STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315360	A. BUILDING _____ B. WING _____	03/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERSON HEALTH CARE CENTER	100 KINDERKAMACK ROAD EMERSON, NJ 07630

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F 000	INITIAL COMMENTS Survey: 3/16/21 CENSUS: 120 SAMPLE: 24 (plus 2 closed records) A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. A COVID-19 Focused Infection Control Survey was conducted in conjunction with the recertification survey. The facility was found not to be in compliance with 42 CFR §483.80 infection control regulations as it relates to the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to set the appropriate [Executive Order] in an [Executive Order 26, 4.b.] used to promote wound healing for [redacted] residents reviewed for [Executive Order 26, 4.b.] according to professional standards of practice. This deficient practice was evidenced for Resident [Executive] and evidenced by the following:	F 658	Criteria #1 Residents affected by deficient practice: Resident [Executive] [Executive Order 26, 4.b.] was immediately checked and was corrected to appropriate [Executive Order 26, 4.b.] [redacted]. Resident's [Executive Order] tracking also reflected improvement.	4/16/21

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

Electronically Signed | 04/01/2021

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F 658	Continued From page 1 Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 3/9/21 at 11:12 AM, the surveyor toured with the Licensed Practical Nurse/Unit Manager (LPN/UM), who informed the surveyor that Resident [redacted] was [redacted], required [redacted] and had a [redacted]. She indicated that the [redacted] and that the resident is on a specialized [redacted] to promote [redacted]. On that same date and time, both the surveyor	F 658	Criteria #2 Identifying other residents who could have been affected by this deficient practice: All residents have the potential to be affected by this deficient practice. An audit was done by all four Unit Managers (UM) on their respective units for all [redacted] for function, placement, correct [redacted] settings and cycles and all were noted to be in compliance based on physician's orders. Criteria #3 Measures or systemic changes to ensure that the deficiencies will not recur: -Director of Nursing/Assistant Director of Nursing (DON/ADON) will in-service all nursing personnel on policies and procedures for ensuring [redacted] are on [redacted] to reflect resident's [redacted] -The resident's [redacted] will be visible on the Treatment Administration Record (TAR) to address proper settting of [redacted] Verify [redacted] monthly. -Audits will be done weekly for residents utilizing specialty [redacted] checking accuracy in cycle settings and appropriate settings to reflect resident's weight. -Audits will be done by the DON/ADON for a 12 month period. Criteria #4 Monitoring of the continued	

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F 658	Continued From page 2 and the LPN/UM observed that the resident was Executive Order 26, 4.b. The Executive Order 26, 4.b. was set at Executive Order 26, 4.b. and Executive Order 26, 4.b. . The LPN/UM stated that the resident was Executive Order 26, 4.b. ; The Executive Order 26, 4 was Executive Order according to manufacturer's specific instructions. She further stated "I don't know" why it was Executive Order 26, 4.b. . I'm not sure what was the Executive Order 26, 4.b means." The LPN/UM stated that it was the nurse's responsibility to make sure that the Executive Order 26, 4.b. was correct. A review of the resident's Face Sheet (an admission summary), indicated that the resident had diagnoses Executive Order 26, 4.b. [redacted]). A review of the 11/27/20 Significant Change/ Minimum Data Set (SC/MDS), an assessment tool used to facilitate the management of care, indicated the resident had Executive Order 26, 4.b. [redacted] A review of the Executive Order 26, 4.b. Order showed an order dated Executive Order 26 for Executive Order 26, 4.b. check function and placement every shift. A review of the Executive Order 26, 4.b. Treatment Administration Record (TAR) showed that the above order was signed by the nurses routinely. On Executive Order 26 at 10:51 AM, the surveyor and the LPN/UM went to the resident's room and checked the Executive Order 26, 4.b. . The surveyor and the LPN/UM observed the resident's Executive Order 26, 4.b. was set at Execu	F 658	effectiveness of the systemic changes: -DON/ADON will report to the Quality Assurance (QA) Committee that meets quarterly finding of audits, any corrective actions as a result of any deficiencies as well compliancy with this standard.	

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F 658		F 658		

Continued From page 3

Executive Order 26, 4.b. . The LPN/UM informed the surveyor and stated, "I immediately corrected it and changed the Executive Order 26, 4.b. " on that same date after the surveyor's inquiry. She further stated, "honestly, I don't know" when asked by the surveyor how did she know that the Executive Order 26, 4.b.

At that same time, the LPN/UM informed the surveyor that no one knew who changed the Executive Order 26, 4.b. at the time the surveyor and LPN/UM observed it. She further stated that she will get back to the surveyor regarding who changed the cycle from Executive Order 26, 4

On Executive Order 26 at 1:00 PM, the surveyors met with the Licensed Nursing Home Administrator (LNHA), Assistant Administrator (AA), Director of Nursing (DON), Infection Preventionist Nurse (IPN), and discussed the above observations and concerns. The surveyor asked for additional information about the Executive Order 26, 4.b. , and the DON stated that they will get back to the surveyor on Monday, Executive Order 26. . Both the LNHA and DON acknowledged that the staff should have been educated about the Executive Order 26, 4.b.

On 3/15/21 at 9:24 AM, the Licensed Practical Nurse (LPN) informed the surveyor that he was the regular nurse of Resident Executiv The LPN stated that it was the nurse's responsibility to change the Executive Order 26, 4.b. of the resident and sign the TAR that he checked the Executive Order 26, 4.b every shift. He further stated that "I don't know what happened" when asked by the surveyor why the Executive Order 26, 4.b.

On Executive Order 26 at 9:30 AM, the LPN/UM informed the surveyor that it was the Executive Order 26, 4.b. who

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F 658	Continued From page 4 changed the Executive Order 26, 4.b.. The LPN/UM stated that according to the Executive Order 2 doctor, Executive Or resident. She further stated that she did not have an "education" about the Executive Order 26, 4.b. with respect to the correct settings. She indicated that "now I know" that the Executive Orde are meant for Executive Order 26, 4.b. On Executive Order 2 at 12:58 PM, the surveyor called the Executive Order doctor and spoke to the office staff. The office staff from the Executive Order doctor stated that she will relay the message to the doctor to call back the surveyor. The Executive Order 2 doctor did not return the surveyors call. On Executive Order 2 at 12:25 PM, the surveyors met with the LNHA, AA, DON, IPN, Assistant Director of Nursing (ADON). The DON stated that there was no negative effect on the resident. A review of the undated facility Prevention of Pressure Ulcer/Injuries Policy, provided by the LNHA, included "Support Surfaces and Pressure Redistribution: use of an alternating air pressure or low air loss mattress assist in the prevention and care of pressure injuries. The inflation and deflation of inflatable air tubes imitate the patient's movements by relieving under-body pressure must be set according to manufacturer's recommendation. Monitoring: 1. Daily checks of Executive Order 26, 4.b. placement and functions every shift. 2. Ensure that low Executive Order 26, 4.b. Executive Order 26, 4.b. is set according to the patient Executive Order 2" NJAC 8:39-11.2 (b)	F 658		

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F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842		4/16/21

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F 842	Continued From page 6 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain complete, accurate, and readily accessible medical records. This deficient practice was identified for [redacted] residents reviewed, Resident [redacted] and was evidenced by the following: This deficient practice was evidenced by the following:	F 842	Criteria #1 Residents affected by deficient practice: This incident for Resident [redacted] was immediately resolved as the communication papers were retrieved from the [redacted] for the months of Executive Order 26, 4.b. of 2021 and placed in their chart. Communication was always reflected through Facetime, phone calls, progress notes and collaboration between	

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F 842	Continued From page 7 On [redacted] at 11:10 AM, during the tour, the Licensed Practical Nurse/Unit Manager (LPN/UM) informed the surveyor that Resident [redacted] was on [redacted]. The resident was [redacted] At that same date and time, the LPN/UM stated that the [redacted] nurse does the [redacted]. She further noted that the facility's protocol was to have [redacted] nurses do [redacted] due to [redacted] in the facility and promote the resident's safety. A review of the resident's Face sheet (an admission summary) disclosed that the resident had diagnoses [redacted] A review of the Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate care management dated [redacted], indicated a [redacted] indicating that Resident [redacted] was [redacted] The QMDS further indicated that the resident was [redacted] A review of the [redacted] 2021 Physician's Order revealed an order for [redacted] A review of the [redacted] Nurse (HN) Plan of Care Information (HN) provided by the LPN/UM in the binder [redacted] for [redacted] 2021. The	F 842	[redacted] and Facility as evidenced in the plan of care. Criteria #2 Identifying other residents who could have been affected by this deficient practice: All [redacted] residents have the potential to be affected by this deficient practice. All [redacted] resident charts were reviewed and noted with monthly notes being readily accessible. Criteria #3 Measures or systemic changes to ensure that the deficiencies will not recur: -DON/ADON will review [redacted] charts per month for accessibility and accuracy for 3 months. -DON/ADON will in-service all appropriate nursing staff on procedures regarding the filing and accessibility of [redacted] communication papers. -DON/ADON will in-service [redacted] Staff on all procedures regarding the filing of their communication papers in the resident's chart making them readily accessible. Criteria #4: Monitoring the continued effectiveness of the systemic changes: The DON/ADON will report to the QA Committee quarterly the POC findings, corrections and/or compliancy with this standard for the next 3 quarterly	

