STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35a010	A. BUILDING: _____ B. WING _____	C 11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY MEWS SENIOR LIVING	**124 GREEN AVENUE WOODBURY, NJ 08096**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: COMPLAINT #: NJ188761 CENSUS: 99 SAMPLE SIZE: 5 TYPE OF SURVEY: Standard Survey of 55 residential units The facility is not in substantial compliance with all the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations. A Life Safety Code Survey was conducted by the State Agency on 11/21/2025. The facility was not in substantial compliance with New Jersey Administrative Code, Chapter 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs.	A 000		
A 389	8:36-4.1(a)(16) Resident Rights (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights:	A 389		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/29/25

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A 389	Continued From page 1	A 389		

16. The right to be free from physical and mental abuse and/or neglect;

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, document review, and facility policy review, the facility failed to honor the resident's right to be free from NJ Exec Order 26 for 1 (Resident #1) of 2 sampled residents reviewed for NJ Exec Order 26.4 Specifically, on NJ Exec Order 26.4b1, a certified home health aide (CHHA) employed by an outside NJ Exec Order 26.4 provider, pulled Resident #1 in a NJ Exec Order 26.4b1, while looking at her cellphone. Resident #1 NJ Exe out of the NJ Exec Order 26.4 wheelchair and onto the NJ Exec Ord NJ Exec Order 26.4b1 Resident #1 was transported to the hospital and treated for a NJ Exec Order 26.4b1 to their NJ Exec Order 26.4b1 and an NJ Exec Order 26.4b1 a result of the incident.

Findings included:

A facility policy titled, "Abuse, Neglect, and Exploitation," dated 06/07/2024, revealed, "Resident abuse, neglect, and exploitation are prohibited. Should any resident experience abuse (by staff, residents, family, or others) or when abuse is suspected, staff and volunteers are required to immediately provide notification to persons/agencies as described in this policy."

A "Resident Information" revealed the facility admitted Resident #1 on NJ Exec Order 26.4b1. According to the Resident Information, the resident had a medical history that included diagnoses of NJ Exec Order 26.4b1.

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A 389	Continued From page 2 Resident #1's "Service Plan," with an admission date of NJ Exec Order 26.4b1, indicated the resident required employees to NJ Exec Order or NJ Exec Or their wheelchair because of a NJ Exec Order 26.4b1. The "LTC [long term care] Reportable Event Summary" dated NJ Exec Order 26.4b1, indicated on NJ Exec Order 26.4b1 at 11:30 AM, a NJ Exec Order 26.4b1 pulled Resident #1 in their NJ Exec Order 26.4b1 while looking at her phone and the resident NJ Exe to the NJ Exec Ord Resident #1's hospital record with an admission date NJ Exec Order 26.4b1, revealed the resident discharged from the hospital on NJ Exec Order 26.4b1 with discharge diagnoses of NJ Exec Order 26.4b1 During an interview on 11/17/2025 at 2:24 PM, Server #3 stated that on NJ Exec Order 26.4b1 around 11:30 AM, she was cleaning tables on Resident #1's unit when she observed NJ Exec Order 2 #7 NJ Exec Order 2 Resident #1 in the resident's NJ Exec Order 26.4b1. Server #3 stated she observed NJ Exec Order 2 #7 with a cellular phone in her left hand, a tablet on her left arm, and NJ Exec Order 2 Resident #1's NJ Exec Order 26.4 with her right hand, facing away from the resident. Server #3 stated she continued to clean the tables when she observed Resident #1 on the NJ Exec Order 26.4b1. Server #3 stated the nursing staff rushed into the room and attended to Resident #1, who was NJ Exec Order 26.4b from their NJ Exec Order 26.4b1 During an interview on 11/18/2025 at 9:57 AM, Health Care Coordinator (HHC) #5 stated she worked the 6:00 AM to 6:00 PM shift on NJ Exec Order 26.4b1 and was sitting at the nurses' station	A 389		

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A 389	Continued From page 3	A 389		

with Medication Technician (MT) #4 when she observed NJ Exec Order 26.4b1 #7 NJ Exec Order 26.4b1 Resident #1 NJ Exec Order 26.4b1 in a NJ Exec Order 26.4b1 while the resident's NJ Exec Order 26.4 NJ Ex Order HHC #5 stated she heard MT #4 NJ Exec Order 26.4b1 and saw Resident #1 NJ Exec Order 26.4b1 and onto the NJ Exec Ord HHC #5 stated she began running into the room when she observed the resident NJ Exec Order but could not make it before the resident NJ Exec Order 26.4b1. HHC #5 stated she ran to where Resident #1 was and NJ Exec Order 26.4b1 to the resident's NJ Exec Order 26.4b1 because they were NJ Exec Order 26.4b1 HHC #5 stated she NJ Exec Order 26.4b1 next to the resident until emergency medical services (EMS) arrived to the facility. HHC #5 stated EMS personnel NJ Exec Order 26.4b1 Resident #1's NJ Exec Ord in a NJ Exec Order 26.4b1 and placed the resident onto a NJ Exec Order 26.4b1 HHC #5 stated she spoke to NJ Exec Order 26.4b1 #7 following the incident, and NJ Exec Order 26.4b1 #7 told her that she was NJ Exec Order 26.4b1 Resident #1's NJ Exec Order 26.4b1 because the resident would NJ Exec Order 26.4b1.

During an interview on 11/18/2025 at 10:16 PM, the Nurse Practitioner stated she would not recommend staff NJ Exec a resident in a NJ Exec Order 26.4 and expected staff to NJ Exec Ord the chair so the resident was in NJ Exec Order 26.4b1 the entire time.

During an interview on 11/18/2025 at 10:33 AM, MT #4 stated she and HHC #5 were standing near the unit nurse's station when they witnessed NJ Exec Order 26.4b1 #7 NJ Exec Order 26.4b1 Resident #1 in a NJ Exec Order 26.4 and the resident was NJ Exec Order 26.4b1 in the chair. MT #4 stated she tried to NJ Exec Order 26.4b1 when she saw NJ Exec Order 26.4b1 #7 NJ Exec Order 26.4b1 the resident, but Resident #1 NJ Exec Order 26.4b1 of the chair and NJ Exec Order 26.4b1 before she could warn NJ Exec Order 26.4b1 #7. MT #4 stated HHC #5 grabbed NJ Exec Order and applied NJ Exec Order 26.4b1 to Resident #1's NJ Exec Ord

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A 389	Continued From page 4	A 389		

NJ Exec Order 2 while she called NJ Exec and gathered paperwork to prepare Resident #1 for transport to the hospital. MT #4 stated she observed Resident #1 NJ Exec Order 26.4b from their NJ Exec Order 26.4b1 MT #4 stated EMS personnel arrived shortly after the phone call, and the resident was transported to the hospital. MT #4 stated NJ Exec Order 2 #7 should not have NJ Exec Order Resident #1 in a NJ Exec Order 26.4b1.

During an interview on 11/19/2025 at 10:24 AM, Registered Nurse #6 stated NJ Exec Order 2 #7 NJ Exec Order 26.4b1 the resident by NJ Exec Order 26.4b1 in a NJ Exec Order 26.4b1 and the residents should not be NJ Exec Order 26.4b1.

During a telephone interview on 11/19/2025 at 12:47 PM, NJ Exec Order 2 #7 stated she was at the facility on NJ Exec Order 26.4b1 to take care of Resident #1. NJ Exec Order 2 #7 stated Resident #1 was NJ Exec Order 26.4b in their NJ Exec Order 26.4b1 in the television room next to the unit nurse's station, and she wanted to take the resident to an activity. NJ Exec Order 2 #7 stated she attempted to NJ Exec Ord Resident #1 in their NJ Exec Order 26.4 but Resident #1 would not NJ Exec Order 26.4 NJ Exec Order 2 #7 stated she began to NJ Exec Resident #1's NJ Exec Order 26.4b1 but had to stop abruptly because a staff member opened the door and she did not want to hit the door. NJ Exec Order 2 #7 stated Resident #1 became NJ Exec Order 26 and attempted to NJ Exec Order 26.4b and NJ Exec Order 26.4b1, NJ Exec Order their NJ Exec Ord on the NJ Exec Ord NJ Exec Order 2 #7 stated MT #4 NJ Exec Order out when she noticed the resident NJ Exec Order 26.4b1, and HHC #5 ran into the room and assessed the resident NJ Ex Order 26.4(b)(1). NJ Exec Order 2 #7 stated facility staff stayed with the resident and did NJ Exec Order 26.4b1 until EMS personnel arrived to take the resident to the hospital. NJ Exec Order 2 #7 stated she was NJ Exec Order 26.4b1 to the facility since the incident.

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A 389	Continued From page 5 During an interview on 11/19/2025 at 1:42 PM, the Director of Health and Wellness stated she would expect staff to [NJ Exec Order] a resident [NJ Exec Order 26] in their wheelchairs, and it would not be acceptable to transport a resident by NJ Exec Order 26.4b1 while the resident's NJ Exec Order 26.4b1 . During an interview on 11/19/2025 at 1:57 PM, the Executive Director stated staff should transport residents in a wheelchair NJ Exec Order 26.4b1 .	A 389		
A 935	8:36-11.4(b) Pharmaceutical Services (b) All medications shall be administered by qualified personnel in accordance with prescriber orders, facility or program policy, manufacturer's requirements, cautionary or accessory warnings, and all Federal and State laws and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of manufacturer's instructions, the facility failed to ensure staff [NJ Exec Order 26] an NJ Exec Order 26.4b1 prior to medication administration for 1 (Resident #4) of 4 residents observed for medication administration. Findings included: The manufacture's "Instructions for Use" for the	A 935		

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A 935	Continued From page 6	A 935		

NJ Exec Order 26.4b1" revised 07/2023, indicated, "Priming your Pen Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you did not prime before each injection, you may get too much or too little insulin."

A "Resident Information" indicated the facility admitted Resident #4 on NJ Exec Order 26.4b1. According to the Resident Information, the resident had an order dated NJ Exec Order 26.4b1, for NJ Exec Order 26.4b1 three times a day with meals. Per the NJ Exec Order 26.4b1, staff were NJ Exec Order 26.4b1 if the resident's NJ Exec Order 26.4b1 was between NJ Exec and NJ Exec Order 26.4b1 per NJ Exec Order 26.4

During medication administration observation on 11/18/2025 at 11:37 AM, Health Care Coordinator (HCC) #5 checked Resident #4's NJ Ex Order 26.4(b)(1) and it was noted the resident's NJ Exec Order 26.4b1. HCC #5 removed Resident #4's NJ Exec Order 26.4b1 from the medication cart, NJ Exec Order the NJ Exec Order 26.4b1, cleansed the top of the NJ Exec Order 26.4b1 with alcohol, and applied a NJ Exec Order 2 to the NJ Ex of the NJ Exec O HCC #5 did not NJ Exec Orde the NJ Exec Order 2 of the NJ Exec Order 26.4b1 prior to administration of the NJ Exec Order 2 to Resident #4.

During an interview on 11/18/2025 at 11:50 AM, HCC #5 stated she did not NJ Exec Orde the NJ Exec Order 2 on the NJ Exec Order 26.4b1 before she administered NJ Exec Order 2 to Resident #4 and was not aware the NJ Exec Order 2 needed to be NJ Exec Order 26.

During an interview on 11/18/2025 at 12:37 PM, Registered Nurse #6 stated nursing staff should NJ Exec Orde the NJ Exec Order 26.4b1 to get any air out.

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A 935	Continued From page 7 During an interview on 11/19/2025 at 1:34 PM, the Director of Health and Wellness (DHW) stated she would expect nursing staff to [NJ Exec Orde redacted] by taking the [NJ Exec Order 26.4b1] out of the medication cart, applying a [NJ Exec Order 2] to the [NJ Exec O] [NJ Exec Order 2] the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 on the [NJ Exec Order 26.] of the [NJ Exec O] The DHW stated she would expect nursing staff to observe a [NJ Exec O] of [NJ Exec Order 2] coming from the [NJ Ex] of the [NJ Exec Order 2] to ensure no [NJ Ex] was in the [NJ Exec Order 2] and to ensure the dose was accurate. During an interview on 11/19/2025 at 1:54 PM, the Executive Director stated she would expect nursing staff to use [NJ Exec Order 26.4b1] in accordance with the manufacturer's guidelines.	A 935		
A 949	8:36-11.5(b)(7) Pharmaceutical Services (b) The registered professional nurse may choose to delegate the task of administering medications in accordance with N.J.A.C. 13:37-6.2 to certified medication aides, as defined in this chapter. 7. Registered professional nurses who participate in certified medication aide training shall attend a Department offered one-day Train-the-Trainer Medication Aide Workshop prior to providing such training to certified medication aides. This REQUIREMENT is not met as evidenced by: Based on interview and facility policy review, the facility failed to ensure Registered Nurse (RN) #6	A 949		

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A 949	Continued From page 8	A 949		

attended a Train-the-Trainer medication aide workshop prior to providing training to medication technicians. This deficient practice had the potential to affect all 99 residents who currently resided in the facility.

Findings included:

A facility policy titled, "Nurse Delegation," dated 06/07/2024, revealed, "Nurse delegation is implemented per State regulations to benefit residents and the Community's ability to provide care. The Registered Nurse (RN) transfers the performance of selected nursing tasks to competent unlicensed assistive personnel in selected situations, in accordance with state regulations." The policy specified, "g. Registered professional nurses who participate in certified medication aide training shall attend a Department offered one-day Train-the-Trainer Medication Aide Workshop prior to providing such training to certified medication aides."

During an interview on 11/18/2025 at 12:37 PM, Registered Nurse (RN) #6 stated she evaluated the nursing staff for competency training related to medication administration.

During a follow-up interview on 11/19/2025 at 10:44 AM, RN #6 stated she did not attend a Train-the-Trainer course.

During an interview on 11/19/2025 at 10:46 AM, the Executive Director stated she was not aware the facility RN was required to complete the Train-the-Trainer course.

During an interview on 11/19/2025 at 11:23 AM, the Director of Health and Wellness stated RN #6 conducted all the facility's competency training

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A 949	Continued From page 9 because she was the only RN in the facility.	A 949		
A1225	8:36-17.3(b)(8)(i-ii) Housekeeping-Sanitation-Safety-Maintenance (b) The following safety conditions shall be met: 8. An electrician licensed in accordance with N.J.A.C. 13:31 shall annually inspect and provide a written statement that the electrical circuits and wiring in the facility are satisfactory and in safe condition; i. The written statement shall include the date of inspection, and shall indicate that circuits are not overloaded, that all wiring and permanent fixtures are in safe condition, and that all portable electrical appliances, including lamps, are Underwriters Laboratories (U.L.) approved; and ii. The written statement shall be available for review by the Department during survey. This REQUIREMENT is not met as evidenced by: Based on interview and facility document review, the facility failed to ensure a licensed electrician annually inspected and provided a written statement that all electrical circuits/wiring were in safe condition during 22 of 22 months. This deficient practice had the potential to affect all 99	A1225		

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A1225	Continued From page 10 residents who currently resided in the facility. Findings included: The facility life safety code (LSC) binder on 11/21/2025 at 10:37 AM revealed no annual electrical inspection for 2024 or yet in 2025. During an interview on 11/21/2025 at 2:27 PM, the Facilities Director (FD) stated he was not aware of the regulatory requirement to have an electrical inspection completed annually. The FD stated he had no documentation of an electrical inspection for 2024 or yet in 2025. The FD stated he was expected to follow all National Fire Protection Association (NFPA) codes, New Jersey Administrative Code (NJAC), and LSC and standards. During an interview on 11/21/2025 at 2:46 PM, the Executive Director (ED) stated she had no documentation of an electrical inspection for 2024 or yet in 2025. The ED stated she was not aware that an annual electrical inspection was required; however, she stated that she expected to follow all NFPA codes, NJAC, and LSC. The ED stated the facility had no policy on ensuring an electrical inspection was completed annually.	A1225		
A1249	8:36-17.7 Housekeeping-Sanitation-Safety-Maintenance The building and grounds shall be well maintained at all times. The interior and exterior of the building shall be kept in good condition to ensure an attractive appearance, provide a pleasant atmosphere, and safeguard against deterioration. The building and grounds shall be kept free from fire hazards and other hazards to	A1249		

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A1249	Continued From page 11 resident's health and safety. This REQUIREMENT is not met as evidenced by: Based on interview and facility document review, the facility failed to ensure the kitchen fire suppression system was inspected semiannually, failed to ensure annual inspection and testing of all fire door assemblies, and failed to exercise the generator under load 30 minutes 12 times per year on 13 of 13 months reviewed. These deficient practices had the potential to affect all 99 residents who currently resided in the facility. Findings included: The facility life safety code (LSC) binder revealed no annual inspection of fire door assemblies other than the "Kitchen System Report" dated 08/08/2023, 02/15/2024, and 08/07/2025. The facility "Logbook Documentation" from November 2024 to November 2025 revealed the generator was not exercised under load for at least 30 minutes on 11/24/2024, 12/31/2024, 02/18/2025, 03/02/2025, and 11/16/2025. There was no documentation of monthly load tests for January 2025, April 2025, May 2025, June 2025, July 2025, August 2025, September 2025, or October 2025. During an interview on 11/21/2025 at 2:27 PM, the Facilities Director (FD) stated he was aware that the kitchen suppression system required	A1249		

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WOODBURY MEWS SENIOR LIVING	124 GREEN AVENUE WOODBURY, NJ 08096

(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
A1249	Continued From page 12 semiannual inspections. The FD stated that the only inspections of the kitchen fire suppression system were dated 08/08/2023, 02/15/2024, and 08/07/2025. The FD stated the facility had six 1 1/2-hour fire-rated doors. The FD stated he was not aware of the requirements to annually inspect and test all fire-rated barrier door assemblies. The FD stated he had no documentation that the six fire-rated doors were inspected in 2024 or yet in 2025. The FD stated they used the load run time, and the generator was not exercised 30 minutes on 11/24/2024, 12/31/2024, 02/18/2025, 03/02/2025, or 11/16/2025. The FD acknowledged there was no documentation of monthly load tests for January 2025, April 2025, May 2025, June 2025, July 2025, August 2025, September 2025, or October 2025. He stated he expected to follow all National Fire Protection Association (NFPA) codes, New Jersey Administrative Code (NJAC), and LSC and standards. During an interview on 11/21/2025 at 2:46 PM, the Executive Director (ED) stated she was aware the kitchen fire suppression system required semi-annual inspection. The ED stated the only inspections of the kitchen fire suppression system were dated 08/08/2023, 02/15/2024, and 08/07/2025. She stated that she was aware of the code requirement that the fire barrier doors required annual inspection; however, she had no documentation they had been inspected in 2024 or yet in 2025. The ED stated she was not aware the generator required exercise for 30 minutes 12 times a year. She stated that the generator was not exercised for 30 minutes on 11/24/2024, 12/31/2024, 02/18/2025, 03/02/2025, or 11/16/2025. She acknowledged there was no documentation of monthly load tests for January 2025, April 2025, May 2025, June 2025, July	A1249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35a010	A. BUILDING: _____ B. WING _____	C 11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY MEWS SENIOR LIVING	**124 GREEN AVENUE WOODBURY, NJ 08096**

(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
A1249	Continued From page 13 2025, August 2025, September 2025, or October 2025. The ED stated she expected to follow all NFPA codes, NJAC, and LSC and standards. The ED stated she had no policy for exercising the generator for at least 30 minutes 12 times a year, on semiannually inspecting the kitchen fire suppression system, on annually inspecting fire barrier doors, or on annually inspecting the facility's electrical system.	A1249		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
35a010 Y1	A. Building B. Wing Y2	1/13/2026 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY MEWS SENIOR LIVING	124 GREEN AVENUE WOODBURY, NJ 08096

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 A0389	Correction	ID Prefix A0935	Correction	ID Prefix A0949	Correction
Reg. # 8:36-4.1(a)(16)	Completed	Reg. # 8:36-11.4(b)	Completed	Reg. # 8:36-11.5(b)(7)	Completed
LSC	01/06/2026	LSC	01/06/2026	LSC	03/26/2026
ID Prefix A1225	Correction	ID Prefix A1249	Correction	ID Prefix	Correction
Reg. # 8:36-17.3(b)(8)(i-ii)	Completed	Reg. # 8:36-17.7	Completed	Reg. #	Completed
LSC	12/08/2025	LSC	01/31/2026	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/21/2025	☐ YES ☐ NO