

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: I5W32J	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/08/2025
NAME OF PROVIDER OR SUPPLIER NEW LIFE ADULT MEDICAL DAY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 340 EVELYN STREET PARAMUS, NJ 07652		
(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
M 000	Initial Comments Type of Survey: Complaint Complaint #: NJ 00188745 Census: 10/7/25 - 98 & 10/8/25 - 99 Sample Size: 3 The facility was not in substantial compliance with all of the standards in the New Jersey Administrative Code, Chapter 8:43F, Standards for Licensure of Adult Day Health Services. 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 New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	M 000		
M 223	8:43F-3.1(b)(1-7) Administration (b) The administrator shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including participant rights; 2. Planning and administering the managerial, operational, fiscal, and reporting components of the facility; 3. Participating in the quality improvement program for participant care and staff performance;	M 223		

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

TITLE

(X6) DATE

11/21/25

New Jersey Department of Health

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M 223	Continued From page 1 4. Ensuring that all personnel are assigned duties based upon their education, training, competencies, and job descriptions; 5. Ensuring the provision of staff orientation, staff education, and ongoing staff training in accordance with N.J.A.C. 8:43F-6.3; 6. Establishing and maintaining liaison relationships and communication between facility staff and services providers and with participants and their caregivers; and 7. Verifying that each Medicaid-eligible participant is eligible to receive services available at the adult day health services facility prior to the participant's entry into the program. For the purposes of this section, the administrator shall be entitled to rely on any prior authorization performed by the Department for the participant in accordance with N.J.A.C. 8:86. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00188745 Based on interview and record review, it was determined that the Administrator failed to implement the facility's policies on "Documentation, Consumer Grievance Policy,	M 223			

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M 223	Continued From page 2 and position description for the Social Worker" for 1 of 3 participants reviewed, Participant #2. This deficient practice was evidenced by the following: On 10/7/25 at 9:58 a.m., the surveyor interviewed Participant #2 and inquired about the transportation services at the facility. Participant #2 stated that he/she expressed a concern to the Director of Social Work (DSW), regarding the bus driver using his cell phone while driving the facility vehicle during the transport of participants. During continued surveyor interview, Participant #2 stated that he/she reported the concern multiple times to the DSW and was not made aware of the outcome regarding his/her grievance. At 11:41 a.m., the surveyor reviewed Participant #2's medical record (MR), which revealed that the participant was admitted to the program in NJ Exec Order 26.4b1 with a diagnosis of NJ Exec Order 26.4b1. The surveyor did not observe documentation which reflected that Participant #2's concern was acknowledged or addressed. On 10/8/25 at 11:18 a.m. and 12:25 p.m., the surveyor interviewed the DSW and inquired about the bus driver using his phone while transporting participants to and from their destinations. The DSW stated that she was aware of the complaint; however, that the complaint was unsubstantiated. The surveyor then inquired if the DSW informed the Administrator of the complaint. The DSW stated that she did not notify the Administrator, but she did notify the Director of Transportation who re-educated all the drivers. During continued surveyor interview, the DSW stated that she did not document the investigation	M 223		

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M 223	Continued From page 3 of Participant #2's complaint. The surveyor reviewed a facility policy titled, "Consumer Grievance Policy," last reviewed on 2/3/17, which revealed, " ... The Adult Care Center shall have a mechanism to ensure that all consumers have the opportunity to express their concerns and have their grievances dealt with in a fair and impartial manner ..." The surveyor reviewed a facility policy titled, "Documentation," last reviewed on 2/3/17, which revealed, " ... shall document all services provided by the staff of the New Life Adult Medical Day Care Center ... Documentation shall consist of: ... Event Triggered Notes ..." Additionally, the surveyor reviewed the facility's position description for the Social Worker which revealed, "... Provide a liaison between consumer/staff, consumer/agencies and consumer/family ..."	M 223		
M 235	8:43F-3.3(d)(1) Administration (d) A policy and procedure manual(s) for the organization and operation of the facility shall be developed, implemented, and reviewed at intervals specified in the manual(s). Each review of the manual(s) shall be documented, and the manual(s) shall be available in the facility to representatives of the Department at all times. The manual(s) shall include at least the following: 1. A written statement of the program's philosophy and objectives and the services provided by the facility.	M 235		

If continuation sheet 5 of 10

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M 263	Continued From page 5 immediately by telephone at 609-633-9034 (609-392-2020 after business hours), followed by written confirmation within 72 hours of the following: 5. All fires, all disasters, and all deaths resulting from accidents or incidents in the facility or related to facility services. The written confirmation shall contain information about injuries to participants and/or personnel, disruption of services, and extent of damages. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to notify the Department of Health (DOH) of a NJ Ex Order 26.4(b)(1) which involved a facility vehicle that was transporting 2 of 3 participants reviewed, Participant #2 and Participant #3. This deficient practice was evidenced by the following: On 10/7/25 at 9:58 a.m., the surveyor interviewed Participant #2 and inquired about the transportation services at the facility. Participant #2 stated that he/she was involved in an NJ Exec Or while being transported from the facility in a facility vehicle in NJ Exec Ord At 10:15 a.m., the surveyor interviewed the Director of Nursing (DON) and inquired if there were any NJ Ex Order 26.4(b)(1) within the last year,	M 263		

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M 263	Continued From page 6 which involved facility vehicles. The DON stated that there was a [REDACTED] about [REDACTED] and provided the surveyor the incident report for the [REDACTED] which occurred in [REDACTED] titled "Transportation [REDACTED] Report" ([REDACTED]). At 11:14 a.m., the surveyor reviewed the [REDACTED] dated [REDACTED], which revealed, the front of the facility's vehicle was [REDACTED] while the [REDACTED]. Additionally, the report revealed that there were 23 participants who were documented as "passengers" of the vehicle during the [REDACTED]. The surveyor reviewed the list of passengers and identified Participant #2 and Participant #3 who were passengers at the time of the [REDACTED]. At 11:41 a.m., the surveyor reviewed Participant #2's medical record (MR), which revealed that the participant was admitted to the facility in [REDACTED] with a diagnosis of [REDACTED]. Continued surveyor review of Participant #2's Client Notes (CNs) in the MR revealed that the participant [REDACTED] at the time of the incident; however, Participant #2 was then evaluated at a local hospital for [REDACTED]. At 11:53 a.m., the surveyor reviewed Participant #3's MR, which revealed that the participant was admitted to the program in [REDACTED] with a diagnosis of [REDACTED]. Continued surveyor review of Participant #3's CNs revealed that the participant reported [REDACTED], and [REDACTED] at the time of the incident. Further review of the CNs revealed that Participant #3 was transported to the hospital and diagnosed with a [REDACTED]. The surveyor was [REDACTED] Participant #3 due to [REDACTED].	M 263		

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M 263	Continued From page 7 At 11:58 a.m., the surveyor interviewed the DON and inquired if the [NJ Exec Order 26.4b1] was reported to the DOH. The DON stated that she was unsure if the incident was reported. On 10/8/25 at 10:58 a.m., the surveyor interviewed the Director of Transportation (DOT) and inquired about the [NJ Exec Order 26.4b1]. The DOT stated that the facility vehicle was transporting participants home after the program and the [NJ Exec Order 26.4b1] occurred [NJ Exec Order 26.4b1] from the facility. The DOT stated that he, the DON, and Activities Director went to the [NJ Ex Order 26.4(b)(1)] to assist participants. The DOT stated that the [NJ Ex Order 26.4(b)(1)] were called to [NJ Ex Order 26.4(b)(1)] and confirmed that Participant #3 was transported to the hospital from [NJ Ex Order 26.4(b)(1)] on [NJ Exec Order 26.4b1]. At 11:18 a.m., the surveyor interviewed the AA and inquired about the [NJ Exec Order 26.4b1]. The AA stated that the [NJ Exec Order 26.4b1] was not reported to the DOH and that the [NJ Exec Order 26.4b1] were called to [NJ Ex Order 26.4(b)(1)] of the [NJ Exec Order 26.4b1]. The surveyor reviewed a facility policy titled, "Mandatory Reporting," last reviewed on 2/3/17, which revealed, "... will notify the Department of Health ... of the following events: ... incidents in the facility or related to facility services ... The owner and administrator shall be aware of regulations regarding the mandatory reporting of certain events, and will notify the Department of Health ..."	M 263		
M 393	8:43F-6.1(b) General Services The facility, at a minimum, shall provide the following services directly in the facility: nursing,	M 393		

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M 393	Continued From page 8 dietary, activities, pharmaceutical, and social work. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to provide social work services while the social worker functioned as the Alternate Administrator (AA). This deficient practice was evidenced by the following: On 10/7/25 at 9:01 a.m., the surveyor requested to meet with the Administrator. The Director of Nursing (DON) informed the surveyor that the Administrator was not at the facility and that the AA was the Director of Social Work (DSW). At 9:27 a.m., the surveyor interviewed the DSW and inquired about the facility's appointment of designees. The DSW confirmed that she was the AA and confirmed that she was the only social worker employed at the facility. At 10:21 a.m., the surveyor reviewed the facility's document titled, "Appointment of Designees" which revealed that the DSW was the designated AA. On 10/8/25 at 11:18 a.m., the surveyor interviewed the DSW and inquired about the social services at the facility while she performed the duties of the AA. The AA stated that she provided social work services to the participants simultaneously as she performed as the AA. The surveyor reviewed a facility policy titled, "Administrator Coverage," last reviewed on 2/3/17, which revealed, " ... The Administrator	M 393		

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M 393	Continued From page 9 shall assign an employee to fulfill administrative responsibilities in his/her absence to ensure the safe operation of the Adult Care Center and the compliance with all local, state and federal regulations ..."	M 393			

POC #2 received 11/25/25
Accepted 11/25/25

New Life

Adult Medical Day Care Center

Bergen County Adult Day Care LLC

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11/25/25

We are in receipt of the Statement of Deficiencies from your office. Enclosed please find our facility's Plan of Correction for the listed deficiencies.

In response to 8:43F-3.1(b)(1-7) Administration M223, please find below the appropriate steps taken by the facility.

Section 1 – Corrective Action for the Identified Client

The facility acknowledges that the grievance reported by the client was not documented in accordance with policy and that the Social Worker reported the concern to the Director of Transportation rather than the Administrator. The Participant (#2) with the respective grievance continues to be a part of the census and attends the facility consistently. On October 13th, 2025, the Administrator trained the Social Worker, the Administrative Designee, and all staff members on the proper grievance reporting procedure, including the requirement that all grievances be reported directly to the Administrator and documented in a timely and accurate manner. The facility will continue to follow its existing grievance policy and will ensure that all staff understand and uphold their responsibilities in receiving, reporting, documenting, and responding to grievances.

Section 2 – Identification of Other Potentially Affected Clients

To determine whether other clients may have been affected by similar issues, the Administrator, the Director of Activities, the Social Worker Department Head, and the Director of Nursing reviewed all respective grievances. In addition, council meetings will be held with each group of clients before December 5th, 2025, to identify any additional concerns or grievances that may not have been previously reported. Any issues raised during these meetings will be reviewed and addressed in accordance with the facility's grievance policy. While the deficient practice did not affect any other clients on the roster, it had the potential to affect all clients if grievances were not documented and responded to in a timely manner.

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Section 3 – Systemic Changes to Prevent Recurrence

The facility has reinforced and clarified its existing grievance policy, highlighting the requirement that all grievances be reported directly to the Administrator and fully documented. The Administrator will complete, by December 5th, the re-education of staff across all departments, including transportation and social services, ensuring that all personnel understand their responsibilities in the grievance process and the importance of timely reporting and documentation. The Director of Transportation has also been instructed that any client complaint must be communicated directly to the Administrator rather than addressed solely within the department. All corrective actions related to systemic improvement will be completed before December 5th, 2025.

Section 4 – Monitoring to Ensure Ongoing Compliance

Beginning December 5th, 2025, the Administrator and members of the Quality Assurance team will conduct quarterly audits of the grievance process to ensure continued compliance. These audits will verify that all grievances are properly reported, documented, and addressed in accordance with the facility's policy. The results will be reviewed during Quality Assurance meetings, and any concerns identified through ongoing monitoring will be corrected promptly to maintain compliance.

Completion Date: All steps related to correcting the deficient practice will be completed by December 5th, 2025.



approved 11/25/25

In response to 8:43F-3.1(b)(5) Administration M235, please find below the appropriate steps taken by the facility.

Section 1 – Corrective Action for the Identified Issue

The facility acknowledges that during the inspection, the Administrator was not present, and the Administrative Designee failed to present documentation showing that the annual review of policies and procedures had been signed off by the Administrator. A legacy document in the binder was mistakenly provided to the auditor, which did not reflect the ongoing and current review. The facility accepts that the correct documentation was not made available at the time of inspection. On October 13th, 2025, the Administrator retrained the Administrative Designee and Director of Nursing on the location of the current annual review, ensuring that they can locate and present the appropriate documentation to an auditor in the event of the Administrator's absence.

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Section 2 – Identification of Other Potentially Affected Clients

Because this deficiency is strictly administrative in nature, no clients were directly affected, and no potential clients were placed at risk. Nonetheless, the Administrator has confirmed that all policies and procedures are up-to-date and appropriately reviewed and has verified that the Administrative Designees understand how to locate and present the current annual review documents should they be requested during future inspections. While the deficient practice did not affect any specific clients on the roster, it had the potential to affect all clients if policies and procedures across all areas of service were not reviewed and updated to meet all ongoing requirements.

Section 3 – Systemic Changes to Prevent Recurrence

To prevent recurrence of this issue, the Administrator reinforced expectations regarding the maintenance and presentation of policy and procedure documentation. The Administrative Designee will be trained by the Administrator by December 5th, 2025, on the location of the annual review materials and the requirement that these documents must always be accessible and updated in the administrative binder. The Administrator has also established a process to ensure that Administrative Designees can reliably perform this task should the Administrator be unavailable. These systemic steps will ensure that auditors are consistently provided with accurate and current documentation.

Section 4 – Monitoring to Ensure Ongoing Compliance

Beginning December 5th, 2025, the Administrator will begin conducting unannounced reviews monthly for three months and every 6 months thereafter to confirm that the Administrative Designees can correctly identify, locate, and present the updated annual-review documentation. These semi-annual checks will be monitored through the facility's Quality Assurance process to ensure ongoing compliance. Any gaps identified during monitoring will be promptly addressed through retraining or corrective action as needed.

Completion Date: All steps related to correcting the deficient practice will be completed by December 5th, 2025.



approved 11/25/25

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In response to 8:43F-3.4(a)(5) Administration M263, please find below the appropriate steps taken by the facility.

Section 1 – Corrective Action for the Identified Issue

In **NJ Exec Order 26.4b1** occurred involving the facility's transportation vehicle, and several clients were **NJ Ex Order 26.4(b)(1)**. Both Participant #2 and #3, continue to be a part of the active roster and attend the facility consistently. The facility remained in continuous communication with **NJ Ex Order 26.4(b)(1)** the hospital, clients, family members, and the members' respective HMOs throughout the incident.

Although the facility documented these interactions and provided this documentation to the auditor, the facility acknowledges that it failed to notify the Department of Health as required under mandatory reporting regulations. The facility accepts this deficiency and understands the requirement to report certain events in a timely manner. To address this, the Administrator will conduct mandatory reporting training prior to December 5th, 2025, with the Administrative Designee, Director of Nursing, Head of Social Services, Activities Director, and Director of Transportation, as each of these team members may be required to assist in ensuring that all reportable events are brought to the attention of the Administrator or Administrative Designee.

Section 2 – Identification of Other Potentially Affected Clients

Because this deficiency relates specifically to a failure in external reporting and not a lapse in care delivery, the Administrator reviewed all documentation and confirmed that all clients affected by the June 2024 transportation accident received timely and appropriate follow-up from the facility, their families, the hospital, and their HMOs. No additional clients or potential clients were affected. The Administrator will also review all incidents occurring in the current year to ensure that no other mandatory-reportable events were missed and that proper communication and follow-up occurred. If any reportable events are found, they will be reported to the state with the appropriate documentation, by the Administrator. While no other missing cases were found, the deficient practice could have potentially affected all clients for any given event that should have been reported.

Section 3 – Systemic Changes to Prevent Recurrence

To prevent recurrence of this issue, the Administrator will provide targeted training prior to December 5th, 2025, to the Administrative Designee, Director of Nursing, Head of Social Services, Activities

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Director, and Director of Transportation. This training will ensure that all relevant team members understand the facility's mandatory reporting requirements and the necessity of notifying the Administrator immediately when a potentially reportable event occurs. Additionally, the Administrator will conduct an in-service with all staff prior to December 5th, 2025, to ensure that any employee who becomes aware of a potential reportable event promptly informs the Administrator or Administrative Designee so that the appropriate reporting process can be followed.

Section 4 – Monitoring to Ensure Ongoing Compliance

Beginning December 5th, 2025, the Administrator will conduct weekly monitoring for a period of four weeks to ensure that any incidents or potential reportable events are identified and addressed according to mandatory reporting requirements. Following this four-week period, the Administrator and the Quality Assurance team will conduct monthly monitoring to ensure ongoing compliance. Any deficiencies or missed reporting identified during monitoring will result in immediate retraining of the staff or department involved to maintain continued adherence to regulatory reporting obligations.

Completion Date: All steps related to correcting the deficient practice will be completed by December 5th, 2025.



approved
11/25/25

In response to 8:43F-6.1(b)(5) General Services M393, please find below the appropriate steps taken by the facility.

Section 1 – Corrective Action for the Identified Issue

The facility acknowledges that while the Administrator was not in the facility, the Director of Social Work was acting as the Administrative Designee. The facility recognizes that assigning the Director of Social Work to this role created a shortfall in Social Services responsibilities. To correct this, the Administrator has now assigned the Director of Nursing to serve as the Administrative Designee moving forward. The Director of Nursing shall be trained and prepared to act as the Administrative Designee by December 5th, 2025. The Alternate Director of Nursing will support the Director of Nursing in fulfilling designee responsibilities during the Administrator's absence. The Head of Social Services will remain solely in their role and will no longer serve as Administrative Designee, ensuring that Social Services operations are not impacted during future inspections or administrative responsibilities.

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Section 2 – Identification of Other Potentially Affected Clients

This deficiency is strictly administrative in nature and upon review by the Administrator, did not affect any individual clients with respect to individual needs being neglected. The reassignment of administrative roles will ensure no impact to client services or clinical care going forward. No clients were affected because of this deficiency. While no clients were found to be affected by the deficient practice, it could have potentially affected all clients for any given event that should have required attention from either Administration, Nursing or Social Services.

Section 3 – Systemic Changes to Prevent Recurrence

To ensure a smooth and compliant administrative structure in the Administrator's absence, the Administrator shall train the Director of Nursing in their role as the Administrative Designee prior to December 5th, 2025. Additionally, the Director of Nursing will train the Alternate Director of Nursing by December 5th, 2025, on all duties that may be required during an audit or administrative review, as well as ongoing obligations associated with day-to-day operations. The Administrator will update the facility's designee documentation prior to December 5th, 2025, to formally reflect the Director of Nursing as the Administrative Designee once all training has been completed.

Section 4 – Monitoring to Ensure Ongoing Compliance

To ensure continued compliance and adequate administrative coverage, the Administrator will monitor staff vacations, leaves, and planned absences to confirm that the appropriate Administrative Designee coverage is always maintained. The Administrator will ensure that both the designated Administrative Designee and the Alternate Director of Nursing are consistently available and prepared to provide required information during any inspection or administrative review. Any gaps identified during monitoring will be addressed immediately to maintain compliance with regulatory requirements.

Completion Date: All steps related to correcting the deficient practice will be completed by December 5th, 2025.

NJ Exec Order 26

approved
11/25/25

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This narrative plan underscores our commitment to address these deficiencies, ensuring the comfort and well-being of our residents while taking measures to prevent the recurrence of similar issues in the future. We are dedicated to upholding the highest standards in our healthcare facility, and our ongoing monitoring and improvement will be pivotal in achieving this. As of the date of this letter, all issues are anticipated to be rectified by December 5th and we will monitor on an ongoing basis.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER I5W32J	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 11/25/2025
NAME OF FACILITY NEW LIFE ADULT MEDICAL DAY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 340 EVELYN STREET PARAMUS, NJ 07652	

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 M0223	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:43F-3.1(b)(1-7)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/05/2025	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	
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 10/8/2025		☐ 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 I5W32J	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 11/25/2025
NAME OF FACILITY NEW LIFE ADULT MEDICAL DAY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 340 EVELYN STREET PARAMUS, NJ 07652	

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix M0223	Correction	ID Prefix M0235	Correction	ID Prefix M0263	Correction
Reg. # 8:43F-3.1(b)(1-7)	Completed	Reg. # 8:43F-3.3(d)(1)	Completed	Reg. # 8:43F-3.4(a)(5)	Completed
LSC	12/05/2025	LSC	12/05/2025	LSC	12/05/2025
ID Prefix M0393	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:43F-6.1(b)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/05/2025	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 10/8/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
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