STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315276	A. BUILDING _____ B. WING _____	C 01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MILFORD MANOR LLC	**69 MAPLE ROAD WEST MILFORD, NJ 07480**

(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 #s: NJ00154300, NJ00156142, NJ00156143, NJ00156195, NJ00157988, NJ00164616, NJ00164923, NJ00166227, NJ00166491, NJ00166865, NJ00167330, NJ00167635, NJ00169767, and NJ00169867. Survey Dates: 01/03/24 - 01/05/24 Survey Census: 105 Sample Size: 11 A Complaint Survey was conducted on behalf of the New Jersey Department of Health. THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 880 SS=D	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,	F 880		1/26/24

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

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

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F 880	Continued From page 1 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: (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.	F 880		

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F 880	Continued From page 2 §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: Complaint #s: NJ00154300, NJ00164616, NJ00164923, NJ00166227, NJ00167635, and NJ00169867. Based on observations, policy review, and interviews, the facility failed to ensure that staff changed gloves when going from a dirty area to a clean area during NJ EX Order: 2540D care for two of two residents (Resident (R)9 and R4) observed out of a total sample of 11 residents. Failure to appropriately change gloves increases the risk of infection. Findings include: Review of facility policy, title "Standard Precautions," revised 03/23, revealed, "Standard precautions will be used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status. Standard precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents ...Standard precautions include the following practices...2. Gloves ...e. Change gloves, as necessary, during the care of a resident to prevent cross-contamination from one body site to another (when moving from a "dirty" site to a	F 880	Immediately upon notification, the Infection Preventionist Nurse did an in-service and competency evaluation on the CNA, with the facility policy on Standard precautions during NJ EX Order: 2540D care, which includes the change of gloves, as necessary during care of a resident to prevent cross contamination from one body site to another,"(when moving from a dirty site to a clean one)." Resident #9 and #4 were both assessed by the Infection Preventionist Nurse and there was no negative outcome on both residents. All residents have the potential to be affected by the deficient practice of not changing gloves during care of a resident to prevent cross contamination from one body site to another. The Infection Preventionist Nurse conducted a facility wide in-services and competency evaluations on all staff with the facility policy on Standard Precautions, which includes the change of gloves as necessary during care of a resident to prevent cross contamination.	

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F 880	Continued From page 3 "clean" one)." 1. Review of R9's "Face Sheet" revealed that R9 was admitted on [redacted] with diagnoses including [redacted] Review of the admission "Minimum Data Set (MDS)" assessment with Assessment Reference Date (ARD) of [redacted] revealed R9 was always [redacted] and [redacted] Review of R9's electronic medical record (EMR) revealed no evidence of [redacted] During [redacted] care with Certified Nursing Assistant (CNA) 1 on [redacted] at 9:58 AM, upon entering R9's bedroom, CNA1 was observed gathering [redacted] supplies and placing them on R9's over bed table. CNA1 then was observed putting on her gloves, after placing disposable washcloths in R9's basin of water. CNA1 removed linen from R9, including [redacted] gown. CNA1 did not change her gloves, and washed R9's [redacted]. After finishing with R9's [redacted] CNA1 removed R9's soiled brief and proceeded to wash R9's [redacted] area, then assisted R9 in turning over to [redacted], and then [redacted] finishing up cleaning R9. After finishing cleaning R9, CNA1 placed a new brief on R9. With the same gloves, CNA1 assisted R9 into [redacted] wheelchair. CNA1 removed her gloves and washed her hands prior to moving R9 over to the sink. 2. Review of R4's "Face Sheet" revealed that R4 was re-admitted to the facility on [redacted] with a [redacted]	F 880	The Infection Preventionist Nurse will conduct an audit to observe 2 CNAs during incontinent care every shift weekly for 4 weeks, monthly for 2 months to ensure the facility policy on Standard precautions is followed. Negative findings to be corrected immediately and reviewed monthly at the Quality Assurance and Performance Improvement Meeting.	

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F 880	Continued From page 4 Review of a quarterly "MDS" assessment with ARD of [NJ EX Order. 264b1] revealed R4 was always [NJ EX Order. 264b1] and [NJ EX Order. 264b1] Review of a [NJ EX Order. 264b1] Report (facility provided), dated [NJ EX Order. 264b1], revealed '[NJ EX Order. 264b1]. [NJ EX Order. 264b1] is a [NJ EX Order. 264b1] found in the [NJ EX Order. 264b1] Review of hospital "Summary of Care Document" (facility provided), dated [NJ EX Order. 264b1], revealed a [NJ EX Order. 264b1] for [NJ EX Order. 264b1] During [NJ EX Order. 264b1] care with CNA1 on [NJ EX Order. 264b1] at 10:20 AM, upon entering R4's side of the bedroom, CNA1 was observed gathering [NJ EX Order. 264b1] supplies and placing them on R4's over bed table. CNA1 then was observed putting on her gloves, after placing disposable washcloths in R4's basin of soapy water. CNA1 then removed linen off R4, removed R4's gown and R4's [NJ EX Order. 264b1]. Without changing her gloves, CNA1 washed R4's [NJ EX Order. 264b1] and assisted rolling R4 over to [NJ EX Order. 264b1]. After R4 was rolled over, CNA1 finished cleaning up R4. Without changing her gloves, CNA1 placed a new [NJ EX Order. 264b1] on R4 and placed [NJ EX Order. 264b1] inside [NJ EX Order. 264b1] area. Then CNA1 placed R4's pants on [NJ EX Order. 264b1]. After this, with the same gloves, CNA1 adjusted [NJ EX Order. 264b1] glasses on [NJ EX Order. 264b1] head, and washed R4's upper half of [NJ EX Order. 264b1]. Continuing with the same gloves, CNA1 put R4's shirt on [NJ EX Order. 264b1] then moved R4's wheelchair to the other side of the bed. Along with R4's wheelchair, CNA1 obtained R4's [NJ EX Order. 264b1] and shoes. CNA1 placed R4's shoes on [NJ EX Order. 264b1] feet, and assisted R4 on [NJ EX Order. 264b1], assisting [NJ EX Order. 264b1] wheelchair. CNA1 removed her gloves prior to exiting the	F 880		

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F 880	Continued From page 5 room. Interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 01/05/24 at 10:45 AM, both indicated that gloves should be changed when going from a dirty area to a clean area. NJAC-8:39-19.4	F 880		

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	061612	A. BUILDING: _____ B. WING _____	C 01/05/2024

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S 000	Initial Comments Complaint #s: NJ00154300, NJ00156142, NJ00156143, NJ00156195, NJ00157988, NJ00164616, NJ00164923, NJ00166227, NJ00166491, NJ00166865, NJ00167330, NJ00167635, NJ00169767, and NJ00169867. Survey Dates: 01/03/24 - 01/05/24 Survey Census: 105 Sample Size: 11 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 (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #s: NJ00154300, NJ00156142, NJ00156143, NJ00156195, NJ00164616, NJ00166491, NJ00166865, NJ00167330, NJ00167635. Based on review of pertinent facility documentation, it was determined that the facility	S 560	No residents were immediately affected by this deficiency. All residents have the potential to be affected by this deficiency. The Director of nursing provided in-service	1/26/24

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

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S 560	Continued From page 1 failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 43 of 56 day shifts, 1 of 56 evening shifts and 4 of 56 evening shifts as follows: This deficient practice had the potential to affect all residents. Findings include: 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, codified as 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 Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and one direct 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. As per the "Nurse Staffing Report" completed by the facility for the 8 weeks of staffing from; 5/7/23-6/3/23, 6/11/23-6/17/23, 8/13/23-8/19/23, 8/27/23-9/2/23, 9/10/23-9/23/23 and 12/17/23-12/30/23, the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift, one direct care staff member to every 10 residents for the	S 560	to staffing coordinator on appropriate staffing levels. Additional per diem, part time, full time and agency staff were scheduled to meet minimum staff to resident ratios. The facility has advertised open jobs through online recruitment platforms. The facility has conducted open house, job fairs and have partnered with local schools for newly certified aides. The Director of nursing or designee will review the CNA daily staffing sheets daily for 8 weeks to ensure the staffing requirements are met and will audit staffing levels 3x weekly for 8 weeks. All findings will be reported and reviewed monthly at the Quality Assurance and Performance Improvement meeting.	

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S 560	Continued From page 2 evening shift and one direct care staff member to every 14 residents for the night shift as documented below: 1. For the week of staffing from 05/28/2023 to 06/03/2023, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows: -05/28/23 had 7 CNAs for 98 residents on the day shift, required at least 12 CNAs. -05/30/23 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. -06/01/23 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs. -06/02/23 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs. -06/03/23 had 8 CNAs for 94 residents on the day shift, required at least 12 CNAs. 2. For the week of staffing from 06/11/2023 to 06/17/2023, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows: -06/11/23 had 9 CNAs for 98 residents on the day shift, required at least 12 CNAs. -06/12/23 had 8 CNAs for 98 residents on the day shift, required at least 12 CNAs. -06/14/23 had 10 CNAs for 98 residents on the day shift, required at least 12 CNAs. -06/15/23 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs. -06/17/23 had 8 CNAs for 105 residents on the day shift, required at least 13 CNAs. 3. For the week of staffing from 08/13/2023 to 08/19/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staffing for residents on 1 of 7	S 560		

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S 560	Continued From page 3 overnight shifts as follows: -08/13/23 had 6 CNAs for 105 residents on the day shift, required at least 13 CNAs. -08/13/23 had 6 total staff for 105 residents on the overnight shift, required at least 7 total staff. -08/14/23 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. -08/15/23 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. -08/16/23 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. -08/17/23 had 8 CNAs for 107 residents on the day shift, required at least 13 CNAs. -08/18/23 had 9 CNAs for 105 residents on the day shift, required at least 13 CNAs. -08/19/23 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. 4. For the week of staffing from 08/27/2023 to 09/02/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -08/27/23 had 7 CNAs for 103 residents on the day shift, required at least 13 CNAs. -08/28/23 had 9 CNAs for 103 residents on the day shift, required at least 13 CNAs. -08/29/23 had 7 CNAs for 103 residents on the day shift, required at least 13 CNAs. -08/30/23 had 9 CNAs for 103 residents on the day shift, required at least 13 CNAs. -08/31/23 had 11 CNAs for 104 residents on the day shift, required at least 13 CNAs. -09/01/23 had 8 CNAs for 104 residents on the day shift, required at least 13 CNAs. -09/02/23 had 8 CNAs for 104 residents on the day shift, required at least 13 CNAs. 5. For the 2 weeks of staffing from 09/10/2023 to	S 560		

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S 560	Continued From page 4 09/23/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts, deficient in total staff for residents on 1 of 14 evening shift, and deficient in total staff for residents on 3 of 14 overnight shifts as follows: -09/10/23 had 8 CNAs for 107 residents on the day shift, required at least 13 CNAs. -09/11/23 had 10 CNAs for 106 residents on the day shift, required at least 13 CNAs. -09/12/23 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. -09/13/23 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. -09/14/23 had 10 CNAs for 106 residents on the day shift, required at least 13 CNAs. -09/14/23 had 7 total staff for 106 residents on the overnight shift, required at least 8 total staff. -09/15/23 had 7 CNAs for 106 residents on the day shift, required at least 13 CNAs. -09/15/23 had 7 total staff for 106 residents on the overnight shift, required at least 8 total staff. -09/16/23 had 10 CNAs for 106 residents on the day shift, required at least 13 CNAs. -09/16/23 had 10 total staff for 106 residents on the evening shift, required at least 11 total staff. -09/16/23 had 7 total staff for 106 residents on the overnight shift, required at least 8 total staff. -09/17/23 had 11 CNAs for 105 residents on the day shift, required at least 13 CNAs. -09/18/23 had 9 CNAs for 105 residents on the day shift, required at least 13 CNAs. -09/19/23 had 10 CNAs for 104 residents on the day shift, required at least 13 CNAs. -09/20/23 had 8 CNAs for 104 residents on the day shift, required at least 13 CNAs. -09/21/23 had 11 CNAs for 104 residents on the day shift, required at least 13 CNAs. -09/22/23 had 10 CNAs for 104 residents on the	S 560		

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COMPLETE CARE AT MILFORD MANOR LLC	69 MAPLE ROAD WEST MILFORD, NJ 07480

(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
S 560	Continued From page 5 day shift, required at least 13 CNAs. -09/23/23 had 10 CNAs for 104 residents on the day shift, required at least 13 CNAs. 6. For the 2 weeks of staffing from 12/17/2023 to 12/30/2023, the facility was deficient in CNA staffing for residents on 7 of 14 day shifts as follows: -12/17/23 had 8 CNAs for 102 residents on the day shift, required at least 13 CNAs. -12/19/23 had 11 CNAs for 102 residents on the day shift, required at least 13 CNAs. -12/24/23 had 8 CNAs for 106 residents on the day shift, required at least 13 CNAs. -12/25/23 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. -12/26/23 had 11 CNAs for 106 residents on the day shift, required at least 13 CNAs. -12/27/23 had 11 CNAs for 106 residents on the day shift, required at least 13 CNAs. -12/30/23 had 10 CNAs for 104 residents on the day shift, required at least 13 CNAs.	S 560		

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
315276 Y1	A. Building B. Wing Y2	2/1/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MILFORD MANOR LLC	69 MAPLE ROAD WEST MILFORD, NJ 07480

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 F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/26/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
1/5/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061612 Y1	A. Building B. Wing Y2	2/1/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MILFORD MANOR LLC	69 MAPLE ROAD WEST MILFORD, NJ 07480

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/26/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
1/5/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO