STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	C 01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: NJ178902 Survey Date: 1/15/25 - 1/23/25 Census: 103 Sample: 21 + 3 Closed The facility was in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities.	F 000		

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

Electronically Signed | 01/31/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061006	A. BUILDING: _____ B. WING _____	C 01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. 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 the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratio, as mandated by the State of New Jersey, for 1 of 2 weeks of staffing prior to the recertification survey dated 1/23/25. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112,	S 560	1) There was no negative outcome to residents on the shift identified as not meeting NJ staffing requirements on 1/6/2025 day shift. 2) All residents have the potential to be affected. 3) Staffing coordinator was re-educated by the licensed nursing home administrator (LNHA) on the components of this regulation with an emphasis on certified nursing assistant to resident ratios. Jobs are posted on internet job boards, and we have purchased the ad to be seen more frequently. Professional recruiters actively recruit. Provided incentive bonuses for staff who refer	2/3/25

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

Electronically Signed | 01/31/25

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S 560	Continued From page 1 codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One (1) care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. A review of the "Nurse Staffing Report" for the following weeks provided by the facility revealed the following: For the 2 weeks of AAS-11 staffing, the facility was deficient in CNA staffing for residents on 1 of 14 day shifts as follows: -01/06/25 had 11 CNAs for 98 residents on the day shift, required at least 12 CNAs. On 1/21/25 at 10:30 AM, the surveyor requested all staffing policies from the Director of Nursing (DON) who stated the facility did not have any policies related to staffing and that the facility followed state and federal guidelines. On 1/21/25 at 11:51 AM, the surveyor interviewed the Director of Human Resources/Scheduling Coordinator (DHR/SC) who stated that the New	S 560	certified nursing assistants. Contacted local schools to recruit new graduates. Scheduled job fairs for certified nursing assistants. Payment for staff housing and utilization of agency staf. 4) The licensed nursing home administrator/designee will conduct an audit of the staffing schedule 2x per week for 4 weeks and then weekly for 2 months. 5) Findings of these audits will be reported to quality assurance and performance improvement meeting for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061006	A. BUILDING: _____ B. WING _____	C 01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

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S 560	Continued From page 2 Jersey minimum requirements for staffing were one CNA for eight residents on the 7:00 AM - 3:00 PM shift, one direct care staff for 10 residents on the 3:00 PM - 11:00 PM shift, and one direct care staff for 14 residents on the 11:00 PM - 7:00 AM shift. On 1/21/25 at 12:03 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the New Jersey minimum requirements for staffing were one CNA for eight residents on the 7:00 AM - 3:00 PM shift, one direct care staff for 10 residents on the 3:00 PM - 11:00 PM shift, and one direct care staff for 14 residents on the 11:00 PM - 7:00 AM shift. The facility was unable to provide a policy related to the New Jersey minimum requirements for staffing.	S 560		
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees.	S1405		2/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061006	A. BUILDING: _____ B. WING _____	C 01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

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S1405	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure that newly hired employees had completed a health history and received an examination by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant within two weeks prior to employment or upon employment, or within thirty days if a Registered Nurse (RN) completed an assessment upon employment. This deficient practice was identified for 5 out of 10 newly hired employee files reviewed and evidenced by the following: The surveyor reviewed the employee health files of ten random newly hired employees since the last recertification survey date of 10/19/23, which revealed the following: 1.) Employee #3, with a hire date of [NJ Ex Order 26.4], had an Employee Health Examination form which was completed and signed by a physician on [NJ Ex Order 26.4b1] which was [NJ Ex Order 26.4] after hire. There was no evidence of an RN assessment in the employee's health file. 2.) Employee #5, with a hire date of [NJ Ex Order 26.4], had an Employee Health Examination form which was completed and signed by a physician on [NJ Ex Order 26.4],	S1405	1) All staff members listed in the 2567 have received physicals. 2) All residents that are taken care of by staff members that do not have physicals have the potential to be at risk. 3) Human Resources received education that all new hires that did not receive a physical from their personal physician within 2 weeks prior to start date, will have their medical history reviewed and a brief assessment/physical by a registered nurse at the beginning of the day, on their first day of employment. Within 30 days, the Medical Director will conduct a physical The Licensed nursing home administrator/designee will monitor new hires prior to their start date to ensure all physicals are in place prior to 1st day of work or an assessment from a registered professional nurse, that a physical is obtained within the 30 day period. 4) The Licensed nursing home administrator/designee will monitor new hires prior to their start date to ensure all physicals are in place on or prior to 1st day of work or an assessment from a registered professional nurse, that a physical is obtained within the 30-day period. 5) Findings will be reported to quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1405	Continued From page 4 which was NJ Ex Order 26.4 after hire. There was no evidence of an RN assessment in the employee's health file. 3.) Employee #6, with a hire date of NJ Ex Order 26.4, had an Employee Health Examination form which was completed and signed by a physician on NJ Ex Order 26 which was over NJ Ex Order 26.4(b)(1) before the employee was hired. 4.) Employee #8, with a hire date of NJ Ex Order 26.4(b), had an Employee Health Examination form which was completed and signed by a physician on NJ Ex Order 26.4b1 which was over NJ Ex Order 26.4(b)(1) before the employee was hired. 5.) Employee #10, with a hire date of NJ Ex Order 26.4(b), had an Employee Health Examination form which was completed and signed by a physician on NJ Ex Order 26.4b1 which was over NJ Ex Order 26.4(b) after the employee was hired. On 1/21/25 at 10:30 AM, the surveyor requested all staffing policies from the Director of Nursing (DON) who stated the facility did not have any policies related to staffing and that the facility followed state and federal guidelines. On 1/22/25 at 9:52 AM, the surveyor interviewed the Director of Human Resources/Scheduling Coordinator (DHR/SC) who stated she was responsible for ensuring newly hired employees' personnel files had copies of legal documents, a completed background check, and two reference checks. At that time, the Licensed Nursing Home Administrator (LNHA) entered the interview and stated the Licensed Practical Nurse/Infection Preventionist (LPN/IP) was responsible for new hire physicals.	S1405	assurance performance improvement team for review and action as necessary for 3 months.	

