

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL13003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/19/2025
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NAME OF PROVIDER OR SUPPLIER SPRINGPOINT LIVING AT MANALAPAN	STREET ADDRESS, CITY, STATE, ZIP CODE 199 WOODWARD ROAD MANALAPAN, NJ 07726
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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 000	<p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Complaint</p> <p>COMPLAINT #: NJ00188412</p> <p>CENSUS: 51</p> <p>SAMPLE SIZE: 3</p> <p>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.</p>	A 000		
A 310	<p>8:36-3.4(a)(1) Administration</p> <p>(a) The administrator or designee shall be responsible for, but not limited to, the following:</p> <p>1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;</p>	A 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

New Jersey Department of Health

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A 310	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00188412</p> <p>Based on interview, record review, and review of pertinent facility documents, it was determined that the Executive Director (ED) failed to implement and enforce the facility's policies and procedures for 3 of 3 residents reviewed, Residents #1, 2, and 3, and failed to ensure the provision of staff education for a Licensed Practical Nurse (LPN). This deficient practice was evidenced by the following:</p> <p>1. On 8/19/25, the surveyor reviewed the closed Medical Record (MR) of Resident #2, which revealed that the resident had [redacted] on [redacted]. The surveyor observed that following each of the previously mentioned [redacted] staff completed a Progress Note (PN) about the [redacted] follow-up PNs for three days, and updated the risk assessment.</p> <p>However, the surveyor reviewed a PN written by a LPN dated [redacted] which indicated, "Resident was [redacted] NJ Exec Order 26.4b1 [redacted] ... Noted [redacted] to [redacted] resident did [redacted] [his/her] [redacted] noted [redacted] on [redacted] of [redacted] ...". The surveyor did not observe an updated risk assessment, any additional PNs that indicated if Resident #2 was sent out to the hospital to be evaluated following the previously mentioned [redacted], or any [redacted] follow-up PNs for three days.</p>	A 310		

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A 310	<p>Continued From page 2</p> <p>At 1:44 p.m., the surveyor interviewed the LPN to inquire the reason a [redacted] risk assessment and [redacted] follow-up PNs for three days were not completed following Resident #2's [redacted] on [redacted]. The LPN stated that she was not sure if a [redacted] risk assessment had to be completed and that she did not know why the [redacted] follow-up PNs were not completed.</p> <p>At 4:40 p.m., the surveyor interviewed the ED to inquire if LPN #1 was in-serviced on [redacted] and the ED stated that she was. At this time, the surveyor requested the in-service.</p> <p>The surveyor reviewed LPN #1's in-service transcript, which revealed that the LPN was last in-serviced on [redacted] on [redacted].</p> <p>At 4:58 p.m., the surveyor interviewed the ED to inquire the reason LPN #1 was not in-serviced on [redacted] following many [redacted] at the facility, including the [redacted] incident that occurred on [redacted]. The ED stated that LPN #1 may have missed her scheduled in-service on [redacted] when the LPN was on leave.</p> <p>2. At 10:55 a.m., while touring the facility's [redacted] unit, the surveyor reviewed the [redacted] safety check binder, which revealed the "Safety Checks Monitoring Log" for 21 residents were missing documentation for [redacted] at 7:00 a.m.</p> <p>At 2:53 p.m., the surveyor interviewed the Director of Nursing (DON) to inquire how often safety checks were completed, and the DON stated every two hours or more frequently as needed. The surveyor showed the DON copies of the previously mentioned logs that were obtained at 10:55 a.m., and inquired the reason the logs</p>	A 310		

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A 310	<p>Continued From page 3</p> <p>were missing safety check documentation for 7:00 a.m. The DON stated that while providing care, staff would sometimes get busy, so they would document the safety checks when they had free time. The surveyor inquired when the safety checks were supposed to be documented, and the DON stated that the safety checks should be documented right away.</p> <p>3. In addition, the surveyor reviewed the MRs of Residents #1, 2, and 3, which revealed that each resident's Service Plan (SP) had missing interventions, and no care goals or desired health outcomes.</p> <p>The surveyor reviewed the facility's policy titled, "Responsibilities of Executive Director/Administrator," revised on 8/25/08, which indicated, "... The Executive Director/Administrator shall be responsible for, but not limited to the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights ... 4. Ensuring the provision of staff orientation and staff education ..."</p> <p>The surveyor also reviewed the facility's policy titled, "Resident General Service Plan," revised on 4/5/12, which indicated, "1. If the resident's initial assessment indicates that the resident has general service needs, a resident service plan shall be developed within 14 days of admission ... 5. The resident's general service plan shall be reviewed and, if necessary, revised semiannually, and more frequently as needed based upon resident response to care provided and any changes in the resident's physical or cognitive status ..."</p> <p>Further, the surveyor reviewed the facility's policy</p>	A 310		

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A 310	<p>Continued From page 4</p> <p>titled, "Falls Management Program," revised on 11/29/07, which indicated, "... If determined to be at risk, the potential for falls will be addressed in their service plan with appropriate interventions documented ... 8. Post fall documentation shall be in the medical record and include: A. The time and location of the fall B. Resident activity at the time of fall C. Mental status at time of fall D. Vital signs E. The condition of the resident at the time of the fall F. All interventions taken by staff including treatment to the resident, contacting physician, family and other professional services as needed. G. All interventions taken by the physician, diagnostic services and other professionals. H. Outcomes of all interventions ..."</p> <p>Lastly, the surveyor also reviewed the facility's policy titled, "Documentation," revised on 7/9/8, which indicated, "1. Documentation will be completed in accordance with the assisted living regulations. 2. The Executive Director/Administrator and/or Wellness Director shall be accountable for documentation and [ensure] that all information is held in a confidential matter."</p> <p>Reference 8:36-7.3(a) A-0749 and 8:36-15.6(b)</p>	A 310		
A 749	<p>8:36-7.3(a) Resident Assessments and Care Plans</p> <p>(a) The resident general service plan shall be reviewed and, if necessary, revised semi-annually, and more frequently as needed based upon the resident's response to the care provided and any changes in the resident's physical or cognitive status.</p>	A 749		

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A 749	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00188412</p> <p>Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to develop and implement resident Service Plans (SPs) for 3 of 3 residents reviewed, Resident #s 1, 2 & 3. This deficient practice was evidenced by the following:</p> <p>1. On 8/19/25, the surveyor reviewed the Medical Record (MR) of Resident #1, who was admitted to the facility in [redacted] NJ Exec Order 26.4b1, with diagnoses of [redacted] NJ Exec Order 26.4b1, and [redacted] NJ Exec Order 26.4b1. The surveyor reviewed Resident #1's Progress Notes (PNs), which revealed that the resident had [redacted] on [redacted] NJ Exec Order 26.4b1. The surveyor reviewed documentation from Resident #1's [redacted] on [redacted] NJ Exec Order 26.4b1, which indicated that there were existing interventions in place to prevent [redacted] including [redacted] NJ Exec Order 26.4b1, a [redacted] NJ Exec Order 26.4b1, and [redacted] NJ Exec Order 26.4b1. In addition, the documentation indicated that Resident #1 and/or the resident's family were educated on [redacted] NJ Exec Order 26.4b1, and a new intervention was implemented to remind Resident #1 to [redacted] NJ Exec Order 26.4b1.</p> <p>The surveyor reviewed Resident #1's SP, dated [redacted] NJ Exec Order 26.4b1, which did not have [redacted] NJ Exec Order 26.4b1, a [redacted] NJ Exec Order 26.4b1, or reminders documented as interventions to prevent [redacted] NJ Exec Order 26.4b1. Further, Resident #1's SP did not include interventions that addressed the resident's [redacted] NJ Exec Order 26.4b1.</p>	A 749		

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A 749	<p>Continued From page 6</p> <p>2. The surveyor reviewed the closed MR of Resident #2, which revealed that the resident was admitted to the facility in NJ Exec Order 26.4b1, with a diagnosis of NJ Exec Order 26.4b1. The surveyor reviewed Resident #2's PNs, which revealed that the resident had NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1. The surveyor reviewed documentation from Resident #2's NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 which indicated that there were existing interventions in place to prevent NJ Exec Order 26.4b1 including NJ Exec Order 26.4b1, encouraged use of call light, and a NJ Exec Order 26.4b1 room with NJ Exec Order 26.4b1 hazards.</p> <p>At 2:53 p.m., the surveyor interviewed the Director of Nursing (DON) to inquire what interventions were put into place for Resident #2 following the previously mentioned NJ Exec Order 26.4b1. The DON stated that staff implemented common area monitoring, NJ Exec Order 26.4b1 (who provided NJ Exec Order 26.4b1 hours a day). In addition, the DON stated that residents who NJ Exec Order 26.4b1 were brought to the common area to be monitored until they became NJ Exec Order 26.4b1.</p> <p>At this time, the surveyor inquired the reason the SP was a standardized checklist and not an individualized plan with goals, interventions, and desired health outcomes. The DON stated, "I agree it doesn't capture a lot."</p> <p>The surveyor reviewed Resident #2's SP titled, "Resident Summary," dated NJ Exec Order 26.4b1, which did not have NJ Exec Order 26.4b1, encouraged use of call light, a NJ Exec Order 26.4b1 room with NJ Exec Order 26.4b1, common area monitoring or NJ Exec Order 26.4b1 documented as interventions to prevent NJ Exec Order 26.4b1.</p> <p>3. The surveyor reviewed the MR of Resident #3,</p>	A 749		

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A 749	<p>Continued From page 7</p> <p>who was admitted to the facility in [redacted] of [redacted] with diagnoses of [redacted] and [redacted]. The surveyor reviewed Resident #3's PNs, which revealed that the resident had [redacted] on [redacted]. The surveyor reviewed Resident #3's SP, which did not have interventions documented that addressed the resident's [redacted].</p> <p>The SPs for Residents #1, #2, and #3 did not document any care goals or desired health outcomes.</p> <p>At 4:24 p.m., during exit conference, the facility's Corporate Nurse confirmed that the SPs were not specific.</p> <p>The surveyor reviewed the facility's policy titled, "Resident General Service Plan," revised on 4/5/12, which indicated, "1. If the resident's initial assessment indicates that the resident has general service needs, a resident service plan shall be developed within 14 days of admission ... 5. The resident's general service plan shall be reviewed and, if necessary, revised semiannually, and more frequently as needed based upon resident response to care provided and any changes in the resident's physical or cognitive status ..."</p> <p>The surveyor also reviewed the facility's policy titled, "Falls Management Program," revised on 11/29/07, which indicated, "... If determined to be at risk, the potential for falls will be addressed in their service plan with appropriate interventions documented ..." The policy also lists 19 fall prevention measures that could be implemented for high-risk residents.</p>	A 749		

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A1073	Continued From page 8	A1073		
A1073	<p>8:36-15.6(b) Resident Records</p> <p>(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.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00188412</p> <p>Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that health care staff documented in accordance with the standards of professional practice for Resident #2 and 21 of 51 unsampled residents. This deficient practice was evidenced by the following:</p> <p>1. On 8/19/25, the surveyor reviewed the closed Medical Record (MR) of Resident #2, which revealed that the resident was admitted to the facility in NJ Exec Order 26.4b1, with a diagnosis of NJ Exec Order 26.4b1. The surveyor reviewed Resident #2's Progress Notes (PNs), which revealed that the resident had NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1. The surveyor observed that following each of the previously mentioned NJ Exec Order 26.4b1 staff completed a PN about the NJ Exec Order 26.4b1 follow-up PNs for three days, and updated the NJ Exec Order 26.4b1 risk assessment.</p>	A1073		

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A1073	<p>Continued From page 9</p> <p>However, the surveyor reviewed a PN written by a Licensed Practical Nurse (LPN) dated [redacted] which indicated, "Resident was [redacted] ... Noted [redacted] to [redacted], resident did [redacted] [his/her] [redacted] noted [redacted] on [redacted] of [redacted] ...". The surveyor did not observe an updated [redacted] risk assessment, any additional PNs that indicated if Resident #2 was sent out to the hospital to be evaluated following the previously mentioned [redacted], or any [redacted] follow-up PNs for three days.</p> <p>At 1:44 p.m. and 2:53 p.m., the surveyor interviewed the previously mentioned LPN and the Director of Nursing (DON) to inquire what documentation would be completed [redacted] and to inquire about Resident #2's [redacted] on [redacted].</p> <p>The LPN stated that following a fall, nursing staff would complete a PN, risk management form, incident report, and [redacted] follow-up PNs for three days. In addition, the LPN stated that on [redacted] she was informed that Resident #2 was [redacted]. The LPN stated that she went to assess Resident #2 and [redacted] the resident [redacted] from the [redacted] with the assistance of an aide, when she observed a [redacted] on the [redacted] of the resident's [redacted]. The LPN stated that she then called Resident #2's [redacted] nurse, responsible party, and doctor. The LPN stated that the [redacted] nurse came to the facility to assess Resident #2 and decided not to send the resident to the hospital. The LPN stated that she monitored Resident #2 throughout the day following the resident's [redacted] and that the resident did not have any [redacted].</p> <p>At this time, the surveyor inquired the reason a fall risk assessment and [redacted] follow-up PNs for three days were not completed following</p>	A1073		

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A1073	<p>Continued From page 10</p> <p>Resident #2's [redacted] on [redacted] [redacted] The LPN stated that she was not sure if a [redacted] assessment had to be completed and that she did not know why the PNs were not completed.</p> <p>The surveyor reviewed the previously mentioned LPN's in-service transcript, which revealed that the LPN was last in-serviced on [redacted] on [redacted].</p> <p>The DON stated that following a fall, nursing staff would document a [redacted] PN, risk management form, [redacted] follow-up PNs for three days, safety checks, and anything that was related to the [redacted]. In addition, the DON stated that on [redacted] Resident #2 did not go to the hospital following a [redacted] with [redacted]. The DON stated that Resident #2 was on [redacted] and the family [redacted] treatment to avoid further [redacted] to the resident. The surveyor then inquired the reason [redacted] follow-up PNs were not completed following this [redacted] and the DON stated, "I don't know why that was missed". The surveyor then inquired the reason the family's [redacted] of treatment for Resident #2 was not documented, and the DON stated, "Yeah, that's supposed to be indicated".</p> <p>At this time, the surveyor inquired who was responsible for ensuring all [redacted] documentation was completed following a [redacted] and the DON stated that she was.</p> <p>2. At 10:55 a.m., while touring the facility's [redacted] unit, the surveyor reviewed the [redacted] safety check binder, which revealed the "Safety Checks Monitoring Log" for 21 residents were missing documentation for [redacted] at 7:00 a.m.</p> <p>At 2:53 p.m., the surveyor interviewed the DON to</p>	A1073		
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A1073	<p>Continued From page 11</p> <p>inquire how often safety checks were completed, and the DON stated every two hours or more frequently as needed. The surveyor showed the DON copies of the previously mentioned logs that were obtained at 10:55 a.m., and inquired the reason the logs were missing safety check documentation for 7:00 a.m. The DON stated that while providing care, staff would sometimes get busy, so they would document the safety checks when they had free time. The surveyor inquired when the safety checks were supposed to be documented, and the DON stated that the safety checks should be documented right away.</p> <p>The surveyor reviewed the facility's policy titled, "Falls Management Program," revised on 11/29/07, which indicated, "... 8. Post fall documentation shall be in the medical record and include: A. The time and location of the fall B. Resident activity at the time of fall C. Mental status at time of fall D. Vital signs E. The condition of the resident at the time of the fall F. All interventions taken by staff including treatment to the resident, contacting physician, family and other professional services as needed. G. All interventions taken by the physician, diagnostic services and other professionals. H. Outcomes of all interventions ..."</p> <p>The surveyor also reviewed the facility's policy titled, "Documentation," revised on 7/9/8, which indicated, "1. Documentation will be completed in accordance with the assisted living regulations. 2. The Executive Director/Administrator and/or Wellness Director shall be accountable for documentation and [ensure] that all information is held in a confidential matter."</p>	A1073		



SPRINGPOINT LIVING AT MANALAPAN

ASSISTED LIVING & MEMORY CARE

October 23, 2025 revised November 17, 2025 revised November 18, 2025

Please see the Plan of Correction below related to the complaint survey dated 08/19/2025 #NJ00188412 for Springpoint Living at Manalapan Assisted Living AL13003.

RECEIVED 11/25/25
ACCEPTABLE
PDL #3

A0000- Initial Comments- census 51, sample size 3

A310

1. On 8/20/2025 Executive Director reviewed the policies regarding our NJ Exec Or Management Program (rev 8/25/08), Documentation (rev 7/9/08), Resident General Service Plan (rev 4/5/12) Residents #1 and #3 continue to reside at the community. Resident #2 no longer resides at the community NJ Exec Order 26.4b1
2. All residents have the potential to be affected by the deficient practice.
3. The Executive Director/Director of Nursing in-serviced all professional nursing staff, including the LPN mentioned in the 2567, on 8/21/2025, regarding our Falls Management Program (rev 8/25/08), Documentation (rev 7/9/08), Resident General Service Plan (rev 4/5/12) All staff are trained during their new hire orientation and in-serviced annually.
4. The Executive Director or designee will ensure the implementation and enforcement of the policies. Professional nursing staff are trained during their orientation at the time of hire and in-serviced annually regarding the facility's policies and procedures. New Hire training is reviewed after completion of 90 days via Relias and signed-off training. Verification of annual training is done monthly utilizing Relias, this was first reviewed 10/15/25 and is ongoing. All training is also reviewed during our Quality Assurance meeting.
5. Completion date 11/06/25 and ongoing

A749

1. Resident #2 no longer resides at the community NJ Exec Order 26.4b1 Residents #1 and #3 still reside at the community.
2. All residents have the potential to be affected by the deficient practice.
3. The Director of Nursing updated the General Service plan for residents #1 and #3 on 8/21/25. A new Supplemental Plan and Interventions form has been developed and implemented by the Director of Nursing, on 11/13/2025, to provide more detailed interventions for problems identified. For residents #1 and #3 their GSP was updated to meet residents care needs. This included the new Supplemental Plan and Intervention form. The Director of Nursing completed this 11/14/25. (see sample Supplemental Plan and Interventions form attached). Training for all staff regarding the new Supplemental Plan and Intervention started on 11/14/25 to be completed by November 30, 2025.

ACCEPTED 11/25/25

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All residents whose care needs require detailed interventions will have a Supplemental Plan and Interventions form attached to their General Service Plan. These will be updated bi-annually and as needed based on resident's care needs by the Director of Nursing. This will be completed for all current residents by November 30 2025.

4. The Executive Director will audit all current residents who have a General Service Plan along with the Supplemental Plan and Interventions form completion date December 5, 2025. Effective January 2026 and ongoing, the Executive Director will audit 10 percent of the monthly bi-annual assessments and 100% of new move ins (after 14 days)to ensure both the General Service Plan and the Supplemental Plan and Intervention form is completed timely.
5. Completion date: November 30, 2025

accepted 11/25/25

NJ Exec Order 26

A1073

1. Resident #2 no longer resides at the community **NJ Exec Order 26.4b1**
2. All residents have the potential to be affected.
3. The Executive Director/Director of Nursing in-serviced all professional nursing staff regarding our protocols and documentation as it relates to our falls programs on 8/21/2025, including the LPN mentioned. All staff have been in serviced regarding safety checks and documentation beginning on 08/23/2025 and completed on 9/10/25 by Director of Nursing and Memory Care Director. Training will occur annually regarding documentation via Relais and in person training.
4. The shift Nurse will ensure that safety checks documentation is completed on time during each shift. The nurse reviews the documentation with the Director of Nursing or designee to ensure compliance. The Executive Director or designee will ensure the implementation and enforcement of our fall documentation policy by auditing all falls to ensure proper documentation according to our policy for 3 months and report at the Quality Assurance meeting. As of January 2026 and ongoing, weekly audits of 10% of documentation will be conducted and reported at the Quality Assurance meeting to ensure compliance. Safety Checks documentation are monitored each shift in Memory Care by the LPN/CMA and reviewed with the Director of Nursing to ensure compliance.
5. Completion date 11/30/2025 and ongoing

accepted 11/25/25

NJ Exec Order 26.4b1

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL13003	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 11/25/2025
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NAME OF FACILITY SPRINGPOINT LIVING AT MANALAPAN	STREET ADDRESS, CITY, STATE, ZIP CODE 199 WOODWARD ROAD MANALAPAN, NJ 07726
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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 A0310	Correction	ID Prefix A0749	Correction	ID Prefix A1073	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-7.3(a)	Completed	Reg. # 8:36-15.6(b)	Completed
LSC	11/25/2025	LSC	11/25/2025	LSC	11/25/2025
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 <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 8/19/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		