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F 842	Continued From page 8 only notes in the binder for 2021 were notes dated Executive Order 26, and Executive Order 2 that included a fax cover sheet from Executive Order 26, dated Executive Order 26, 4. Further review of the HN notes dated Executive Orde showed that the Executive Order 26, 4.b. plan was documented as Executive Orde There was no care plan for the Executive Order 26, 4.b.. On Executive Order 26 at 11:23 AM, the LPN/UM informed the surveyor that the Executive Order 26, notes were filed in the Executive Order 26, 4. binder. She stated that it was her responsibility to make sure that the Executive Order 26, 4.b. and all other documents about the resident's care regarding Executive Order 26, will be filed in the Executive Order 2 as part of the resident's medical records. At that same date and time, the surveyor and the LPN/UM checked the Executive Order 26, 4.b. and did not find the Executive Order 26, 4 nurse's weekly Executive Order 26, 4.b. notes for Executive Order 26, 4.b. 2021 except for dates Executive Order 26 and Executive Order 26, 4 The LPN/UM stated, "I don't know what happened," why there Executive Order 26, 4.b. Furthermore, the LPN/UM informed the surveyor that the resident was on Executive Order 26, 4.b. She stated that she should have checked the accuracy and availability of Executive Order 26, 4 notes. She further stated that she should have clarified with the HN about the care plan for Executive Order 2 that it should be Executive Order 26, 4.b. and Executive Orde On Executive Order 26, at 1:10 PM, the surveyors met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Assistant Administrator (AA), Infection Preventionist Nurse (IPN) and discussed the above concerns.	F 842	meetings.	

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F 842	Continued From page 9 On [redacted] at 9:33 AM, the LPN/UM informed the surveyor that she received all missing notes from the HN's [redacted]. The LPN/UM indicated that there were no new recommendations. The HN faxed the corrected care plan for [redacted] At that same time, the LPN/UM stated that "moving forward," she would make sure that the [redacted] notes will be check to make sure that it was submitted and filed in the resident's medical records binder on time. On [redacted] at 3:20 PM, the HN informed the surveyor via a phone conversation that Resident [redacted] was doing [redacted] and would eventually be [redacted]. She stated that she "usually" sends the [redacted] notes bi-weekly via fax. She further said, "I don't know what happened," why the [redacted] for [redacted] were not filed and not available in the facility. Furthermore, the HN informed the surveyor that she had fax all [redacted] that were missing as requested by the facility after the surveyor's inquiry. She further stated that she also sent the corrected care plan via fax to include the [redacted]. A review of the facility [redacted] Program Policy provided by the LNHA with a revised date of July 2017 included "[redacted] services are available to residents at the [redacted] Ensuring that our facility staff provides orientation on the policies and procedures of the facility, including resident rights, appropriate forms, and record-keeping	F 842		

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F 842	Continued From page 10 requirements, to [Executive Order 26] staff furnishing care to the residents." On 3/16/21 at 12:25 PM, the surveyors met with the LNHA, DON, AA, IPN, Assistant Director of Nursing (ADON). The facility provided no additional information.	F 842		
F 880 SS=D	NJAC 8:39-35.2 (d)(5) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		4/16/21

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F 880	Continued From page 11 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880		

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F 880	Continued From page 12 Based on observation, interview, record review, and a review of pertinent facility documents, it was determined that the facility failed to ensure personal protective equipment (PPE) was removed in accordance with nationally accepted guidelines for infection prevention and control. This deficient practice was identified for 1 of 4 staff members observed donning and doffing. The evidence was as follows: According to the U.S. Centers for Disease Control and Prevention (CDC) guidelines, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic updated 2/23/21 included, "HCP [Healthcare Personnel] must receive training on and demonstrate an understanding of: when to use PPE, what PPE is necessary, how to properly don (put on), use and doff (remove) PPE in a manner to prevent self-contamination, how to properly dispose of or disinfect and maintain PPE, limitations of PPE." It further included that HCP should perform hand hygiene before putting on and removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process...Remove and discard gloves before leaving the patient room or care area, and immediately perform hand hygiene...Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area. Disposable gowns should be discarded after use. Reusable (i.e., washable or cloth) gowns should be laundered after each use...Healthcare facilities should ensure that hand hygiene supplies are readily available to all	F 880	Criteria #1 Residents affected by deficient practice: The Housekeeping Aide was interviewed by the Administrator and Housekeeping Supervisor regarding this incident. This deficient practice was reviewed with the employee as she has been in-serviced many times throughout her years at facility. Criteria #2 Identifying other residents who could have been affected by this deficient practice: This deficient practice has the potential to affect all housekeeping employees as well as other employees and residents in the facility. Facility staff were interviewed and the process of discarding PPE was reviewed. Criteria # 3 Measures or systemic changes to ensure that the deficiencies to ensure that the deficiencies will not recur: Housekeeping Supervisor will in-service all her staff on proper donning, doffing and discarding of PPE. Housekeeping Supervisor will make observation rounds of her Housekeeping Staff for proper protocols of infection control practices. This will be performed weekly for the next 3 months. Criteria #4 Monitoring the continued effectiveness of the systemic change:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315360	A. BUILDING _____ B. WING _____	03/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 13 personnel in every care location." On [redacted] at 11:55 AM, the surveyor observed a housekeeper on [redacted] which was a dedicated unit for Persons Under Investigation for [redacted] (PUI), exit room [redacted] wearing a blue disposable gown and gloves. The housekeeper removed the gloves and gown right outside of room [redacted]. The housekeeper then placed the gloves and gown into the housekeeping trash bin. The housekeeper then opened the housekeeping cart without performing hand hygiene to look for alcohol-based hand sanitizer to perform hand hygiene. The surveyor observed only two alcohol-based hand sanitizers mounted to the wall on the PUI unit. On [redacted] at approximately 12:00 PM, the surveyor interviewed the housekeeper, who stated that the trash can for the gloves and gown are inside the bathroom of room [redacted]; "I put it inside my housekeeping cart trash." The surveyor inquired if she had any training on how to put on, remove, and discard PPE. The housekeeper stated, "yes." The housekeeper could not speak to why she didn't remove the gown and gloves before leaving the room. On [redacted] at 1:10 PM, the survey team met with the Administrator, Assistant Administrator, Director of Nursing, and the Infection Control Preventionist and discussed the above observation and concern. On [redacted] at 1:35 PM, the DON stated that the housekeeper was re-educated regarding donning and doffing and that the housekeeper didn't think she was in the hallway since she was right outside the room when she took off her gown.	F 880	The Director of Housekeeping will review findings of weekly observation audits for any deficiencies and plan of correction and/or compliancy with the standard and report to the QA Committee that meets on a quarterly basis for the next three quarters. Directed Plan of Correction (DPOC): 1-Root Cause Analysis (RCA) for deficiency cited: Problem: Housekeeper became confused during survey regarding discarding of PPE and due to confusion and conflict as to placement of PPE Receptacles, the Housekeeper became nervous during observation by the Surveyor and used an alternate receptacle. After discarding her PPE at her housekeeping cart, she removed hand sanitizer from her cart to perform hand hygiene. Housekeeper was re educated on facility policy of doffing and discarding of PPE to avoid any confusion moving forward with return demonstration observed by the Director of Nursing. 2-Directed In Service Training Sign-In Sheets as directed by DPOC: All videos listed below have been shown to staff. Nursing Home Infection Preventionist Training Course Module 1- Infection Prevention and Control Program https://www.train.org/main/course/108135	

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F 880	Continued From page 14 The DON and the Administrator acknowledged that the housekeeper should not have placed the blue disposable gown inside the housekeeping cart trash bin. A review of the facility's undated Policy for Personal Protective Equipment-Donning and Doffing included that the policy's purpose was to prevent the spread of infections...remove gloves and discard them into a waste receptacle in the room...if the gown is disposable, discard it into the waste receptacle inside the room and wash the hands. NJAC 8:39-5.1(a)	F 880	0/ Provided to : Topline Staff and Infection Preventionist CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Keep COVID-19 Out! https://youtu.be/7srwrF9MGdw Provided the training to : Frontline Staff CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Use PPE Correctly for COVID-19 https://youtu.be/YYTAw9yav4 Training was provided to all employees.	

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315360		5/7/2021

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERSON HEALTH CARE CENTER	100 KINDERKAMACK ROAD EMERSON, NJ 07630

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 04/16/2021	ID Prefix F0842 Reg. # 483.20(f)(5), 483.70(i)(1)-(5) LSC	Correction Completed 04/16/2021	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 04/16/2021
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
3/16/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**