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S1405	Continued From page 5 On 1/22/25 at 10:38 AM, the surveyor interviewed the LPN/IP who stated she was responsible for ensuring newly hired employees had a physical completed within the year prior to the hire date. The IP further stated that the facility did not conduct any RN assessments for newly hired employees prior to their physical exam. The IP added that she followed the facility policy related to newly hired employee physicals. At that time, the surveyor informed the LPN/IP of the five newly hired employee health physicals that were not conducted within the allowed timeframe and the LPN/IP stated she would look into it. The LPN/IP further stated that it was important for newly hired employees to have a physical done within the allowed timeframe to ensure the employee was "fit to work." On 1/22/25 at 11:09 AM, the surveyor conducted a follow-up interview with the LPN/IP who stated the facility did not have a policy related to newly hired employee physicals. The LPN/IP further stated that Employee #10's physical was completed [redacted] late because the facility did not realize the employee did not have a physical done until last month. On 1/22/25 at 11:37 AM, the surveyor informed the LNHA and DON, in the presence of the survey team, of the five newly hired employees physicals that were not conducted within the allowed timeframe. The LNHA stated the facility should have followed the state regulation regarding newly hired employee physicals. The facility was unable to provide a policy related to newly hired employee physicals.	S1405		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061006 Y1	A. Building B. Wing Y2	2/14/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

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 S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 02/03/2025	ID Prefix S1405 Reg. # 8:39-19.5(a) LSC	Correction Completed 02/03/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	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 1/23/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING **01** B. WING _____	**01/23/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD** **PITTSTOWN, NJ 08867**

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 01/16/25. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 01/16/25 and the facility was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Country Arch Care Center is a one-story building with a partial basement that was built in 1950's. It is composed of Type V protected construction. The facility is divided into seven - smoke zones. The generator powers approximately 50 % of the building per the Maintenance Director. The current occupied beds are 103 of 129.	K 000		
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.	K 351		2/3/25

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

Electronically Signed | 01/31/2025

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	315433	A. BUILDING **01** B. WING _____	**01/23/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD** **PITTSTOWN, NJ 08867**

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K 351	Continued From page 1 In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as 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 by: Based on observation and interview, the facility failed to ensure all sprinklers used in the facility had at least six spare sprinklers heads in the spare sprinkler cabinet in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (2010 Edition) Section 6.2.9.1. This deficient practice had the potential to affect all 103 residents at the facility. Findings include: An observation on 01/15/25 at 1:01 PM of the spare sprinkler cabinet in the sprinkler room revealed no quick response sprinklers were in the spare sprinkler cabinet. During an interview at the time of the observation, the U.S. FOIA (b) (6) confirmed that no quick response spare sprinklers were present in the sprinkler cabinet. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351	1) Facility ordered quick response sprinkler heads. 2) All residents have the potential to be effected. 3) Education of the U.S. FOIA (b) (6) that all sprinklers used in the facility must have at least 6 spare sprinkler heads in accordance with NFPA 13 standard for the installation of sprinkler system section 6.2.9.1 4) The nursing home administrator or designee will audit the spare sprinkler heads 1x per week for 4 weeks and then 1x per month for 3 months. 5) Findings will be reported to quality assurance performance improvement team for review and action as necessary for 3 months.	
K 918 SS=F	Electrical Systems - Essential Electric Syste	K 918		2/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING **01** B. WING _____	**01/23/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 918	Continued From page 2 CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility	K 918	1) Load testing in accordance with NFPA	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 918	Continued From page 3 failed to ensure monthly load tests were conducted on the emergency generator in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 8.4.1. This deficient practice had the potential to affect all 103 residents at the facility. Findings include: A review of the facility's untitled generator reports dated for the year 2024, provided by the facility, revealed monthly load tests were not completed on the emergency generator. During an interview on 01/16/25 at 3:30 PM, the U.S. FOIA (b) (6) stated he could not provide any documented evidence the generator was exercised under load monthly. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	110 Standard for Emergency and Standby Power Systems (2010) Section 8.4.1. 2) All residents have the potential to be effected. 3) U.S. FOIA (b) (6) educated to perform monthly load tests on the emergency generator in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010) Section 8.4.1. 4) Licensed nursing home administrator/ designee will audit generator testing monthly x 6 months for compliance with Standard for Emergency and Standby Power Systems (2010) Section 8.4.1. 5) Findings will be reported quality assurance performance improvement team for review and action as necessary for 3 months.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315433 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/20/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

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 Reg. # NFPA 101 LSC K0351	Correction Completed 02/03/2025	ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 02/03/2025	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
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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	
1/23/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO