STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	55A009	A. BUILDING: _____ B. WING _____	C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MATTISON CROSSING AT MANALAPAN AVENU	93 MANALAPAN AVENUE FREEHOLD, NJ 07728

(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: Type of Survey: Complaint Complaint #: NJ00186295 Census: 116 Sample Size: 3 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 313	8:36-3.4(a)(4) Administrator's Responsibilities (a) The administrator or designee shall be responsible for, but not limited to, the following: 4. Ensuring the provision of staff orientation and staff education; This REQUIREMENT is not met as evidenced by: Complaint#: NJ00186295 Based on interview and record review, it was	A 313		

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A 313	Continued From page 1 determined that the facility Administrator failed to provide documentation that a full investigation was done to include staff education after a resident NJ Exec Order 26.4b1 (Resident #2). The deficient practice was evidenced by the following: On NJ Exec Order 26.4b, the New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by healthcare facilities to report incidents to the NJDOH. The FRE revealed a "date of event" of NJ Exec Order 26.4b1 and a "time of event" of 7:45 p.m., Resident #2 was NJ Exec Orde in his/her apartment with NJ Exec Order 26.4b1 with some NJ Exec O on the floor and some NJ Exec O on the sink. Resident #2 NJ Exec Order 26.4b1. NJ Exec O was immediately called and the resident was admitted to the NJ Exec Order 26.4b During the survey on 6/4/2025 at 10:31 a.m., when the surveyor asked if staff were trained after the incident with Resident #2, the Assistant Director of Nursing/Registered Nurse (ADON/RN) stated that she assumed that the Regional Registered Nurse/Director of Care (RRN/DOC) talked to the staff since she was involved with the incident. In the same interview, when the surveyor asked her what should staff do, if a resident NJ Exec Order 26.4b1, she stated that the resident should be brought to the Wellness Office to be assessed by the nurse and the resident NJ Exec Order 26.4b1. At 11:33 a.m., the surveyor reviewed Resident #2's Medical Record (MR) which revealed that the resident moved in on NJ Exec Order 26.4b with diagnoses that included NJ Exec Order 26 and NJ Exec Order 26.4b1. Review of an incident form dated NJ Exec Order 26.4b1, revealed a late entry note written by the Licensed Practice Nurse (LPN), dated NJ Exec Order 26.4b1, indicating that Resident #2 NJ Exec Order 26.4b1. The LPN indicated that she	A 313		

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was informed by the Resident Care Assistant (RCA) around 7:45 p.m. that Resident #2 was [NJ Exec Orde] in his/her apartment with [NJ Exec Order 26.4b1] and many [NJ Exec Order 26.4b1] and on the sink. The note indicated that the LPN and RCA went to Resident #2's room and that the resident stated, "[NJ Exec Order 26.4b1]." The resident was [NJ Exec Order 26.4b1] was evaluated, and [NJ Exec O] was called. The note indicated that the following were notified: family, RN Supervisor, on-call RN, another LPN, the MD (medical doctor), and the corporate staff (RRN/DOC). Further review of the MR revealed that the ambulance arrived and the resident was sent to [NJ Exec Order 26.4] at 8:10 p.m.

At 12:09 p.m., the surveyor conducted a phone interview with the RRN/DOC regarding the incident. She stated that the LPN called her and stated that Resident #2 was [NJ Exec Order 26.4b1] at dinner, went back to his/her apartment and stated, [NJ Exec Order 26.4b1]." The RCA went to the resident's apartment and became aware that the resident [NJ Exec Order 26.4b1], so the RCA told the LPN who then told the RCA told RCA [NJ Exec Order 26.4b1] for the resident. The RRN/DOC continued to say that the RCA left Resident #2 for about [NJ Exec Order 26.4b1] to the resident's apartment and [NJ Exec Orde] that there were [NJ Exec Order 26.4b1] on the floor and another, an empty [NJ Exec Orde] of [NJ Exec Order 26] on the counter. Resident #2 was in the [NJ Exec Order 26] and was [NJ Exec Order 26.4b] The RCA asked him/her why and the resident stated, [NJ Exec Order 26.4b1]" and [NJ Exec Order 26] " The LPN then called the RRN/DOC, called [NJ Exec O] and the on-call Registered Nurse. The RRN/DOC stated that she did not know the resident, but that the resident had a history of [NJ Exec Order 26.4b1]

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In the same interview, the RRN/DOC stated that she spoke to the family, who stated that Resident #2 was NJ Exec Order 26.4b1. When the surveyor asked if witness statements were done, she stated that she talked to other staff. She stated that the RCA gave a witness statement and that she thought she sent an email to other staff involved, including another care giver, the LPN, and the dietary server, but that she was not sure.

On further interview with the RRN/DOC, the surveyor asked about the facility's procedure regarding staff training and in-services after an incident. She stated that it would be the ADON's responsibility to do the staff training. She also indicated that she was not aware that the in-service training was not done. The surveyor also asked if facility has a protocol regarding what staff should do when a resident NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. The RRN/DOC stated that the resident would be sent out for a NJ Exec Order 26.4b1 and that staff should stay with the resident and call for help.

Concerning the investigation, when the surveyor asked if other residents were interviewed and if there was a protocol, the RRN/DOC stated that she did not think other residents were interviewed and that there was no protocol in place. She stated that she did what she knew and notified the RN on-call, the Executive Director, the doctor, the family, and the reportable was done.

At 3:27 p.m., the surveyor interviewed the RCA who cared for Resident #2 on NJ Exec Order 26.4b1. She stated that while she was NJ Exec Order 26.4b1 the resident back to his/her room, the resident was NJ Exec Order and stated that NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1

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NJ Exec Or The RCA asked the resident if he/she NJ Exec and that the resident NJ Exec Order 26.4b1 . The RCA told the LPN, and the LPN said to NJ Exec Order for the resident, so the RCA NJ Exec Order 26.4b1 When the RCA returned, after 15 minutes later, there were NJ Exec Order 26.4b1 , she then called the nurse. The RCA asked Resident #2 what happened, he/she stated, 'NJ Exec Order 26.4b1 ."

When asked why she left the resident, the RCA stated that if Resident #2 NJ Exec Order 26.4b1 of daily livings (ADLs), like NJ Exec Order 26.4b1 or NJ Exec Order 26.4b when he/she NJ Exec Order 26.4b1

She stated that Resident #2 would say, 'NJ Exec Order 26.4b but that she NJ Exec Order 26.4 because Resident #2 had said this before, about two (2) days before the incident and in the past. She stated that she did not remember how many times before the resident said that NJ Exec Order 26.4b1; however, she said that she did not document but she always told the nurse. In the same interview when the surveyor asked her if she received training after the incident, the RCA confirmed that she did not receive training after Resident #2's NJ Exec Order 26.4 incident.

At 5:00 p.m., during an interview with the Administrator, the surveyor asked how staff ensure resident's safety when a resident NJ Exec Order 26.4b1 . the Administrator stated that staff were to notify the nurse right away. She was not present for this incident, but she continued to say, if the RCA notified the nurse, then it was the nurse's responsibility to observe the resident, the resident comes first.

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A 313	Continued From page 5 In the same interview, the Administrator stated that staff do [redacted] if a resident caused them [redacted] and that they know to notify the nurse and there was training available that dealt with staff and resident care. At 5:23 p.m., during the survey, an Investigation Policy was requested, but the Administrator stated that the policy was part of the "Reportables" policy provided. Surveyor review of a 7/2024 facility policy titled, "When to Call Reportable Events Internal Reporting" revealed, "Purpose: The purpose of this policy is to ensure critical and sentinel events are being reported to the appropriate Home Office team members...." Surveyor review of an undated facility policy titled, "Incident and Accident Reporting" states, "Policy [:]...[The Facility] and its assisted living communities will proactively prevent associate and resident incidents and accidents by implementing appropriate safety orientation, training and education programs. The content of the programs must take into consideration the findings of the incident report review, trend analysis and recommended follow-up actions...."	A 313		
A 451	8:36-5.1(c) Types of Services Provided to Residents (c) The assisted living residence, comprehensive personal care home, or assisted living program shall provide supervision of self-administration of medications, and administration of medications by trained and supervised personnel, as needed by residents and in accordance with this	A 451		

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A 451	Continued From page 6 chapter. This REQUIREMENT is not met as evidenced by: Complaint#: NJ00186295 Based on interview and record review, it was determined that the facility failed to provide NJ Exec Order 26.4b1 of medications for 3 of 3 residents reviewed, Resident #s 1, 2 & 3. This deficient practice was evidenced by the following: On NJ Exec Order 26.4b1 the New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by healthcare facilities to report incidents to the NJDOH. The FRE revealed a "date of event" of NJ Exec Order 26.4b1 and a "time of event" of 7:45 p.m., Resident #2 was NJ Exec Order 26.4b1 Resident #2 NJ Exec Order 26.4b1. NJ Exec P was immediately called and the resident was admitted to the NJ Exec Order 26.4b 1. On 6/4/2025 at 11:33 a.m., the surveyor reviewed the Medical Record (MR) that revealed Resident #2 had a move in date of NJ Exec Order 26.4b and diagnoses of NJ Exec Order 26 and NJ Exec Order 26.4b1 Record review of the "Physician Clearance Form (PCF)" dated NJ Exec Order 26.4b1, revealed the resident was NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 his/her NJ Exec Order 26.4b1 2. On 6/4/2025 at 12:36 p.m., the surveyor reviewed the MR of Resident #3 that revealed a move in date of NJ Exec Order 26.4 and diagnoses of NJ Exec Order 26	A 451		

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and [redacted] Review of Registered Nurse (RN) assessment dated [redacted] revealed the resident was [redacted] with his/her [redacted]

3. On 6/4/2025 at 12:40 p.m., the surveyor reviewed the MR of Resident #1 that revealed a move in date of [redacted] and diagnoses of [redacted]. Record review of the PCF dated [redacted] revealed the resident was [redacted] with [redacted] his/her [redacted] Further review of the RN assessment dated [redacted], revealed that the resident was [redacted] with his/her [redacted]

At 10:30 a.m., the surveyor received the [redacted] medication list of residents from the Administrator, revealing a total of 25 residents.

At 10:31 a.m., when the surveyor asked the Assistant Director of Nursing/Registered Nurse (ADON/RN) regarding residents who [redacted] medications, she stated that the residents took the medications as prescribed, and that the nurse did not [redacted], unless a change was noted.

At 11:32 a.m., the ADON/RN stated there was no log or Medication Administration Record (MAR) for residents who [redacted], there was only a physician's order. When the surveyor asked how she knew the residents took their medications since they were not monitored, the ADON/RN stated that either the residents told the nurse, or the family would help to set up the medications. She continued to say that [redacted], [residents were]

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A 451	Continued From page 8 not on a medication plan, not a charged service. At 1:35 p.m., during an interview with Resident #3, the surveyor asked if the resident NJ Exec Order 26.4b1 his/her medications, and if any staff NJ Exec Order 26.4b1 him/her, Resident #3 confirmed that he/she NJ Exec Order 26.4b1 his/her mediations. The resident stated that no one NJ Exec Order 26.4b1 him/her while NJ Exec Order the NJ Exec Order 26.4b1 Surveyor review of an undated facility policy titled, "Resident Self-Administration of Medication" revealed "Policy [:] Residents who are capable of self-administration have the right to purchase and self-administer over-the-counter medications; however, the residence must make every reasonable effort to be aware of such medications in order to monitor for and educate the residents about possible adverse reactions or interactions with other medications...."	A 451		
A 735	8:36-7.2(e)(1-5) Health Care Assmnt. and Health Service Plan (e) Based on the health care assessment, a written health service plan shall be developed. The health service plan shall include, but not be limited to, the following: 1. Orders for treatment or services, medications, and diet, if needed; 2. The resident's needs and preferences for himself or herself; 3. The specific goals of treatment or services, if appropriate; 4. The time intervals at which the resident's	A 735		

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A 735	Continued From page 9 response to treatment will be reviewed; and 5. The measures to be used to assess the effects of treatment. This REQUIREMENT is not met as evidenced by: Complaint#: NJ00186295 Based on interview and record review, it was determined that the facility failed to develop and implement written health service plans (HSPs) for a resident with a history of NJ Exec Order 26.4b1 (Resident #2), a resident who had NJ Exec Order 26.4b1 (Resident #3), and for residents who NJ Exec Order 26.4b1 their own medications (Resident #s 1, 2 & 3). This deficient practice was evidenced by the following: On NJ Exec Order 26.4b, the New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by healthcare facilities to report incidents to the NJDOH. The FRE revealed a "date of event" of NJ Exec Order 26.4b1 and a "time of event" of 7:45 p.m., Resident #2 was NJ Exec Orde in his/her apartment with NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 . Resident #2 NJ Exec Order 26.4b1 . NJ Exec O was immediately called and the resident was admitted to the hospital. 1. On 6/4/2025 at 11:33 a.m., the surveyor reviewed the Medical Record (MR) that revealed Resident #2 had a move in date of NJ Exec Order 26.4b and diagnoses of NJ Exec Order 26 and NJ Exec Order 26.4b1 Record review of the "Physician Clearance Form (PCF)"	A 735		

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dated NJ Exec Order 26.4b1 revealed the resident was NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 his/her NJ Exec Order 26.4b1

Continued surveyor review of the MR, indicated a Physician's Order (PO) dated NJ Exec Order 26.4b1, which revealed an order for NJ Exec Order 26.4b1 Review of a Progress Note (PN) dated NJ Exec Order 26.4b1 at 1:54 p.m., written by the Nurse Practitioner (NP) revealed that Resident #2 was having a NJ Exec Order 26.4b1

At the time of the survey, there was no documented evidence from the NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 for Resident#2.

On 6/6/2025 at 4:00 p.m., post survey, the Assistant Director of Nursing/Registered Nurse (ADON/RN) emailed the surveyor a "Standard Progress Note (SPN)" written by the NJ Exec Order 26.4b1 dated NJ Exec Order 26.4b1 that revealed Resident #2 "...referred by staff for evaluation of NJ Exec Order 26.4b1 Pt. [patient] recently had a NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 his/her NJ Exec Order and in his/her NJ Exec Order NJ Exec Order 26.4b1' ...." The SPN also revealed Resident #2's NJ Exec Order was NJ Exec Order 26.4b1 and that the "Plan" was 'NJ Exec Order 26.4b1." Further review of the MR indicated this was the only time Resident #2 was seen by NJ Exec Order 26.4b1

The surveyor reviewed "Service Plans (SPs)" dated NJ Exec Order 26.4b1 the SPs showed no documented evidence that Resident #2 was followed by the NJ Exec Order 26.4b1 Further review of the SP dated NJ Exec Order 26.4b1 revealed the latest assessment was for a 'NJ Exec Order 26.4b1." Review of the Progress Notes (PNs) revealed no documentation of a NJ Exec Order 26.4b1 for Resident #2.

There was no HSP developed for Resident #2 to

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ensure goals, interventions and effects of treatment were evaluated and reassessed for the effectiveness for the NJ Exec Order 26.4b1 treatment and for the NJ Exec Order 26.4b1 .

2. On 6/4/2025 at 12:36 p.m., the surveyor reviewed the MR of Resident #3 that revealed a move in date of NJ Exec Order 26.4b1, and diagnoses of NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. Review of the Registered Nurse (RN) assessment dated NJ Exec Order 26.4b1, revealed the resident was NJ Exec Order 26.4b1 with his/her NJ Exec Order 26.4b1. Surveyor review of Resident #3's SP dated NJ Exec Order 26.4b1 revealed the resident had NJ Exec Order 26.4b1 and to "Assist resident in managing NJ Exec Order 26.4b1. The Resident becomes NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 at caregivers." There was no HSP developed for Resident #3 to ensure goals, interventions, and effects of treatment were evaluated and reassessed for effectiveness for the NJ Exec Order 26.4b1 and for the NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1

3. On 6/4/2025 at 12:40 p.m., the surveyor reviewed the MR of Resident #1 that revealed a move in date of NJ Exec Order 26.4b1 and diagnoses of NJ Exec Order 26.4b1 . Record review of the PCF dated NJ Exec Order 26.4b1 revealed the resident was NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 his/her NJ Exec Order 26.4b1. Further review of the RN Assessment dated NJ Exec Order 26.4b1 revealed the resident was NJ Exec Order 26.4b1 with his/her NJ Exec Order 26.4b1. There was no HSP developed for Resident #1 to ensure goals, interventions and effects of NJ Exec Order 26.4b1 were evaluated and for the NJ Exec Order 26.4b1 .

At 4:20 p.m., when the surveyor asked what was the NJ Exec Order 26.4b1 indicated on Resident #2's NJ Exec Order 26.4b1 SP, the ADON/RN stated she did not

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 735	Continued From page 12 know since there was no PN or incident report done. At 5:12 p.m., when the surveyor asked about NJ Exec Order 26.4b1 services, the ADON/RN stated that since NJ Exec Order 26.4b1 was not a scheduled service, it was only as needed, it would not be care planned. In the same interview, when the surveyor asked how a new nurse knows the residents who were NJ Exec Order 26.4b1, the ADON/RN stated that NJ Exec Order 26.4b1 was an RN assessment and it was not on the service plan and a list of NJ Exec Order 26.4b1 residents was provided as a part of training. She continued to say that NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 were not charged, not listed and not on a Medication Level, so that was why they were not shown on the service plan. Surveyor review of an undated facility policy titled, "Service Plans/Care Plans/Health Care Plans" revealed "Policy [:] The community shall maintain a Resident Service Plan for each Resident ...Procedure [:] 1. The Resident Service Plan shall ...also based on the initial assessment and medical clearance forms. 2. The Resident Service Plan shall at a minimum, include the following individualized care needs: ...Identification of the resident's problems and needs; Resident goals and intervention plans. Types and frequency of services provided. All services provided, informal, formal, and ancillary. Medications that are to be self-administered ...." Surveyor review of an undated facility policy titled, "Resident Self-Administration of Medication" revealed "Policy [:] Residents who are capable of self-administration have the right to purchase and	A 735		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	55A009	A. BUILDING: _____ B. WING _____	C 06/04/2025

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A 735	Continued From page 13 self-administer over-the-counter medications; however, the residence must make every reasonable effort to be aware of such medications in order to monitor for and educate the residents about possible adverse reactions or interactions with other medications... Procedure [:] ...7. Document on resident's Service Plan if he/she will self-administer...."	A 735		
A 763	8:36-7.4(b) Health Care Services (b) A registered professional nurse shall be responsible for developing nursing practice policies and procedures and the coordination of all health care services required in the resident's health service plan. This REQUIREMENT is not met as evidenced by: Complaint#: NJ00186295 Based on interview and record review, it was determined that a Registered Nurse failed to coordinate health care services for 1 of 3 residents reviewed, Resident #2. This deficient practice was evidenced by the following: On [redacted], the New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by healthcare facilities to report incidents to the NJDOH. The FRE revealed a "date of event" of [redacted] and a "time of event" of 7:45 p.m., Resident #2 was [redacted]	A 763		

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A 763	Continued From page 14 NJ Exec Order 26.4b1. Resident #2 NJ Exec Order 26.4b1. NJ Exec was immediately called and the resident was admitted to the hospital. 1.On 6/4/2025 at 11:33 a.m., the surveyor reviewed the Medical Record (MR) that revealed Resident #2 had a move in date of NJ Exec Order 26.4b and diagnoses of NJ Exec Order 26 and NJ Exec Order 26.4b1 Review of a Progress Note (PN) dated NJ Exec Order 26.4 at 1:54 p.m., written by the Nurse Practitioner (NP) revealed that Resident #2 was having a NJ Exec Orde the Director of Nursing made aware and the NJ Exec Order 26.4b1 came to see resident today, encouraged to NJ Exec Order 26.4b1 if the resident NJ Exec Order 26.4b1 There were no other PNs referring to the issue in the MR. The surveyor reviewed "Service Plans (SPs)" dated NJ Exec Order 26.4b1, they showed no documented evidence that he/she was followed by the NJ Exec Order 26.4b1 The SP did indicate that Resident #2 had NJ Exec Order 26.4b1 On 6/4/2025 at 10:10 a.m., the surveyor interviewed an unsampled resident, who resided NJ Exec Order 26.4b1 Resident #2, he/she stated that the resident NJ Exec Order 26.4b1 and this resident would ask NJ Exec Order 26.4b1 and Resident #2 said he/she did NJ Exec Order 26.4b1. At 10:31 a.m., the Assistant Director of Nursing/Registered Nurse (ADON/RN) stated that Resident #2 was seen by the NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1 At 1:35 p.m., the surveyor interviewed Resident #3, he/she stated that if NJ Exec Order 26.4b1, if anything happened, Resident #2 NJ Exec Order 26.4b1 but the resident was NJ Exec Order 26.4b1.	A 763		

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A 763	Continued From page 15 Resident #3 continued to say that he/she knew the resident since NJ Exec Order 26.4b1 but something NJ Exec Order 26.4b with Resident #2, he/she NJ Exec Order 26.4b1 [redacted] At 3:27 p.m., the surveyor interviewed the Resident Care Associate (RCA) who cared for Resident #2 that day, she stated while she was NJ Exec Order 26.4b1 back to his/her room, the resident was NJ Exec Order and stated that NJ Exec Order 26.4b1 [redacted]. The RCA asked the resident if he/she NJ Exec [redacted] the resident NJ Exec Order 26, the RCA told nurse, nurse said to order NJ Exec Ord so the RCA left the resident to get NJ Exec Order 26.4b1. When the RCA returned about 15 minutes later, there were NJ Exec Order 26.4b1 [redacted], then she called the nurse. The RCA asked Resident #2 what happened, he/she stated that 'NJ Exec Order 26.4b1 When the surveyor asked her why she left the resident, the RCA stated that if Resident #2 NJ Exec Orde [redacted], like NJ Exec Order 26.4b1 or NJ Exec Order 26.4b when he/she tried to do by NJ Exec Order 26.4b1 [redacted], Resident #2 would say, "NJ Exec Order 26.4b1 [redacted] Then, the RCA told the nurse, but she did not think twice this time because Resident #2 had said this before this time, 2 days before the incident and in the past, the RCA did not remember how many times before the resident said he/she NJ Exec Order 26.4b1, and she did not document, but she always told the nurse. At the time of the survey, other staff involved in the FRE were not available for interview. At the time of the survey, further review of the MR revealed no documented evidence from the	A 763		

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A 763	Continued From page 16 NJ Exec Order 26.4b1 or the NJ Exec Order 26.4b1 for Resident #2. On 6/6/2025 at 4:00 p.m., post survey, the ADON/RN emailed the surveyor a "Standard Progress Note (SPN)" written by the NJ Exec Order 26.4b1 dated NJ Exec Order 26.4b1 that revealed Resident #2 was "...referred by staff for evaluation of NJ Exec Order 2 Pt. [patient] recently had a NJ Exec Order 26.4b1 and in his/her NJ Exec Order 26.4b1." The SPN also revealed Resident #2's NJ Exec Order was NJ Exec Order 26.4b1 and that the "Plan" was "...NJ Exec Order 26.4b1." Further review of the MR indicated this was the only time Resident #2 was seen by NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 On 6/9/2025, the surveyor requested the hospital records for Resident #2. Review of the hospital record revealed that on the admission date, NJ Exec Order 26.4b1, the resident stated that he/she had NJ Exec [redacted], but did not want to be a NJ Exec Order 26.4b1 and that the resident was still exhibiting signs of NJ Exec Order [redacted] go, and the hospital then referred the resident for NJ Exec Order 26.4b1 consult.	A 763		
A 779	8:36-7.5(c) Provision of Health Care Services (c) The registered professional nurse shall be called at the onset of illness, injury or change in condition of any resident to arrange for assessment of the resident's nursing care needs or medical needs and for needed nursing care intervention or medical care.	A 779		

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A 779	Continued From page 17 This REQUIREMENT is not met as evidenced by: Complaint#: NJ00186295 Based on interview and medical record review, it was determined that the facility's Licensed Practical Nurse (LPN) failed to notify the Registered Nurse (RN) of a resident's [NJ Exec Order 26.4b1] in [NJ Exec Order 26.4b1] for 1 of 3 residents reviewed, Resident #2. The deficient practice was evidenced by the following: On [NJ Exec Order 26.4b1], the New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by healthcare facilities to report incidents to the NJDOH. The FRE revealed a "date of event" of [NJ Exec Order 26.4b1] and a "time of event" of 7:45 p.m., Resident #2 was [NJ Exec Order 26.4b1] Resident #2 [NJ Exec Order 26.4b1]. [NJ Exec Order 26.4b1] was immediately called, and the resident was admitted to the hospital. 1.On 6/4/2025 at 11:33 a.m., the surveyor reviewed the Medical Record (MR) that revealed Resident #2 had a move in date of [NJ Exec Order 26.4b1] and diagnoses of [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] Review of a Progress Note (PN) dated [NJ Exec Order 26.4b1] at 1:54 p.m., written by the Nurse Practicioner (NP) revealed that Resident #2 was having a [NJ Exec Order 26.4b1] the Director of Nursing	A 779		

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A 779	Continued From page 18	A 779		

made aware and the [NJ Exec Order 26.4b1] came to see resident today, [NJ Exec Order 26.4b1] if the resident [NJ Exec Order 26.4b1].

There were no other PNs referring to the issue in the MR.

The surveyor reviewed document titled,"Service Plans (SPs)" dated [NJ Exec Order 26.4b1] which indicated no documentation that the resident was being followed or seen by a [NJ Exec Order 26.4b1]

On 6/4/2025 at 10:10 a.m., the surveyor interviewed an unsampled resident, who resided [NJ Exec Order 26.4b1] to Resident #2, he/she stated that the resident [NJ Exec Order 26.4b1] and this resident would ask [NJ Exec Order 26.4b1] and Resident #2 said he/she did [NJ Exec Order 26.4b1].

At 3:27 p.m., the surveyor interviewed the Resident Care Associate (RCA) who cared for Resident #2 on [NJ Exec Order 26.4b1], she stated while she was [NJ Exec Order 26.] the resident back to his/her room, the resident was [NJ Exec Order] and stated that "[NJ Exec Orde] " The RCA stated that she asked the resident if he/she [NJ Exec O] the resident stated that he/she [NJ Exec Order 26.] The RCA told the nurse, an LPN and that she was told to [NJ Exec Order 26.4b1] for the resident, so she left the resident to get [NJ Exec Order 26.4b1]. When the RCA returned about 15 mintues later, there were [NJ Exec O] then the RCA called the nurse. The RCA asked Resident #2 what happened, the resident stated, [NJ Exec Order 26.4b1] "

When the surveyor asked the RCA why she left the resident, the RCA stated that Resident #2

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A 779	Continued From page 19 NJ Exec Order 26.4b1 (ADLs), like NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 and would say, "NJ Exec Order 26.4b1 The RCA stated that she told the nurse. She also stated that Resident #2 had said this before. The RCA stated that she could not remember how many times before the resident said that he/she NJ Exec Order 26.4b1, but that she she did not document. She stated that she always told the nurse. Review of PNs revaled no documented evidence that the RN was notified of Resident #2's NJ Exec Order 26.4b1 The RN was not notified of resident's NJ Exec Order 26.4b1, a NJ Exec Order 26.4b1. At the time of the survey, other staff involved in the FRE were not available for interview. Surveyor review of an undated facility policy titled, "Change of Resident Status" revealed, "Policy [:] In the event there is a significant change in the resident's mental, medical, or functional status, a change in the Resident Service Plan may be indicated. The Resident Care Director will notify the resident's family/responsible party and the physician of record whenever there is a significant change in the status of the resident ... Procedure [:] 1. Any change in the resident's demeanor, functional status, or behavior will be reported immediately to the Resident Care Director or designee. It the Resident Care Director is unavailable, the Executive Director is to be notified ...3. When there is a noticeable, but not life-threatening or emergent change in the mental, medical or functional status of a resident, the Resident Care Director or designee will assess and document the resident's condition ...."	A 779		

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A 783	Continued From page 20	A 783		
A 783	8:36-7.5(e) Provision of Health Care Services (e) Each resident shall have an annual physical examination by a physician, advanced practice nurse or physician assistant, which shall be documented in the resident's record. The physician, advanced practice nurse or physician assistant shall certify annually that the resident does not have needs which exceed the care that the facility or program is capable of providing. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that an annual physical examination was conducted and documented in the resident's record, and failed to ensure that an annual physician certification was conducted anddocumented to confirm that the resident's needs did not exceed the facility's ability to provide care for 1 of 3 residents reviewed, Resident #3. This deficient practice was evidenced by the following: On 6/4/2025, upon surveyor's review of Resident #3's Medical Record (MR) the surveyor noted that there was no confirmation from the residents' physicians of their appropriateness for the Assisted Living facility. There was no documentation provided of a NJ Exec Order 26.4b1 [redacted] and of a certification that resident's care needs did not exceed what the facility could provide.	A 783		

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A 783	Continued From page 21 At 10:31 a.m., the surveyor interviewed the Assistant Director of Nursing/Registered Nurse (ADON/RN), she stated that the [NJ Exec Order 26 redacted] and Physician Certifications were done yearly, and they were in the chart. At 12:36 p.m., the surveyor reviewed the MR of Resident #3 that revealed a move in date of [NJ Exec Order 26 redacted] and diagnoses of [NJ Exec Order 26 redacted] and [NJ Exec Order 26.4b1 redacted] At 12:40 p.m., the surveyor requested from the Administrator, documentation of the [NJ Exec Order redacted] and the annual physician's certification for Resident #3. Further review of Resident #3's MR revealed no statement or documentation from the physician that the resident was appropriate to live in an Assisted Living facility, and that the resident's care needs did not exceed what the facility could provide. Additionally, at the time of the survey, there was no policy provided regarding Physician Certification.	A 783		
A1073	8:36-15.6(b) Resident Records (b) All assessments and treatments by health care and service providers shall be entered according to the standards of professional practice. Documentation and/or notes from all health care and service providers shall be entered according to the standards of professional practice.	A1073		

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A1073	Continued From page 22 This REQUIREMENT is not met as evidenced by: Complaint#: NJ00186295 Based on interview, and record review, it was determined that the facility failed to provide documentation that safety checks were done for 2 of 3 residents reviewed, Resident #s 2 and 3. This deficient practice was evidenced by the following: On [NJ Exec Order 26.4b], the New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by healthcare facilities to report incidents to the NJDOH. The FRE revealed a "date of event" of [NJ Exec Order 26.4b1] and a "time of event" of 7:45 p.m., Resident #2 was [NJ Exec Order 26.4b1] Resident #2 [NJ Exec Order 26.4b1]. [NJ Exec O] was immediately called, and the resident was admitted to the hospital. 1.On 6/4/2025 at 11:33 a.m., the surveyor reviewed the Medical Record (MR) that revealed Resident #2 had a move in date of [NJ Exec Order 26.4b] and diagnoses of [NJ Exec Order 26] and [NJ Exec Order 26.4b1]. The suveyor reviewed Resident #2's "Service Plan (SP)" dated [NJ Exec Order 26.4b1] which indicated that the resident had [NJ Exec Order 26.4b1] per day by the Resident Care Assistant (RCA) to ensure resident [NJ Exec Order 2] 2. On 6/4/2025 at 12:36 p.m., the surveyor reviewed the MR of Resident #3 that revealed a move in date of [NJ Exec Order 26.] and diagnoses of [NJ Exec Order 26]	A1073		

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A1073	Continued From page 23 and NJ Exec Order 26.4b1 The surveyor reviewed the SP of Resident #3 that revealed the resident had NJ Exec Order 26.4b1 per day by the RCA to ensure resident safety. On 6/4/2025 at 3:04 p.m., when the surveyor asked about the NJ Exec Order 26.4b1, the Assistant Director of Nursing/Registered Nurse (ADON/RN) stated that the RCA saw residents every shift. She also stated that since it was for Assisted Living residents that "it was just NJ Exec Order 2 NJ Exec Ord on NJ Exec Order 26.4b1 unless there was an issue, then the RCA would tell the nurse." At the time of the survey, there was no documented evidence provided to confirm that NJ Exec Order 26.4b1 were done to ensure the NJ Exec Order of Resident #2 and Resident #3.	A1073		

POC #8
acceptable
3/3/26

Mattison Crossing
93 Manalapan Ave
Freehold NJ 07728
License Number 55A009
Date of survey June 4th, 2025

MATTISON℠
CROSSING

A Discovery Management Group Community

Plan of correction dated June 4th, 2025, Plan of Corrections Updated 2/25/26

A-0313-8:36 3.4(a) Administrators Responsibility

Resident #2 remains living in the AL community, receiving NJ Exec Order 26.4b1 services and NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 Director of Health and Wellness created a NJ Exec Order 26.4b1 t to ensure the safety of resident #2. He/she received NJ Exec Order 26.4b1 from nursing staff every hour to NJ Exec Order 26 resident's NJ Exec Order 26.4b1 The safety check continued for NJ Exec Order 26.4b1 and continues weekly, then ongoing monthly. This audit was created on July 10th, 2025, and will be used ongoing,

All residents have the potential to be affected by this deficient practice.

The Director of Health Wellness in-serviced on 7/8/2025 to the care manager and nursing staff on the following topics: Psychiatric Emergencies, Monitoring Residents/Change in Status/Hourly Checks, Suicidal Ideations/Actions, change in status Documentation, Notification of when resident has a Change in Status, Will continue with the education on going and quarterly. Completion date 7/8/26 All Staff are instructed to report any resident change of status to their direct supervisor, immediately.

Resident#2 was sent out of the community on NJ Exec Order 26.4b1 and did not return to the community until NJ Exec Order 26.4b1. Prior to his/her return, NJ Exec Order 26.4b1 services were requested for NJ Exec Order 26 and NJ Exec Order 26.4b1 , NJ Exec Order were also initiated. NJ Exec Order 26.4b1 , was completed; he/her score is a NJ Exe which indicates the resident has a NJ Exec Order 26.4b1 .

Director of Health and Wellness notified all nursing staff of his/her return. In-services were completed on 7/08/2025 on the following topics: Psychiatric Emergencies, Monitoring Residents/Change in Status/Hourly Checks, Suicidal Ideations/Actions, change in status Documentation, Notification of when resident has a Change in Status.

In-services were completed on 7/08/2025 on the following topics: Psychiatric Emergencies, Monitoring Residents/Change in Status/Hourly Checks, Suicidal Ideations/Actions, Change in Status Documentation, Notification of when resident has a Change in Status. Will continue with the education on going and quarterly. Completion date 7/10/25. All Staff are instructed to report any resident change of status to their direct supervisor, immediately.

Mattison Crossing
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Freehold NJ 07728
License Number 55A009
Date of survey June 4th, 2025

Completion Date 7/10/25

A451- 8:36-5.1 (a)(4) Types of Services Provided to Residents

Resident 1,2 &3 all remain in the community. Resident #2 is now on the NJ Exec Order 26.4b1. Residents 1 & 3 continue to be NJ Exec Order 26.4b1 assessment semiannually and as needed. MD order on file approving NJ Exec Order 26.4b1 status. Director of Health and Wellness completed or (designee) the NJ Exec Order 26.4b1 assessments in NJ Exec Order 26.4b1 and completed the NJ Exe-month assessment in NJ Exec Order 26.4b1

Completions Date June 2025

All residents have the potential to be affected by this deficient practice.

A meeting was conducted with the family of resident #2 which resulted in resident number #2 being placed on the NJ Exec Order 26.4b1. All medications in resident #2's apartment were destroyed on NJ Exec Order 26. Our Certified Medication technician or LPN's are now administering medication as of NJ Exec Order 26.4b1 All residents that are NJ Exec Order 26.4b1 were reassessed during the month of NJ Exec Order 26.4b1. Director of Health and wellness did the NJ Exec Order 26.4b1 and quarterly.

NJ Exec Order 26.4b1 assessments will be reviewed every quarter and as needed, MD order, Health Care Service Plans with be completed and updated. Completion Date 1/9/26

Director of Health Wellness has initiated a biweekly NJ Exec Order 26.4b1 for resident #3 and resident# 1 all residents that NJ Exec Order 26.4b1 This is to ensure each resident is NJ Exec Order 26.4b1 bi-weekly. Completion Date:1/16/26

A735-8:36-7.2 (e)

Health Care Assessment and Health Service Plan

Residents #1, #2 and #3 all remain in the community. Residents 1 & 3 continue to NJ Exec Order 26.4b1. Health Service Plans were updated.

Medical Doctor orders(scripts)are on file approving NJ Exec Order 26.4b1. Health Care Service Plans will be implemented for Resident #1 and Resident #3 for NJ Exec Order 26.4b1. Completion Date 1/9/26.

Created Health Services Plans for resident #3 for NJ Exec Order 26.4b1 and Resident #2 for NJ Exec Order 26.4b1

All residents who administer their own medications, residents with behavior and history of depression have the potential to be affected by this deficient practice.

Resident's #2 Medication is being administered by Certified Medication Aide or Licensed Practical Nurse.

Resident #2 is no longer a NJ Exec Order 26.4b1 as of NJ Exec Order 26.4b frequent c NJ Exec Order 26 with resident were conducted hourly for NJ Exec Order 26.4b1, monthly- ongoing by caregivers. Documented via spread sheet located in the nurse's station. Monthly NJ Exec Order 26 ongoing by nurses or Care managers. Resident #2 found to be responding to the NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 is completed, quarterly and as

needed, by the Director of Health and Wellness or Registered Nurse. Health Service Plans will be implemented by the Director of Health and Wellness. Completion date 7/10/25.

The Director of Health and Wellness will implement Health Service Plans to reflect goals of self-administering medication, behavior concerns and history of depression and monitored semi- annually and as needed. All residents who self-administer their medications, residents with behavior concerns and history of depression will be assessed quarterly and as needed. The MD will provide a written order approving self-administration.

Health Service Plans were created by the Director of health and wellness as of 1/9/26 created and implemented to reflect goals of self-administering medication, behavior and history of depression and monitored semi-annually and as needed. Completion date 1/9/26

How the facility will monitor its corrective action to ensure the deficient practice is being corrected

Health Service Plans were created by the Director of Health and Wellness as of 1/9/26 and implemented to reflect goals of self-administering medication, behavior and history of depression and monitored semi-annually and as needed. Completion date 1/9/26

A763-8:36 7.4 (b) Health Care Services

Resident #2 remains living in the AL community, receiving NJ Exec Order 26.4b1 and medication management and monitoring. On NJ Exec Order 26.4b1 Resident was evaluated initiated ongoing services monthly and as needed.

All residents have the potential to be affected by this deficient practice.

Resident #2 -Receives NJ Exec Order 26.4b1 monthly and was prescribed new medication for NJ Exec Order 26.4b1 by physician. Resident #2 is NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1

Health Service Plans audits were implemented by the Director of Health and Wellness and will be implemented to reflect goals of self-administering medication and semi-annual and as needed. Completed by 7/10/25

Director of Health and Wellness Completed In-services with nurses, home health aides and certified medication aides on reporting suicidal thoughts and being proactive when a resident expresses, they want to harm themselves 7/8/25 and ongoing.

Progress notes are kept in the residents' medical record. All resident names receiving outside services are kept in a binder and are reviewed and updated and overseen by the Director of Health and Wellness or other RN.

Health Service Plans audits will be implemented to reflect goals of self-administering medication and semi-annual and as needed.

To ensure this deficient practice will not occur again, The Director of Health and Wellness or RN will complete our Semi-annual assessment and either review the Health Service plans or initiate a new one if

needed. Starting 03/01/2026, the Executive Director will complete a weekly audit for three months, and ongoing quarterly during the Quality Assurance/Quality Improvement meetings to make ensure the effectiveness of the above plan of correction. Completed 3/1/2026.

A779-8:36-7.5(c) Provision of Health Care Services

Resident #2 remains living in the AL community, receiving NJ Exec Order 26.4b1 services and NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1

All residents have the potential to be affected by this deficient practice.

Director of Health and Wellness provided In-services LPNs on notifying RN of onset of illness or change in condition of resident on 7/9/25 and quarterly.

In-serviced Care managers, Certified Medication Aides and Licensed Practical Nurse on the importance of not leaving a resident alone when statements of harming themselves 7/8/25 and quarterly.

In-serviced Care managers, Certified Medications Aides or Licensed Practical Nurse on whenever there is any change in a resident's demeanor or behavior that, Director of Health and Wellness must be notified. Completed 7/9/25.

Director of Health and Wellness, in serviced the staff on 7/24/25 and again on 1/21/26 about change of conditions and onset of illness, to notify the Director of Wellness. Completed on 7/24/25 and 1/21/26.

To ensure this deficient practice will not occur again, The Director of Health and Wellness or RN will complete our Semi-annual assessment and either review the Health Service plans or initiate a new one if needed. Completed by 1/21/26

0783-8:36 7.5 (e)Provision of Health Care Services Provision of Health Care Services

Resident #3 continues to live in the community, and continues to be NJ Exec Order 26.4b1 assessment completed semiannually and as needed. MD order on file approving NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 were completed on NJ Exec Order 26.

All residents have the potential to be affected by this deficient practice.

Director of Health and Wellness or RN will audit all residents' charts to ensure all H&P are completed. Started Health audits on 1/9/26. Completed 1/9/26.

Physicians Health Care services – Annual Physicals are completed by Physicians and are noted in residents' files.

History and Physicals are implemented and will be reviewed annually by residents' Physician.

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A checklist was created 1/16/26 by the Director of Health and Wellness to determine when a residents Physical is due date. This process is monitored by Licensed Practical Nurse Supervisor.

Completion date is 1/16/26.

A1073 8:36-15.6 (b) Resident Records

Resident #2 remains living in the AL community, receiving NJ Exec Order 26.4b1 services and NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 Resident was assessed by the Director of Health and Wellness on NJ Exec Order 26.4 and determined she/he will now be on our NJ Exec Order 26.4b1 .

Residents # 3 continues to be NJ Exec Order 26.4b1 are completed semi-annually and as needed. Medical Doctor orders(scripts)are on file NJ Exec Order 26.4b1 . Health Care Service Plans are implemented, for Resident #3 for NJ Exec Order 26.4b1. Completion Date 1/9/26

Director of Health Wellness has initiated a biweekly self-medication tracker for resident # 3 and all residents that NJ Exec Order 26.4b1 This is to ensure each resident is supervised bi-weekly.

Safety checks will be implemented, documented and reviewed semi-annually or as needed by the Director of Health and Wellness to reflect goals of self-administering medication, behaviors related to anxiety and monitored via safety checks as ordered and as needed. Completion date 1/9/2026 and ongoing.

All residents have the potential to be affected of this deficient practice.

The Director of Health and Wellness re-educated all care managers, Certified Medication Aides, LPNs, and Registered Nurses on completing and documenting safety checks as ordered, including required frequency and proper documentation in the resident record. Completed on 7/8/2025.

A Safety check documentation log was implemented to ensure safety checks are completed and documented each shift as required. Nurses will review safety check documentation daily to ensure compliance and address any missed or incomplete entries immediately.

Residents requiring safety checks have updated service plans reflecting safety checks frequency. This measure ensures safety checks are consistently completed and documented to prevent recurrence of the deficient practice.

Completed on 1/16/2026

The Director of Health and Wellness or Registered Nurse will conduct weekly audits of resident safety check documentation for four weeks to ensure safety checks are completed and documented. Following this period, audits will be conducted monthly for three additional months to ensure continued compliance.

Any identified missing or incomplete safety check documentation will be addressed immediately with the staff member, and re-education will be provided as needed.

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The Director of Health and Wellness and Executive Director will review the safety check log and audit findings during quarterly clinical and quality assurance meetings to ensure ongoing compliance and to prevent recurrence of the deficient practice.

Completed on 1/16/2026.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
55A009 Y1	A. Building B. Wing Y2	3/3/2026 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MATTISON CROSSING AT MANALAPAN AVENUE	93 MANALAPAN AVENUE FREEHOLD, NJ 07728

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 A0313 Reg. # 8:36-3.4(a)(4) LSC	Correction Completed 01/16/2026	ID Prefix A0451 Reg. # 8:36-5.1(c) LSC	Correction Completed 01/16/2026	ID Prefix A0735 Reg. # 8:36-7.2(e)(1-5) LSC	Correction Completed 01/09/2026
ID Prefix A0763 Reg. # 8:36-7.4(b) LSC	Correction Completed 03/01/2026	ID Prefix A0779 Reg. # 8:36-7.5(c) LSC	Correction Completed 01/21/2026	ID Prefix A0783 Reg. # 8:36-7.5(e) LSC	Correction Completed 01/16/2026
ID Prefix A1073 Reg. # 8:36-15.6(b) LSC	Correction Completed 01/16/2026	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	
6/4/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO