 08057

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F 000	INITIAL COMMENTS A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health. The facility was not found to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 10/24/22 through 10/27/22 Survey Census: 13 Sample Size: 14 Supplemental Residents: 0	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives	F 578		11/18/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/18/2022

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F 578	Continued From page 1 and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of facility policy, the facility failed to ensure the right to formulate EX Order 26 § 4b1 EX Order 26 § 4b1 by failing to ensure a current copy of each resident's EX Order 26 § 4b1 was in the resident's medical record for two of three residents (Resident (R) 6 and R7) reviewed for EX Order 26 § 4b1 . Findings include: 1. Review of R7's profile located on the "Profile" tab of the electronic medical record (EMR) revealed R7 was admitted to the facility on EX Order 26 § 4b1 Review of the "Misc" (miscellaneous) tab in EMR revealed a notarized durable power of attorney dated EX Order 26 § 4b1 and signed by R7. Review of the document revealed no reference to health care	F 578	1. The EX Order 26 § 4b1 and the health care EX Order 26 § 4b1 documents for R7 and R6 were placed in their physical chart on 10/27/22, as well as scanned into electronic medical record. The EX Order 26 orders for both residents are still current and active according to their wishes. 2. An audit was conducted on all 11 residents by the social services coordinator on 10/27/22, no missing documents were identified, also all their EX Order 26 § 4b1 EX Order 26 § 4b1 orders were verified. 3. A performance improvement project has been initiated by the health services coordinator, to make sure that upon admission, all residents EX Order 26 § 4b1 and health care EX Order 26 § 4b1 EX Order 26 § 4b1 are	

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F 578	Continued From page 2 decision making. Review of the physician's orders under the "Orders" tab of the EMR revealed physician's '[redacted] EX Order 26 § 4b1 order dated 10/10/2022. Review of the "Misc" tab in EMR revealed a document titled "E.P._Admission Paperwork." Review of the admission paperwork document revealed R7 had received written information about New Jersey [redacted] The document indicated R7 had a [redacted] and had given a copy to the facility. During an interview with the Social Services Director (SSD) on 10/26/22 at 3:56 PM, SSD was told there was no [redacted] in R7's record. SSD stated she was responsible for the admission paperwork but did not know why R7's [redacted] was not in the record or where it was located. SSD stated she would check R7's paper record. On 10/26/22 at 4:49 PM, SSD was unable to locate a [redacted] for R7 and stated R7's family will bring physical copy of his [redacted] but was not sure it would match MD's [redacted] order. SSD stated she will discuss with MD about MD'S [redacted] order. SSD also stated that when R7 moved from assisted living to skilled nursing care, the system failed to carry over the [redacted] from assisted living. On 10/27/22, at about 12:00 noon, SSD produced a 'EX Order 26 § 4b1 [redacted] ' dated 08/08/2001 for R7. SSD acknowledged that the record for R7 had been incomplete until the [redacted] was located. The	F 578	obtained when available. Once confirmed, this will be communicated to the physician and Nurse Practitioner (NP) prior to the [redacted] orders are written. Information and acknowledgment forms will be provided to the residents/Power of Attorneys, and to follow up with them as needed. The health services coordinator and the social services coordinator will confirm receiving of those documents as part of the admission check list. A 48-hour post admission chart audit will be performed by the Director of Nursing (DON) or designee, to ensure the documentation of [redacted] and advanced health care directive are obtained. 4. The performance improvement project will be ongoing, to assure that residents, current health care [redacted] and [redacted] are scanned in the electronic medical record. The Performance Improvement Plan report will be submitted to Quarterly QAPI committee for three months or until 100% compliance is achieved.	

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F 578	Continued From page 3 EX Order 26 § 4b1 included a [redacted].	F 578		

2. Review of the "Misc." tab in the EMR for R6 revealed a durable power of attorney (DPOA) dated 08/03/18. The DPOA failed to reveal any references to R6's health care management, [redacted] or [redacted].

Review of the physician's orders under the "Orders" tab of the EMR revealed physician's 'EX Order 26 § 4b1 order dated 06/12/22.

During an interview on 10/26/22 at 3:56 PM, SSD was asked if R6 had an [redacted] and if SSD had enquired from the resident or family about [redacted] SSD stated there was an MD order in the medical record indicating R6 was a DNR. SSD stated she would find out if there was any document that reflected R6's wishes for her care, and that the document may have failed to transfer from assisted living to the skilled nursing.

On 10/26/22 at 4:30 PM, SSD produced a '[redacted]" for R6, dated 8/3/18. SSD stated the document had failed to cross over with the resident from her assisted living facility. SSD admitted that the medical record for R6 was incomplete without R6's [redacted]

Review of policy #H11 titled "Health Care Records" dated 12/2017 revealed the policy of the facility was "to strive to maintain a health care record for each resident that is complete, accurately documented, readily accessible, systematically organized and per the policies and procedures of the Privacy Protection Manual."

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F 578	Continued From page 4	F 578		

Review of the facility's policy #A-07 dated 12/2018 and titled "[redacted] for Residents in Skilled Care Center and Residential Community" revealed its purpose was:
"To strive to establish procedures to support effective administration of residents' advance health care directives in Acts skilled care centers and residential communities and to strive to ensure compliance with the Federal Patient Self-Determination Act and the State Advance Directives Statutes.
1. The skilled care center and residential community will honor properly executed and clearly stated Advance Health Care Directives so that residents and their families will be assured that medically indicated treatment decisions correspond with their wishes.
2. Periodic discussion on the subject of Advance Health Care Directives will be held at the skilled care center and/or residential community.
3. Information concerning Advance Health Care Directives will be made available to all residents upon move-in and as requested.
Note: This information is found in the Resident Information Book.
4. While the director of nursing (DON), ... nurse practitioner (NP), social services coordinator or his/her designee may review the contents of the information provided to the resident in the Resident Information Book, he/she shall make dear to the resident that he/she is not providing legal advice and direct the resident to contact his/her attorney with any questions pertaining to his/her circumstances."

The policy further provided that upon admission, residents will be provided information of the following.

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F 578	Continued From page 5 EX Order 26 § 4b1 EX Order 26 § 4b1 [redacted] EX Order 26 § 4b1 l. A copy of any EX Order 26 § 4b1 [redacted] shall be kept as part of the resident's health record. NJAC 8:39-9.6(a)(b)	F 578		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure foods stored in dry storage were resealed closed when opened. This failure had the potential to affect the 12 residents who ate food prepared by the kitchen. Findings include:	F 812	1. Identified items were immediately corrected on the spot by putting into tightly sealed containers such as craisins (dried cranberries), raisins, thick it and almonds; other items were discarded such as crispy fried onions and cake mix. We do have a policy on proper food storage, titled	11/18/22

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F 812	Continued From page 6 The following observations in the kitchen were made with and verified by the Director of Culinary and Nutrition Services (DCN). On 10/24/22 at 10:30 AM, observation of the dry storage room revealed one box of thickener, one bag of dried cranberries, one bag of cake mix, one container of fried onion sticks, one bag of raisins, and one container of chopped nuts, that were open to air. During an interview on 10/24/22 at 10:43 AM, DCN stated, "The food items should be sealed closed after opened. I understand that bugs can get into anything that is open." During an interview on 10/27/22 at 10:49 AM, the Interim Administrator stated, "My expectation for the kitchen is that any food item that is opened should be sealed shut." The facility did not provide a policy that addressed ensuring open food items in storage were sealed. NJAC 8:39-17.2(g)	F 812	Operational Standard, Storeroom which was created and revised in 2017. The policy states to keep opened food items tightly sealed. 2. All other food items were inspected by the culinary and nutrition services director immediately and were found to be properly stored. 3. A department wide education on proper food storage was held on 11/17/22. The education was focused on how to store opened food items to avoid contamination. Daily inspection will be conducted by culinary management staff and will be followed with correction/education as needed. A performance improvement project (PIP) has been initiated to inspect proper food storage by conducting random audits weekly by the opening and closing managers. The audit will focus on dried food items, checking for labeled dates when opened and inspecting proper storage. The audit will be documented and shared with culinary staff with timely correction as needed. The director of culinary and nutrition service or designee will conduct daily round to assure compliance. The director of culinary and nutrition service or designee will oversee the PIP to assure completion weekly. 4. The weekly audit will be ongoing for three months or until 100% compliance is achieved. The audit report will be submitted to the Quarterly QAPI committee.	

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F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		12/30/22

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F 880	Continued From page 8 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, observations, and staff interviews, the facility failed to follow appropriate infection control practices for hand hygiene and glove wearing for two out of five residents (Resident (R6 and R115) observed during medication administration, and one out of one resident (R115) observed during EX Order 26 § 4b1 Findings include: Observation on 10/25/22 at 9:37 AM revealed	F 880	1. R6, R115 and R12 who were interacted with and assisted by RN1 are functioning in their baseline physically and mentally, no negative impact identified by the deficiency. 2. The infection preventionist (IP) completed an audit of all nursing staff on infection control protocol, including proper handwashing and glove wearing 0n 10/27/22 and 10/28/22. A random daily	

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F 880	Continued From page 9 Registered Nurse (RN) 1 applying an EX Order 26 § 4b1 [redacted]) to R6. RN1 approached R6 in the dining area and RN1 EX Order 26 § 4b1 [redacted] R6 to R6's room. RN1 did not perform hand hygiene. RN1 stood R6 up and pulled down R6's pants in order to access R6's EX Order 26 § 4b1 [redacted]. RN1 opened the EX Order 26 § 4b1 [redacted], pulled off the protective film and applied the EX Order 26 [redacted] to R6's Ex.Order 26.4(b)(1) [redacted]. RN1 pulled R6's pants back up, did not don gloves and did not perform hand hygiene. RN1 EX Order 26 § 4b1 [redacted] R6 back to the dining area at 9:41 AM. RN1 proceeded to pull medications for R4 from the medication cart, administered the medications to R4, and still did not perform hand hygiene. RN1 pulled and administered medications to R9, assisted R9 in taking the medications with a spoon, and still performed no hand hygiene. RN1 performed hand hygiene at 10:01 AM. Further observation of RN1 on 10/26/22 at 9:31 AM revealed RN1 administering medications to R12 in R12's room. RN1 performed no hand hygiene before entering R12's room. On 10/26/22 at 9:47 AM, RN1 assisted R115 with taking EX Ord [redacted] pills. RN1 held R115's straw and cup while R115 took Ex.Order [redacted] pills one at a time and sipped from the cup held by RN1. R115 requested more ice. RN1 lifted a Styrofoam cup with a lid that had been lying on R115's bedside table and took the cup out of the room and into the hallway. RN1 made a brief stop in the Director of Nursing's (DON) office, placed R115's used cup briefly on a table in the DON's office; RN1 retrieved the cup, took it to the kitchen, filled it with ice and took it back to R115's room. On 10/26/22 at 10:25 AM, observation of RN1	F 880	round by the DON, ADON and IP will assure that the policies and procedures of infection control and prevention are always being followed while providing resident care. The state recommended infection control training courses were completed by staff working in Willowbrooke Court, including nurses, CNAs, culinary, housekeeping, maintenance, recreation, and rehab department on 12/1/22 and 12/2/22. The topline staff and IP completed video module #1 Infection Prevention and Control, #4 Infection Surveillance, #5 Outbreaks, #6A Principles of Standard Precautions, #6B Principles of Transmission Based Precautions, and #7 Hand Hygiene; and front line staff completed all required training courses per state. All training will be completed by 12/30/2022. 3. Root cause analysis concluded that 1) No return demonstration of EN 1□s hand washing/glove wearing were completed along with orientation. 2) No random observation was completed by the infection preventionist. 3) The nursing management team made a wrong assumption that RN1 should have the knowledge and be able to follow infection control protocols being an experienced RN. The DON reviewed survey findings with RN1 and provided additional training to her on 10/31/22 regarding hand hygiene and the importance to wear gloves while providing resident care. The DON also spent an eight-hour shift with her the next day on 11/1/22, to observe	

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F 880	Continued From page 10 placing another EX Order 26 § 4b1 EX Order 26 § on R6. RN1 did not perform hand hygiene or don gloves. RN1 removed the EX Order 26 from the package, placed the packet on the floor, peeled off the protective film and applied the EX Order 26 § with bare hands on R6, EX Order 26 § 4b1. RN1 picked the packet off the floor, proceeded to the medication cart to retrieve R6's phone, took the phone down the hall to R6's room, returned to the medication cart, and finally performed hand hygiene with hand sanitizer. Observation of EX Order 26 § care with RN1 and Assistant Director of Nursing (ADON) on 10/26/22 at 10:11 AM revealed RN1 donned a pair of gloves without first performing hand hygiene. RN1 removed the old dressing in R115's back and changed gloves. No hand hygiene was performed before changing gloves. ADON, who was assisting RN1, removed her gloves and donned another pair without performing hand hygiene. At the conclusion of the EX Order 26 § 4 care, RN1 took off the gloves with which she had performed EX Order 26 § 4 care. RN1 touched the resident, the resident's EX Order 26 § 4b1, and the resident's EX Order 26 § 4b before performing hand hygiene. During an interview on 10/26/22 at 12:24 PM, the DON was asked what her expectations were for nurses to perform hand hygiene and don gloves. DON stated staff should don gloves during EX Orde [redacted] briefs, or taking someone to the toilet. Also, when giving certain medications if the staff is pregnant and the medication would be harmful to staff. DON stated staff did not need to wear gloves if touching a resident who is clothed.	F 880	her performing hand hygiene and proper glove wearing. RN1 has been closely monitored by the IP, DON and ADON after she completed all required infection control and prevention trainings. The IP will work with current nurses and newly hired nurses, regardless of their education level and past work experience, to review infection control policies and procedures. No nurse will be assigned to work on the unit until the infection control check list is completed, including return demonstration and observation meet requirement and standards. A performance improvement project has been initiated by the infection preventionist, to conduct random weekly audit and observation on hand hygiene and glove wearing . The audit and observations will be documented weekly, any noncompliance will be immediately addressed. 4. The weekly audit/observation will be random and on all three shifts, bur RN1 will be included every week. The audit/observation will be completed for six months or until 100% compliance is achieved. The audit report will be submitted to Quarterly QAPI committee.	

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F 880	Continued From page 11 The foregoing observations were discussed with the DON, and she agreed that they were breaches in infection control and prevention standards and RN1 should have performed hand hygiene in the scenarios observed. DON added that gloves should be worn when rubbing cremes and applying a EX Order 26 § 4b1 and hand hygiene "after each thing you do." During an interview with RN1 at 12:45 PM on 10/26/22 the forgoing observations were discussed. RN1 agreed that they were breaches in infection control and prevention standards. RN1 further stated that it was difficult to apply a EX Order 26 § 4b1 with gloved hands because the EX Order 26 became twist and difficult to control. RN1 stated she was careful not to touch the medication when she applied it. During an interview with the facility's Infection Preventionist, (ICP) the foregoing observations were discussed with the ICP, and she confirmed that they were all breaches of infection control standards contrary to what she had been teaching. ICP stated more training would be done with staff. Review of facility's policy# B-03.81C titled "HAND WASHING AND HAND HYGIENE" revealed the policy was "to strive to prevent infections through adequate hand washing and hand hygiene techniques." Policy further provided: " C. Always decontaminate hands: When coming on and going off duty Before and after direct resident contact. Before and after inserting urinary catheter,	F 880		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315077	A. BUILDING _____ B. WING _____	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SKILLED CARE AT EVERGREENS	309 BRIDGEBORO RD MOORESTOWN, NJ 08057

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F 880	Continued From page 12	F 880		

intravenous catheter, or other invasive devices.
Before and after entering isolation precaution settings
Before and after changing a dressing
After contact with a resident's intact skin (i.e., when taking a pulse or blood pressure and lifting a resident).
After blowing and wiping nose
After contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings.
If moving from a contaminated body site to a clean body site during resident care.
After contact with inanimate objects (including medical equipment) in the immediate vicinity of the resident.
After handling soiled or used linens, dressings, bedpans, catheters and urinals
After removing gloves'

Review of facility's policy #B-03.6IC, revised 03/2020 titled "Gloves" revealed "gloves are worn . . . for all procedures or tasks involved with touching blood and body fluids, mucous membranes, or non-intact skin."

NJAC8:39-19.4(a)1

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	030303	A. BUILDING: _____ B. WING _____	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SKILLED CARE AT EVERG	309 BRIDGEBORO RD MOORESTOWN, NJ 08057

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S 765	8:39-9.2(a) Mandatory Administration (a) The facility shall be directed by an individual who holds a current New Jersey license as a nursing home administrator. The administrator shall be administratively responsible for all aspects of the facility. This REQUIREMENT is not met as evidenced by: Based on interviews and a review of pertinent facility documents on 10/27/22, it was determined that the facility failed to ensure the Administrator of record had a current New Jersey Administrator's License. This deficient practice was evidenced by the following: During the entrance conference with the Director of Nursing (DON), the Executive Director (ED) and the Interim Administrator (Admin#1), on 10/24/22 at 10:16 am, the Executive Director stated the previous administrator departed the facility on September 30, 2022. The ED further stated that the facility was in the process of hiring another administrator and in the meantime the interim director was Admin#1. When asked if Admin#1 was a licensed administrator, the ED stated, 'Yes. In the state of Delaware'. The ED further stated he had sent a letter on October 1st, 2022, to the state informing the state of the change in administrator. Admin#1 confirmed, at that time, that she was licensed in the state of Delaware but not in the state of New Jersey.	S 765	1. Admin #1 is the Regional Clinical Director for the facility. This individual continues to be present in the facility to support daily operations focusing on clinical services since the nursing home administrator position became vacant on September 30, 2022 for unforeseeable reasons. 2. Pursuant to a Directed Plan of Correction letter issued to the facility by NJDOH on November 1, 2022, the facility has contracted with a nursing home administrator currently licensed by the State of New Jersey (and approved in advance by NJDOH) to serve as an administrator consultant to the facility for a minimum of 20 hours per week, beginning on November 10, 2022. Such individual will continue in this capacity so long as the Directed Plan of Correction is in force. 3. The facility continues to actively recruit a new nursing home administrator licensed in the State of New Jersey, with the position posted both internal and externally. A qualified candidate is in the final stages of the interview process. The	11/18/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/18/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 765	Continued From page 1	S 765	facility will notify NJDOH once an offer of employment has been made and accepted. 4. The vacant positions will be reviewed at weekly management meetings. Any posting that lasts longer than 30 days with no candidates will be reported to the corporate human resources department, including the corporate talent acquisition specialist for support. This will also be reviewed at quarterly QAPI meetings. The administrator consultant with continue to work 20 hours a week until a new administrator is hired.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315077	A. Building B. Wing	2/3/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SKILLED CARE AT EVERGREENS	309 BRIDGEBORO RD MOORESTOWN, NJ 08057

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0578 Reg. # 483.10(c)(6)(8)(g)(12)(i)-(v) LSC	Correction Completed 11/18/2022	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 11/18/2022	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 12/30/2022
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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 10/27/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	030303	A. BUILDING: _____ B. WING _____	R 02/03/2023

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{S 765}	8:39-9.2(a) Mandatory Administration (a) The facility shall be directed by an individual who holds a current New Jersey license as a nursing home administrator. The administrator shall be administratively responsible for all aspects of the facility. This REQUIREMENT is not met as evidenced by:	{S 765}		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315077	A. BUILDING **02** B. WING _____	**10/27/2022**

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WILLOWBROOKE COURT SKILLED CARE AT EVERGREENS	**309 BRIDGEBORO RD** **MOORESTOWN, NJ 08057**

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 10/25/22. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 10/25/22 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 Occupancy. Willowbrooke Court Skilled Care at Evergreens is a two-story building that was built in 2012. It is composed of Type II protected construction. The facility is divided into three smoke zones. The generator does approximately 100% of the building as per the Director of Physical Plant Services. The current occupied beds are 13 of 34.	K 000		
K 100 SS=F	General Requirements - Other CFR(s): NFPA 101 General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced	K 100		11/18/22

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Electronically Signed | 11/18/2022

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K 100	Continued From page 1 by: Based on observation and interview, facility failed to ensure that steel beams were properly protected with fire proofing for a type II (111) building in accordance with NFPA 101 Life Safety Code 19.1.6.3 (2012 Edition). This deficient practice had the potential to affect all 13 residents. Findings include: An observation on 10/25/2022 at approximately 1:40 PM revealed fire proofing had broken off or was missing from steel beams in the storage room behind the elevators on the second floor. The Director of Physical Plant Services was present at the time of observation and confirmed that the fire proofing was missing from the steel beams in the storage room. NJAC 8:39-31.1(b)-(c), 31.2(e)	K 100	A. The deficient fireproofing of the steel beams was repaired on 11-30-22 by one of the facility□s vendors. B. The repairment, upon completion, was documented by the Director of Physical Plant Services (DPPS) and the Nursing Home Administrator (NHA). All other areas that require fireproofing were inspected on 11-15-22 and no deficiencies were identified. C. The Director of Physical Plant Services (DPPS) or his/her designee will inspect on a monthly basis the storage areas where the steel beams are visible for a period of 3 consecutive months to ensure that the fireproofing is present and in compliance. D. All findings will be reported to the Safety Committee (which meets on a monthly basis) and QAPI Committee (which meets on a quarterly basis) to review and discuss.	
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by:	K 211		11/18/22

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K 211	Continued From page 2 Based on observation and staff interview, the facility failed to ensure the force required to fully open any door leaf manually in a means of egress did not exceed 15 pounds of force (lbf) to release the latch, 30 lbf to set the door leaf in motion, and 15 lbf to open door leaf in accordance with NFPA 101 Life Safety Code (2012 Edition) 7.2.1.4.5.1. This deficient practice had the potential to affect 11 residents. Findings include: An observation on 10/25/22 at 1:30 PM revealed the exit door, located on the first floor and adjacent to the stairs which served as exit discharge for the East Wing center stairwell, required pressure of more than 30 lbf to set the door in motion. The Surveyor applied pressure with a door pressure gauge which ranged 0-35 Lbs and the force required to open the door did not register on the gauge. During an interview at the time of the Director of Physical Plant Services affirmed the force to open the exit door exceeded 30lbf. NJAC 8:39-31-1(c), 31.2(e)	K 211	A. The exit door was repaired on 11-14-22 by the facility□s maintenance department.¿ B. The repairment, upon completion, was documented by the Director of Physical Plant Services (DPPS) and all other exit doors were inspected on the same day and no deficiencies were identified. C. The Director of Physical Plant Services (DPPS) or his/her designee will inspect all exit doors in the building on a monthly basis for 3 consecutive months to ensure that the doors are in compliance.¿ D. All findings will be reported to the Safety Committee (which meets on a monthly basis) and the QAPI Committee (which meets on a quarterly basis) to review and discuss.	
K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit	K 293		1/25/23

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K 293	Continued From page 3 travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure directional signs, which showed the direction of travel, were placed in every location where the direction of travel to reach the nearest exit was not apparent in accordance with NFPA 101 (2012 edition) section 7.10.2.1. This deficient practice had the potential to affect all 13 residents. Findings include: An observation between 11:57 AM and 12:30 PM revealed directional signs were not placed to indicate the direction of travel on the East and West Wings . During an interview at the time of the observation, the Director of Physical Plant Services confirmed that the direction of travel was not apparent on the East and West Wings. NJAC 8:39-31.1(c), 31.2(e)	K 293	A. The noted deficiency concerning the fire exit signs had the potential to impact all 13 residents. The fire exit signs will be replaced with ones that are visible from multiple sides no later than 1-25-23.¿ B. The fire exit sign replacement, upon completion, will be documented as part of the monthly fire exit sign preventative maintenance work orders.¿ C. The Director of Physical Plant Services (DPPS) or his/her designee will perform a monthly audit of the fire exit signs for 3 consecutive months to ensure that the signs are illuminated and otherwise in compliance. D. All findings will be reported to the Safety Committee (which meets on a monthly basis) and QAPI Committee (which meets on a quarterly basis) to review and discuss.	
K 300 SS=E	Protection - Other CFR(s): NFPA 101 Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	K 300		11/18/22

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K 300	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, facility failed to ensure that the low voltage room East B was smoke tight in accordance with NFPA 101 Life Safety Code 19.3.2. This deficient practice had the potential to affect 11 residents. Finding include: An observation on 10/25/2022 at approximately 2:14 PM revealed the low voltage room on East B was not smoke tight where the sprinkler pipe hanger went through the drywall ceiling. The Director of Physical Plant Services was present at the time of observation and confirmed that the ceiling was not smoke tight around sprinkler hanger. NJAC 8:39-31.1(c), 31.2(e)	K 300	A. The fire sprinkler pipe hanger fire caulking was repaired on 11-15-22 by the facility□s maintenance department. B. All areas of the building where smoke barriers are present were inspected on the same day to ensure that there are no gaps in coverage.¿ C. The Director of Physical Plant Services (DPPS) or his/her designee will perform a monthly audit of all storage areas and workspaces for 3 consecutive months to ensure that all required fire proofing is present and in compliance with the requirements.¿ D. All findings will be reported to the Safety Committee (which meets on a monthly basis) and the QAPI Committee (which meets on a quarterly basis) to review and discuss.	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.	K 353		11/18/22

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K 353	Continued From page 5 a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to replace a missing concealed sprinkler cover in accordance with NFPA 13 Standard for Automatic Sprinkler Systems 6.2.7 (2010 Edition). This deficient practice had the potential to affect 11 residents. Findings Include: An observation on 10/25/2022 at approximately 2:15 PM revealed a concealed sprinkler cover (also, known as an escutcheon) was missing from the sprinkler head in room 218. The Director of Physical Plant Services was present at the time of observation and confirmed that the concealed sprinkler cover was missing. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 353	A. The escutcheon cover for the sprinkler head was replaced on 10-26-22 by the facility□s fire suppression vendor. B. The escutcheon cover replacement, upon completion, was documented and the remaining areas on the floor were inspected on the same day and found to be in compliance.¿ C. The Director of Physical Plant Services (DPPS) or his/her designee will perform a monthly audit of the Health Care Center floors for 3 consecutive months to ensure that the sprinkler heads are in compliance.¿ D. All findings will be reported to Safety Committee (which meets on a monthly basis) and the QAPI Committee (which meets on a quarterly basis) to review and discuss.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers	K 355		11/18/22

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K 355	Continued From page 6 Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure portable fire extinguishers other than wheeled extinguishers were installed securely on a hanger intended for the extinguisher in accordance with NFPA 10 (Standard for Portable Fire Extinguishers) 2010 Edition 6.1.3.4(1). This deficient practice had the potential to affect all 13 residents. Findings include: An observation on 10/25/22 at 2:30 PM revealed the Class K fire extinguisher located in the Country Kitchen was not installed securely on a hanger intended for the extinguisher. During an interview at the time of the observation, the Director of Physical Plant Services confirmed the Class-K fire extinguisher was not installed securely on a hanger. NJAC 8:39-31.1(c), 31.2(e) NFPA 10, 96	K 355	A. The K type fire extinguisher hanger was replaced with the correct one on 11-14-22 by the facility□s maintenance department. The replacement of the hanger was documented. B. All K type fire extinguisher hangers were inspected in the building on 11-14-22 and found to be in compliance. ¿ C. The Director of Physical Plant Services (DPPS) or his/her designee will perform an audit of the K type fire extinguisher hangers for 3 consecutive months to ensure that all are in compliance.¿ D. All findings will be reported to the Safety Committee (which meets on a monthly basis) and QAPI Committee (which meets on a quarterly basis) to review and discuss.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core	K 363		11/18/22

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315077	A. BUILDING **02** B. WING _____	**10/27/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SKILLED CARE AT EVERGREENS	**309 BRIDGEBORO RD MOORESTOWN, NJ 08057**

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K 363	Continued From page 7 wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure corridor doors closed and latched in their frames and there were no impediments to the closing of the doors on the West Wing in accordance with NFPA 101 Life Safety Code	K 363	A. The two doors were repaired at the time of inspection on 10-26-22 by the facility□s maintenance department.¿ B. All remaining doors were inspected on	

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	315077	A. BUILDING **02** B. WING _____	**10/27/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SKILLED CARE AT EVERGREENS	**309 BRIDGEBORO RD MOORESTOWN, NJ 08057**

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K 363	Continued From page 8 (2012 edition) 19.3.6.3. This deficient practice had the potential to affect all 13 residents. Findings include: An observation on 10/25/22 at 2:25 PM revealed the door to Room 205 failed to latch when closed and the door to Room 204 was binding with the door frame. During an interview at the time of the observations, the Director of Physical Plant Services confirmed the door to Room 204 was binding and the door to Room 205 failed to latch when closed. NJAC 8:39-31.1(c), 31.2(e)	K 363	the same day and were found to be in compliance. The inspection was documented on the room check sheet.¿ C. The Director of Physical Plant Services (DPPS) or his/her designee will perform a monthly audit of the doors during monthly room checks for 3 consecutive months to ensure that the doors are in compliance.¿ D. All findings will be reported to the Safety Committee (which meets on a monthly basis) and QAPI Committee (which meets on a quarterly basis) to review and discuss.	
K 919 SS=D	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure appliances were protected against overcurrent in accordance with NFPA 70 (National Electrical Code) 2011 Edition 422 and 422.11. This deficient practice had the potential to affect any staff in use of the device. Findings include:	K 919	A. The outlet in question was replaced with a GFCI outlet on 11-15-22 by the facility□s maintenance department and the replacement documented. B. The outlets in other area were inspected on the same day with no issues.¿	11/18/22

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	315077	A. BUILDING **02** B. WING _____	**10/27/2022**

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WILLOWBROOKE COURT SKILLED CARE AT EVERGREENS	**309 BRIDGEBORO RD MOORESTOWN, NJ 08057**

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K 919	Continued From page 9 Observation on 10/25/22 at 2:23 PM revealed the drinking water cooler, located in the Administration Office, did not have overcurrent protection. During an interview at the time of the observation, the Director of Physical Plant Services confirmed the drinking water cooler did not have overcurrent protection. NJAC 8:39-31.2(e) NFPA 70	K 919	C. The Director of Physical Plant Services (DPPS), or designee will perform a monthly audit of the outlets for 3 consecutive months to ensure compliance.¿ D. All findings will be reported to the Safety Committee (which meets on a monthly basis) and QAPI Committee (which meets on a quarterly basis) to review and discuss.	
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.	K 920		11/18/22

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	315077	A. BUILDING **02** B. WING _____	**10/27/2022**

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WILLOWBROOKE COURT SKILLED CARE AT EVERGREENS	**309 BRIDGEBORO RD MOORESTOWN, NJ 08057**

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K 920	Continued From page 10 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to ensure three-prong or two-prong adapters were not used in accordance with NFPA 99 (Healthcare Facilities Code) 2012 Edition 10.2.4.1. This deficient practice had the potential to affect all 13 residents. Findings include: An observation on 10/25/22 at 2:00 PM revealed the office, located adjacent to the East Wing Housekeeping, had an electric fragrance diffuser plugged into a three-prong wall tap adapter. During an interview at the time of the observation, the Director of Physical Plant Services, confirmed the use of three-prong wall tap adapter. NJAC 8:39-31.2(e) NFPA 99	K 920	A. The three-prong outlet adapter was removed at the time of inspection on 10-26-22.¿ B. All multi-plug adapters were inspected the same day and those that were found not to be in compliance were removed from use.¿ C. The Director of Physical Plant Services (DPPS) or his/her designee will perform a monthly audit during room checks for 3 consecutive months to ensure that all adapters meet the code requirements.¿ D. All findings will be reported to the Safety Committee (which meets on a monthly basis) and QAPI Committee (which meets on a quarterly basis) to review and discuss.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315077 Y1	A. Building 02 - NEW SKILLED NURSING B. Wing Y2	2/3/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SKILLED CARE AT EVERGREENS	309 BRIDGEBORO RD MOORESTOWN, NJ 08057

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0100	11/18/2022	LSC K0211	11/18/2022	LSC K0293	01/25/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0300	11/18/2022	LSC K0353	11/18/2022	LSC K0355	11/18/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0363	11/18/2022	LSC K0919	11/18/2022	LSC K0920	11/18/2022
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	
10/27/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO