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

PRINTED: 07/01/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315532	B. WING			01/ ⁻	16/2024
	PROVIDER OR SUPPLIER	NNE HOSPITAL CENTER TCU		STREET ADDRESS, CITY, STATE, ZI 29 EAST 29TH STREET BAYONNE, NJ 07002	PCODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD HE APPROPF	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	тѕ	FC	000			
	Survey Date: 01/1	6/2024					
	Survey Census: 2						
	Sample Size: 2						
	conducted by the N Health. The facility	certification survey was New Jersey Department of Was found to be in substantial CFR 483 subpart B for long					
LABORATORY	V DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE			(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		315532	B. WING			01/	16/2024
	PROVIDER OR SUPPLIER	NNE HOSPITAL CENTER TCU		STREET ADDRES 29 EAST 29TH S BAYONNE, NJ			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	VIDER'S PLAN OF CORRECTIO CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	rs	K 0	00			
K 351 ss=D	by the New Jersey Facility Survey and 01/16/2024. Carepo Center TCU was fo with the requiremer Medicare/Medicaid Safety from Fire, ar National Fire Protectife Safety Code (L Health Care Occup Carepoint Health-Bis wing on the third six-story Type II Protection The TCU is License The facility has a 45 Generator that supplication. Sprinkler System - CFR(s): NFPA 101 Spinkler System - CFR(s): NFPA 101 Spinkler System - It 2012 EXISTING Nursing homes, and construction type, a approved automatic accordance with NF Installation of Sprin In Type I and II commeasures are permisprinkler protection or local regulations In hospitals, sprinkle closets of patient slofthe closet does in the closet does	ayonne Hospital Center TCU (3rd.) floor of a Hospital in a otected building built in 1954. ed for seventeen (17) beds. 50 KW Diesel Emergency olies emergency power to the Installation d hospitals where required by are protected throughout by an esprinkler system in FPA 13, Standard for the kler Systems. struction, alternative protection inted to be substituted for in specific areas where state	К3	51			
I ABORATORY	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14

days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

02/05/2025

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

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 315532 B. WING 01/16/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 29 EAST 29TH STREET **CAREPOINT HEALTH - BAYONNE HOSPITAL CENTER TCU** BAYONNE, NJ 07002 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 351 | Continued From page 1 K 351 required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced Based on observation, interview and review of facility provided documentation, in the presence of facility management, it was determined that the Facility failed to install sprinklers, as required by CMS regulation §483.90(a) physical environment, to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition. The deficient practice is evidenced by the following. On 01/16/2024 during the survey entrance at approximately 11:42 AM, a request was made to the US FOIA (b) (6) and US FOIA (b) (6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a six-story (6) building with the TCU in the "A Building" on the 3rd. floor. There are three (3) exit stairwells (East, Center and West) that resident, staff and visitors would use in the event of an emergency to exit the building. There are common areas and 13 resident sleeping rooms on the 3rd, floor TCU. Starting at approximately 12:09 PM in the presence of the facility's stour of the facility was conducted.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		315532	B. WING	i	01/	16/2024	
	PROVIDER OR SUPPLIER	NNE HOSPITAL CENTER TCU		STREET ADDRESS, CITY, STATE, ZIP COD 29 EAST 29TH STREET BAYONNE, NJ 07002			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE	
K 351	Along the tour of the observed the follow provide proper fire: 1) At approximately observed inside the of fire sprinkler covapproximately 8' by The surveyor observed inside the of fire sprinkler of landing. Code requires fire: at the top landing, other floor in between the surveyor observed inside the of fire sprinkler covapproximately 8' by The surveyor observed in floor landice Code requires fire: at the top landing, other floor in between the top landing, other floor in between the surveyor observed inside the evidence of fire sprinkles at the top landing, other floor in between the surveyor observed in side the evidence of fire sprinkles at the top landing, other floor in between the top landing, other floor in between the surveyor observed in side the evidence of fire sprinkles at the top landing, other floor in between the surveyor observed in side the evidence of fire sprinkles at the top landing, other floor in between the surveyor observed in side the evidence of fire sprinkles at the top landing, other floor in between the surveyor observed in side the evidence of fire sprinkles at the top landing, other floor in between the surveyor observed in side the evidence of fire sprinkles at the top landing, other floor in between the surveyor observed in side the evidence of fire sprinkles.	e facility the surveyor ring locations that failed to sprinkler coverage: y 12:43 PM, the surveyor e "East" stairwell no evidence erage inside the 3rd. floor 7'-6" landing. rved this stairwell has 5 floors overage on the 5th. floor sprinkler coverage in stairwells bottom landing and every en. y 12:57 PM, the surveyor e "West" stairwell no evidence erage inside the 3rd. floor 8'-6" landing. rved this stairwell has 4 floors or coverage on the 4th., 3rd. ngs. sprinkler coverage in stairwells bottom landing and every en. y 1:00 PM, the surveyor e "Center" stairwell no inkler coverage inside the 3rd. 8' by 7'-6" landing. rved this stairwell has 6 floors or coverage on the 6th., 5th., floor landings. sprinkler coverage in stairwells bottom landing and every	K3	351			

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

PRINTED: 07/01/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 315532 B. WING 01/16/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 29 EAST 29TH STREET **CAREPOINT HEALTH - BAYONNE HOSPITAL CENTER TCU** BAYONNE, NJ 07002 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 351 | Continued From page 3 K 351 inside the ten (10) feet by twenty-two (22") electrical closet. At this time the surveyor asked the "SFOIA (0) "Do you see any fire sprinklers in the electrical closet." The looked up and around and said, no. The confirmed the findings at the times of observations. The US FOIA (b) (6) was informed of the deficiency during the survey exit on 01/16/2024 at approximately 2:15 PM. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 01 - TGU UNIT	(X3) DATE SURVEY COMPLETED		
		NJ4061001	B. WING	200.000			
AME OF P	ROVIDER OR SUPPLIER		1 1	01/16/2024			
AREPOI	NT HEALTH - BAYONNE	HOSPITAL CENTER TCU	1	29 EAST 29TH STREET BAYONNE, NJ 07002			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETI		
K 000	INITIAL COMMENTS		K 000	REVISED POC See below:			
	by the New Jersey De Facility Survey and Fi 01/16/2024. Carepoin Center TCU was foun with the requirements Medicare/Medicaid at Safety from Fire, and National Fire Protectic Life Safety Code (LSC Health Care Occupan Carepoint Health-Bay is wing on the third (3 six-story Type II Prote TCU is Licensed:	t Health Bayonne Hospital d to be in noncompliance for participation in 42 CFR 483.90(a), Life the 2012 Edition of the on Association (NFPA) 101, C), Chapter 19 EXISTING		STEEL CHOSE 25.			
K 351	Generator that supplie building. Sprinkler System - Ins CFR(s): NFPA 101	s emergency power to the tallation	K 351	Element #1 POC:	02/05/25		
	Spinkler System - Inst 2012 EXISTING Nursing homes, and h construction type, are approved automatic sp accordance with NFPA Installation of Sprinkle in Type I and II construmeasures are permitted	ospitals where required by protected throughout by an prinkler system in 13, Standard for the Systems. In a systems. Indicate the substituted for specific areas where state		All residents have the potential taffected by this alleged deficient practice. We have not identified any other common areas or closets to be affeory this alleged deficient practice.	actice. r		
	In hospitals, sprinklers closets of patient sleep of the closet does not	are not required in clothes sing rooms where the area exceed 6 square feet and ers the closet footprint as					

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that "ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days wing the date of survey whether or not a pian of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ways following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		O-FIOI'vfAWSER'i7fCE	_	-		RM APPROVED O 0938-0391
JSTATEMENT (OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DA	E SURVEY
IDPEN OF CONNECTION				•TCU UNIT		
		NJ4061001	B. WING		0	1/16/2024
NAME OF P	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
CAREPOI	NT HEALTH - BAYONNI	HOSPITAL CENTER TOU	700	EAST 29TH STREET AYONNE, NJ 07002		
(X4)10 PREFIX TAG	(EACH DEFICIENCE	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	COMPLETION DATE
K 351	Sprinkler Systems. 19.3.5.1, 19.3.5.2, 1 19.4.2, 19.3.5.10, 9. This REQUIREMEN by: Based on observatifacility provided doct of facility manageme Facility failed to insta CMS regulation §48: to all areas in accord of NFPA 1012012 Ed. 9.7.1.1 and National (NFPA) 13 Installation. The deficient practic following, On 01/16/2024 during approximately 11:42 the US FOIA (b) (6) and to provide a copy of identifies the various compartments in the A review of the facility is a six-st in the "A Building" of three (3) exit stairwes that resident, staff at event of an emerger	3, Standard for Installation of 9.3.5.3, 19.3.5.4, 19.3.5.5, 7, 9.7.1.1(1) T is not met as evidenced on, interview and review of umentation, in the presence ent, it was determined that the all sprinklers, as required by 3.90(a) physical environment, dance with the requirements dition, Section 19.3.5.1, 9.7, Fire Protection Association on of Sprinkler Systems 2012 e is evidenced by the ag the survey entrance at AM, a request was made to dig US FOIA (b) (6) the facility lay-out which is rooms and smoke	K 351	This page is intentionally let	ft blank.	
		ately 12:09 PM in the lity's ^{USFOOL} a tour of the facility				

was conducted.

		ND HUMAN SERVICES				MAPPROVED
		MEDICAID SERVICES				0. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A CONTRACTOR OF THE PROPERTY O	E CONSTRUCTION 01 - TCU UNIT		SURVEY
		NJ4061001	B. WING		01/	16/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
010000	NATIONAL PAYOUNE	LICODITAL OFFITED TOLL		29 EAST 29TH STREET		
CAREPOI	NI HEALIH - BAYONNE	HOSPITAL CENTER TCU		BAYONNE, NJ 07002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
				DEFICIENCY		
K 351	Continued From page	2	K 351			
	Along the tour of the f	facility the surveyor		REVISED POC:		02/05/25
		g locations that failed to		NEVIOLET CO.		02/00/20
	provide proper fire spi					
				Flores = 1 #2 0 #4.		
	1) At approximately 1	2:43 PM, the surveyor	1	Element #3 & #4:	Moot "	
	observed inside the "E	East" stairwell no evidence		1. Sprinklers installed in "East', "Vand Center stairwell at the top land	vest,	
	of fire sprinkler covera	age inside the 3rd. floor		bottom landing and every other fl	oor in	
	approximately 8' by 7'	-6" landing.		between.	001 111	
	The surveyor observe	d this stairwell has 5 floors	1	2. City of Bayonne inspected com	pleted	
	with fire sprinkler cove	erage on the 5th. floor		sprinkler installation and issued fi	nal	
	landing.			permit on 2/5/2025.		
		inkler coverage in stairwells		Sprinkler company also inspect	ted and	
1		ttom landing and every		issued sprinkler report stating the is satisfactory, and issued report 2	WOIK	
	other floor in between	•		4. Director of Plant Operations or		
				designee will ensure all inspection	is I	
		2:57 PM, the surveyor		are completed according to CMS	.	
1		Vest" stairwell no evidence		and LSC rules and regulations.		
		ge inside the 3rd, floor		5. Any findings will be brought for the QAPI team for their review an	th to	
	approximately 8' by 8'-				d	
		d this stairwell has 4 floors		feedback.	- 1	
		overage on the 4th., 3rd.		* *		
	and 2nd. floor landings				1	
	at the top landing, bot	nkler coverage in stairwells				
	other floor in between.				1	
	Other floor in Detween.	<u>k</u>	İ		ĺ	
	3) At approximately 1:	:00 PM, the surveyor		22		
	observed inside the "C			NJ Exec Order 26.4b1		
1		ler coverage inside the 3rd.				
	floor approximately 8' I					
		this stairwell has 6 floors				
		overage on the 6th., 5th.,				
	4th., 3rd. and 2nd. floo	r landings.				
	Code requires fire sprin	nkler coverage in stairwells				
	at the top landing, bot	tom landing and every				
	other floor in between.					
	3) At approximately 1:	05 PM, the surveyor				
	observed no fire enrish	2004 B B B B B B B B B B B B B B B B B B				

PRINTED: 01/29/2024

	NICKET OF THE ALTHUR	D. H. HAALLOEDI AOCO					D: 01/29/2024
		D HUMAN SERVICES					MAPPROVED
	S FOR MEDICARE &						0.0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1.		E CONSTRUCTION	(X3) DATE	SURVEY
NO PEAN OF	CONNECTION	IDENTIFICATION NOMBER.	A. BUILD	ING	01 - TCU UNIT	COM	LLICO
1							
		NJ4061001	B, WING	_		01/	16/2024
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE		
CAREPOI	NT HEALTH - BAYONNE	HOSPITAL CENTER TOU		3	29 EAST 29TH STREET		- 1
					BAYONNE, NJ 07002		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5)
PREFIX TAG	[1] [1] [1] [1] [1] [1] [1] [1] [1] [1]	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
,,,,		•			DEFICIENCY)		
			1				
K 351	Continued From page	3	к	351	REVISED POC:		02/05/25
	inside the ten (10) fee						
	electrical closet.	,			1. All residents have the potential	to be	
		yor asked the ^{us rola (b} "Do you			affected by this alleged deficient pro 2. We have not identified any other	r actice.	
	see any fire sprinklers	in the electrical closet."			common areas or closets to be affe	cted	
	The US FOIA looked up a	nd around and said, no.			by this alleged deficient practice.		
	TILL US FOIA				3. A fire rated door was installed to		
		ne findings at the times of			contain any fire within the electrical closet should a fire occur.	ll	
	observations.				4. Director of Plant Operations or		
	The US FOIA (b) (6) wa	s informed of the deficiency			designee will inspect all doors on a	1	
	during the survey exit				routine basis and report any finding	s or	
	approximately 2:15 P				irregularities to the QAPI team for review and feedback. This will be of	heir	
	,,				in accordance with local, State, Fed		
	Fire Safety Hazard.				and LSC rules and regulations.		
	NJAC 8:39-31.1(c), 3	1.2(e)					1
	NFPA 13						
ı							
							1
			1				
					NJ Exec Order 28.4b1		
							!

		POST	-CERTIFI	CAHO	N KEVISII R	REPORT		
	ER / SUPPLIER		ONSTRUCTION				DATE	OF REVISIT
315532	CATION NUMBI	A. Building (B. Wing)1 - TCU UNIT				_{Y2} 3/13/2	2025 _{Y3}
NAME O	FACILITY				STREET ADDRESS, C		ODE	
CAREPO	DINT HEALTH	- BAYONNE HOSPIT	AL CENTER TO	U	29 EAST 29TH STREE	T		
					BAYONNE, NJ 07002			
program correcte provision	, to show those d and the date	e deficiencies previou such corrective action the identification pref	isly reported on t on was accomplis	the CMS-256 shed. Each d	edicaid and/or Clinica 7, Statement of Defici eficiency should be fune CMS-2567 (prefix o	encies and Plan o	of Correction, that g either the regu	at have been lation or LSC
ITE	M	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y 5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	l Reg.#		Completed	Reg. #		Completed
LSC	K0351	02/05/2025	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
Daa #		O a manufactura	_			Dec #		
Reg. # LSC		Completed	Reg.#		Completed	Reg. # LSC		Completed
								_
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	l 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		_
REVIEWI STATE A		REVIEWED BY (INITIALS)	DATE	SIGNATU	JRE OF SURVEYOR		DATE	
REVIEWI CMS RO	ED BY	REVIEWED BY (INITIALS)	DATE	TITLE			DATE	
FOLLOWUP TO SURVEY COMPLETED ON 1/16/2024					CORRECTED DEFICIENCIES (CMS-2567)			ES NO