New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65C003	A. BUILDING: _____ B. WING _____	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE PARK SPECIAL CARE CENT	1400 ROUTE 70 LAKEWOOD, NJ 08701

(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	Initial Comments Initial Comments: Type of Survey: Standard Census: 18 on 4/2 and 4/3/25 Sample Size: 8 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.	A 000		
A 310	8:36-3.4(a)(1) Administration (a) The administrator or designee 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;	A 310		

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

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A 310	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility Administrator failed to ensure that the facility followed its policy on monitoring resident weight changes; and failed to develop, and implement the policy and procedure for Certified Medication Aide training and medication review and oversight by a Registered Nurse for 1 of 8 residents reviewed, Resident #8. This deficient practice was evidenced by the following: 1. On 4/2/25 at 2:30 p.m., the surveyor requested the Registered Nurse/Certified Medication Aide (RN/CMA) oversight training, and medication review records from the Executive Director (ED). In addition, the surveyor requested the facility policy and procedure for RN/CMA training and medication review/oversight. The ED stated that the staff had online training but was unable to provide the surveyor with documentation of RN/CMA training, and medication review/oversight records. Further, the ED stated that there was no policy and procedure for RN/CMA oversight and training. 2. On 4/3/25 at 10:19 a.m., the surveyor reviewed Resident #8's medical record (MR) which revealed that Resident #8 moved into the facility in [redacted] *NJ Ex Order 26. 4B1* The surveyor reviewed Resident #8's [redacted] NJ Exec Order 26.4 which were as follows:	A 310		

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A 310	Continued From page 2 *NJ Ex Order 26. 4B1* [redacted] The surveyor observed a discrepancy of [redacted] from NJ Exec Order 26.4b1. Further review of the weights revealed that Resident #8's [redacted] was documented as [redacted] on [redacted] which reflected a *NJ Ex Order 26. 4B1*., when compared to the [redacted] documented in [redacted] Further review of the MR revealed that there was no documentation to reflect that Resident #8's [redacted] was rechecked for accuracy, or that the Registered Nurse (RN) or Physician were notified. At 1:09 p.m., the surveyor interviewed the Assistant Director of Nursing (ADON) and inquired about the process for resident [redacted] She explained that the resident [redacted] were taken by the Nurses Aides or Nurse, and that the Nurse entered the [redacted] into the computer. The ADON further explained that if there was a NJ Exec Order 26.4b1 in a resident's [redacted] the Physician would be notified. The surveyor asked if a [redacted] visited the facility and reviewed the resident's [redacted] and the ADON stated that she was not sure when the [redacted] visited. At 2:00 p.m., the surveyor interviewed a CMA, who identified herself as the Memory Care Coordinator (MCC). The MCC stated that if a resident had a [redacted] she would notify the Director of Health and Wellness (DHW), but since the DHW was no longer employed at the facility, the staff now reported changes to the Executive Director (ED), or the Licensed Practical Nurse (LPN) in charge. The MCC stated that she was not aware of a *NJ Ex Order 26. 4B1* for Resident #8.	A 310		

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A 310	Continued From page 3 The surveyor reviewed a facility policy dated 9/1/23, titled, "Monitoring Resident Weight Changes" which indicated the following: "I. Policy Statement This policy provides guidelines for monitoring significant resident weight changes. IV. Provision(s) and Procedure(s) D. If the weight shows an undesirable loss/gain of five (5) pounds or 5% in one month, 7.5% in 3 months, ...from the prior weight recorded, another weight will be obtained and recorded within 24 hours. E. The resident and/or the resident's responsible party and the physician/healthcare provider is notified of any significant weight loss/gain. F. Significant weight loss/gain is addressed by updating the service plan and documenting in the resident's medical record. Refer to A1433, 8:36 - 22.2	A 310		
A 887	8:36-10.4(a)(1) Dining Services (a) If indicated, according to residents' needs, a dietitian shall be responsible for providing resident care, including, but not limited to, the following: 1. Assessing the nutritional needs of the resident. If indicated, preparing the dietary portion of the health care plan on the basis of the assessment, providing dietary services to the resident as specified in the dietary portion of the health plan, reassessing the resident, and revising the dietary portion of the health care plan. Each of these activities shall be documented in the resident's record;	A 887		

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A 887	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to consult a dietician to assess a resident's [NJ Exec Order 26.4b1] needs who had sustained a [NJ Ex Order 26. 4B1] for 1 of 8 residents reviewed, Resident #8. This deficient practice was evidenced by the following: On 4/3/25 at 10:19 a.m., the surveyor reviewed Resident #8's medical record (MR) which revealed that Resident #8 moved into the facility [NJ Ex Order 26. 4B1] . The surveyor reviewed Resident #8's [NJ Exec Order 26.4] which were as follows: [NJ Ex Order 26. 4B1] The surveyor observed a discrepancy of [NJ Ex Ord] [NJ Exec Order 26.] from [NJ Exec Order 26.4b1]. Further review of the [NJ Exec Order 26.4] revealed that Resident #8's [NJ Exec Order 2] was documented as [NJ Ex Order 2] on [NJ Exec Order 26.], which reflected a [NJ Ex Order 26. 4B1]., when compared to the [NJ Exec Order 26.4] documented in [NJ Exec Order 26.4b1] Further review of the MR revealed that there was no documentation to reflect that Resident #8's [NJ Exec Order 2] was rechecked for accuracy, or that the Registered Nurse (RN) or Physician or responsible party were notified. At 1:09 p.m., the surveyor interviewed the Assistant Director of Nursing (ADON) and inquired whether a [NJ Exec Order 26.4b] visited the facility to consult and/or review weights, and she stated that she was not sure when the [NJ Exec Order 26.4b] visited the facility last.	A 887		

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A 887	Continued From page 5 Further review of Resident #8's MR revealed no documentation to reflect that Resident #8 was seen by a [NJ Exec Order 26.4b] since admission to the facility. At 1:51 p.m. the surveyor interviewed that Food Service Director (FSD) who stated that the [NJ Exec Order 26.4b] used to visit regularly every [NJ Ex Order 26. 4B] and that the [NJ Exec Order 26.4b] would leave a written report with recommendations. The FSD further stated that since the new consulting company took over, he had not seen a [NJ Exec Order 26.4b] in the facility. When the surveyor inquired approximately how long that may have been, the FSD stated that he has not seen a [NJ Exec Order 26.4b] since end of [NJ Ex Order 26. 4B]. The surveyor reviewed a facility policy dated 9/1/2018, titled, Use of Consultant Dieticians", which revealed the following: ...III. Policy Guidelines A. The Executive Director/Administrator is responsible for retaining Consultant Dieticians as needed. E. The Consultant Dietician's schedule of visits to the community is sufficient to provide dietary consultation as determined by the state requirements... IV. Provisions and Procedures A. The Consultant Dietician prepares a list of recommendations at each visit and discusses these with the Director and, if appropriate, other community leadership. The Consultant Dietician prepares a report at each visit that outlines the Dietary Consultant's activities, findings, new recommendations, and progress toward previous recommendations and discusses the same with the Director....B. The Executive Director retains the Consultant Dietician's reports."	A 887		
A 891	8:36-10.5(a) Dining Services	A 891		

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A 891	Continued From page 6 (a) The facility and personnel shall comply with the provisions of N.J.A.C. 8:24, Retail Food Establishments and Food and Beverage Vending Machines Chapter XII of the New Jersey Sanitary Code. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to comply with the provisions of Chapter 24, N.J.A.C. 8:24. "Sanitation in Retail Food Establishments and Food and Beverage Vending Machines," which placed all 18 residents at risk for foodborne illnesses. This deficient practice was evidenced by the following: On 4/2/25 at 9:54 a.m., the surveyor toured Kitchen #1 and observed the following: 1. One open and undated quart of [NJ Exec Order 26.4b] s Half and Half 2. One open and undated 46 fl. oz. bottle of [NJ Exe] Low Sodium Vegetable Juice 3. One open and undated 64 fl. oz. carton of [NJ Exec O] Almond Milk At that time, the surveyor also observed a three-gallon tub of [NJ Exec Order 26.4b1] Butter Pecan Ice Cream in a freezer without a lid, with another three-gallon tub of ice cream that was placed on top of the uncovered tub.	A 891		

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A 891	Continued From page 7 At 10:23 a.m., the survey toured the dry storage area in Kitchen #1 and observed the following: 1. Seven undated and unopened 31 oz. loaves of [redacted] White Bread 2. Ten undated and unopened 40 oz. loaves of [redacted] #3 Sandwich Rye Bread 3. Three undated and unopened 31 oz. loaves of [redacted] Whole Wheat Bread 4. Twelve undated and unopened 22 oz. loaves of [redacted] Cinnamon Raisin Bread All of the previously mentioned bread was undated by both the bread company and the facility. During the surveyor's tour of Kitchen #1, the Food Service Director (FSD) entered the dry storage area, and the surveyor interviewed him to inquire the reason the bread was not labeled or dated. The FSD stated that the facility received a delivery of fresh bread every other day and that the bread should have been labeled. In addition, the FSD stated that Kitchen #1 cooked breakfast and dinner for independent living and memory care. The surveyor continued the tour of the dry storage area in Kitchen #1 and observed the following: 1. Three undated 5.2 oz. packages of Traditional Stuffing Mix Seasoning Packets 2. One open and undated 28 oz. package of [redacted] Gyro Bread 3. One unopened, unlabeled, and undated bag of what appeared to be quinoa 4. One open and undated 2 lb. 10 oz. container of [redacted] Quick 1-minute Oats	A 891		

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A 891	Continued From page 8 5. One open, unwrapped, and undated 1 lb. 12 oz. box of [NJ Exec Order 26.4b1] Creamy Wheat Enriched Farina 6. Three unlabeled and undated wrapped packages of [NJ Exec Order] Spaghetti Noodles 7. One open and undated 2 lb. bag of [NJ Exec Order] Classic Almonds Sliced 8. One open, unsealed, and undated 2 lb. bag of [NJ Exec Order] Classic Almonds Sliced 9. One open and undated 2 lb. bag of [NJ Exec Order] Confectioners Sugar 10. One open and undated 1 qt. 1.81 oz. bottle of [NJ Exec Order 26.4b1] Sesame Seed Oil At 11:14 a.m., the surveyor observed a 6-door refrigerator in Kitchen #1 and observed the following: 1. One open and undated gallon of [NJ Exec Order 26.4b] Worcestershire Sauce 2. One open and undated gallon of [NJ Exec Order 26.4b1] BBQ Sauce 3. One open and undated 1 qt. 1.81 oz. bottle of [NJ Exec Order 26.4b1] Sesame Seed Oil 4. Two open and undated 7 lb. 6 oz. containers of [NJ Exec Order 26.4b1] Sliced Strawberry Topping 5. One open gallon of [NJ Exec Order 26.4b1] Sesame Dressing dated opened on 1/3/24 with an expiration date of 10/14/24 6. Two open and undated one-gallon of [NJ Exec Orde] with Feta Cheese and Black Olives Vinaigrette 7. Seven open and undated one-gallon tubs of [NJ Exec Orde] dressing (one Blue Cheese, two Italian, two Thousand Island, one Balsamic, and one Ranch) 7. One opened 4.5 lb. container of [NJ Exec Order 26.4b1] Maraschino Cherries with Stem dated opened on 11/6/24 with no visible expiration date 8. One open and undated gallon of [NJ Exec Or] Mayo 9. One open and undated 8 lb. container of	A 891		

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A 891	Continued From page 9 [redacted] Mustard 10. One open gallon of [redacted] Pickles Hot Banana Pepper Rings dated opened on 12/18/23 with no visible expiration date 11. Apple Slices wrapped with a label that indicated the apples expired on 2/23/25 At 11:35 a.m., the surveyor walked with the FSD through Kitchen #1 and pointed out all the previously mentioned concerns. At that time, the FSD started to fill a cart with expired and open items to discard. At 10:17 a.m., the surveyor observed a manual can opener attached to a tabletop that was corroded with a reddish-brown substance. At 11:49 a.m., the surveyor showed the FSD the corroded manual can opener and inquired how often the can opener was cleaned. The FSD stated that the can opener was cleaned once a week. At 11:52 a.m., during continued tour of Kitchen #1, the surveyor observed Kitchen Aide (KA) #1 with no hair restraint, KA #2 with her ponytail hanging out of her hairnet, and the FSD without a hair restraint. The surveyor interviewed KA #1 to inquire the reason he did not have a hair restraint on, and the KA stated that he forgot to re-apply the hair net after his lunch break. The surveyor asked KA #2 to place her ponytail into her hair net. At 11:58 a.m., the FSD followed the surveyor into Kitchen #2, and the surveyor asked the FSD to apply a hair restraint. The FSD then asked the surveyor if staff in Kitchen #1 had to wear hair nets even if they served independent living. The surveyor explained that Kitchen #1 also served	A 891		

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A 891	Continued From page 10	A 891		

memory care residents and that hair restraints should be worn.

At 12:06 p.m., the surveyor asked the FSD to run the dishwasher in Kitchen #2. The temperature gauge for the wash cycle did not move and stayed at 140 degrees Fahrenheit (F) and the rinse cycle reached a temperature of 180 degrees F. The surveyor observed the dishwasher's manufacturer requirements on the side of the dishwasher, which indicated that the minimum wash temperature should be 155, and the minimum rinse temperature should be 180. The FSD ran the dishwasher three times, and each time the temperature gauge for the wash cycle did not move. The FSD called a vendor to service the dishwasher.

On 4/3/25 at 10:16 a.m., the surveyor checked the dishwasher in Kitchen #2 again. The wash cycle temperature was 120 degrees F, and the rinse cycle temperature was 192 degrees F.

At 12:18 p.m., the FSD introduced the surveyor to the vendor who serviced the dishwasher in Kitchen #2. The vendor stated that the wash cycle sensor on the dishwasher was not supposed to move. The surveyor explained that the wash cycle temperature gauge should move like the rinse cycle gauge to indicate the temperature of the wash cycle. The vendor stated that he serviced dishwashers for many years and that the wash cycle sensor should not move.

The surveyor reviewed a October 2022 policy titled, "5.4 Food Expiration & Rotation," provided by the FSD, which indicated that, "Standard [:] Foods that have expired must be discarded and not used or served ... Must do [:] Discard any foods that are past expiration, those that do not

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A 891	Continued From page 11 have a date, or have an illegible date ... Monitor foods in storage, display and in preparation to ensure only non-expired foods are being used ... Methods to ensure First In, First Out Rotation...Mark the date received on each product prior to storage ..." The surveyor reviewed another October 2022 policy titled, 5.3 Dating & Labeling of Food in Production," which indicated that, "Standard [:] All foods, including prepared items, bulk foods, frozen foods, and ingredients present in [the] facility must be labeled at all times ... RTE, TCS [Ready-to-Eat, Time/Temperature Control for Safety] food that was commercially processed, opened by the unit, and held refrigerated for more than 24 hours must be served on the premises, sold, or discarded within 7 days ... Must do [:] Date and label all foods opened or prepared in-house according to the standard ..." In addition, the surveyor reviewed a October 2022 policy titled, "6.6 Maintaining Sanitary Condition," which indicated that, "Standard [:} Equipment food-contact surfaces and utensils must be clean to sight and touch ... Must Do [:] Monitor facility, equipment, and other surfaces daily to ensure they are maintained in a clean condition ..." Lastly, the surveyor reviewed a October 2022 policy titled, "2.4 Uniforms," which indicated that, "Standard [:] All food handlers (including those who are bald) must wear hair restraints such as hats, hair coverings or nets, beard/mustache restraints, and clothing that covers body hair ..."	A 891		
A1097	8:36-16.6 Physical Plant All facilities shall be provided with a fire	A1097		

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A1097	Continued From page 12 suppression system in accordance with the Uniform Construction Code, N.J.A.C. 5:23. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to install sprinkler heads in 6 closets. This deficient practice was evidenced by the following: On 4/2/25 at 11:30 a.m., in the presence of the facility Director of Maintenance (DOM), the surveyor inspected rooms *NJ Ex Order 26. 4B1* [redacted] and observed that the rooms had no sprinklers in the closets. The surveyor interviewed the DOM who acknowledged that the closets did not have sprinkler heads and stated that the closets were newly built during their renovation.	A1097		
A1225	8:36-17.3(b)(8)(i-ii) Housekeeping-Sanitation-Safety-Maintenance (b) The following safety conditions shall be met: 8. An electrician licensed in accordance with N.J.A.C. 13:31 shall annually inspect and provide a written statement that the electrical	A1225		

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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
A1225	Continued From page 13 circuits and wiring in the facility are satisfactory and in safe condition; i. The written statement shall include the date of inspection, and shall indicate that circuits are not overloaded, that all wiring and permanent fixtures are in safe condition, and that all portable electrical appliances, including lamps, are Underwriters Laboratories (U.L.) approved; and ii. The written statement shall be available for review by the Department during survey. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to provide an electrical inspection report. This deficient practice was evidenced by the following: On 4/2/25 at 11:54 a.m., during review of the facility documentation provided by the Director of Maintenance (DOM), the surveyor observed that the documentation did not include the electrical inspection report for 2024. The surveyor interviewed the DOM regarding the electrical inspection report for 2024. The DOM stated that the electrical inspection was not done and explained that he thought it was supposed to be done every two years, and not annually.	A1225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65C003	A. BUILDING: _____ B. WING _____	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE PARK SPECIAL CARE CENT	1400 ROUTE 70 LAKEWOOD, NJ 08701

(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
A1249	Continued From page 14	A1249		
A1249	8:36-17.7 Housekeeping-Sanitation-Safety-Maintenance The building and grounds shall be well maintained at all times. The interior and exterior of the building shall be kept in good condition to ensure an attractive appearance, provide a pleasant atmosphere, and safeguard against deterioration. The building and grounds shall be kept free from fire hazards and other hazards to resident's health and safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain smoke barrier doors. This deficient practice was evidenced by the following: On 3/2/25 at 11 a.m., in the presence of the facility Director of Maintenance (DOM), the surveyor tested the smoke barrier double doors by the laundry room and observed that the smoke double doors did not close and latch. The surveyor interviewed the DOM who acknowledged that the smoke barrier doors should have closed and latched.	A1249		
A1433	8:36-22.2 Comprehensive Personal Care Homes Each comprehensive personal care home shall comply with the following: N.J.A.C. 8:36-1	A1433		

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	65C003	A. BUILDING: _____ B. WING _____	04/03/2025

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LEISURE PARK SPECIAL CARE CENT	1400 ROUTE 70 LAKEWOOD, NJ 08701

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A1433	Continued From page 15 through 15, 16.8(c), 16.15, 16.16, 17 (except 17.5(a)4), and 18 through 22.Each comprehensive personal care home shall comply with the following: N.J.A.C. 8:36-1 through 15, 16.8(c), 16.15, 16.16, 17 (except 17.5(a)4), and 18 through 22. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to comply with all standards of practice according to "N.J.A.C. 8:36 Standards for Licensure of Assisted Living Residences to ensure resident care, medication administration, and assessments, and physician certifications were implemented and overseen by a Registered Nurse (RN) for 7 of 8 residents reviewed, Resident #'s 2, 3, 4, 5, 6, 7, and 8. This deficient practice was evidenced by the following: 1. On 4/2/25 at 9:27 a.m., the surveyor interviewed the Executive Director (ED) regarding who was the Director of Health and Wellness (DHW/RN) at the facility. The ED stated that she worked at the facility for [redacted] and that the RN was [redacted]. In addition, the ED stated that the DHW from a sister facility assisted with completing assessments. The ED stated that she believed the Regional RN oversaw the LPN's. At 12:14 p.m., the surveyor interviewed a Certified Medication Aide (CMA) who was the Memory Care Coordinator regarding RN oversight. The CMA stated that the RN was no longer employed at the facility. In addition, the CMA stated that she notified the LPN in charge or the wellness office at another sister facility if there	A1433		

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A1433	Continued From page 16 was a concern with resident care or medications. At 12:50 p.m., the surveyor interviewed the Regional RN (RRN) regarding who oversaw resident care at the facility. The RRN stated that the DHW was NJ Ex Order 26. 4B1, and a Clinical RN Specialist (CRNS) oversaw the facility. In addition, the RRN stated that the CRNS was absent on day of survey NJ Ex Order 26. and was unsure of the date of her return. The RRN explained that she covered NJ Ex Order 26. 4B1 as the RN and today NJ Ex Order 26. she filled in for the CRNS. At 2:30 p.m., the surveyor requested CMA training and medication review records from the ED. The ED provided the surveyor with pharmacy audits and review but was unable to provide the surveyor with CMA documentation of RN training and medication review records. In addition, the surveyor requested the CMA delegation oversight and training policy and procedure from the ED. The ED stated that the facility did not have a policy for CMA oversight and training policy. At 2:35 p.m., the surveyor interviewed the RRN regarding the CMA training and medication review oversight. The RRN stated that the prior DHW would have been overseeing medication administration and training. In addition, the RRN stated that she was unable to locate the binder for CMA training and medication review oversight. On 4/3/25 at 9:22 a.m., the surveyor interviewed the ED regarding RN coverage at the facility. The ED stated that the RRN was absent, and the CRNS was on vacation. In addition, the ED stated that the DHW from a sister facility was covering in there absence.	A1433		

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A1433	Continued From page 17 At 1:13 p.m., the surveyor interviewed the Assistant Director of Health/Wellness, who was also an LPN (ADHW/LPN), regarding RN oversight at the facility. The LPN stated that she was ADHW for the Comprehensive Personal Care Homes and Assisted Living. In addition, the LPN stated that the CRNS was unknown to her and that she never saw the CRNS at the facility. At 1:19 p.m., the surveyor reviewed the facility list of employees which revealed that there was no RN listed or employed to cover the facility. 2. On 4/3/25 at 10:15 a.m., the surveyor reviewed the medical record (MR) of Resident #2, which revealed the resident moved [redacted] In addition, the surveyor reviewed the "Resident Level of Care Admission/Move-In evaluation" assessment dated [redacted], which revealed an LPN signed and dated the assessment. At 10:45 a.m., the surveyor reviewed the MR of Resident #3 which revealed that the resident moved [redacted]. In addition, the surveyor reviewed the resident's initial assessment dated [redacted] and observed that the assessment was signed and completed by a LPN. The surveyor also observed in the MR that the resident's annual '[redacted]" and "Medical Certification (MC- physician signature approving that the resident is appropriate for stay at the facility)" was [redacted] overdue and dated [redacted] At 11:30 a.m., the surveyor reviewed the MR of Resident #5 and observed that the resident's [redacted] was dated [redacted] which was [redacted]	A1433		

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A1433	Continued From page 18 [redacted] overdue. At 12:00 p.m., the surveyor reviewed the MR of Resident #6 that revealed the resident moved into [redacted]. According to the residents "MC" dated [redacted] the resident was approved for continuous skilled nursing care and not for the [redacted] Home. At 12:15 p.m., the surveyor notified the ED that the resident [redacted] and MC's were overdue, and Resident #6's MC was not applicable to reside in the [redacted]. The ED stated that Resident #6's MC must have been incorrectly documented for continuous skilled nursing care by the physician. At 12:58 p.m., the surveyor interviewed the DHW who worked at a sister facility regarding her duties. The DHW stated that she was an LPN who assisted the facility with completing resident [redacted] assessments and [redacted] plans in the absence of the RN. The DHW/LPN continued to explain that she also approved resident admissions. At 3:00 p.m., the surveyor reviewed the "Essential Duties" for the position of LPN that revealed ".Essential Duties: Perform nursing assessments, including vital signs monitoring, physical examinations, and health status evaluations, to identify and address resident needs promptly. ...document all nursing assessments, interventions, and resident responses. ..." 3. On 4/3/25 at 10:00 a.m., the surveyor reviewed Resident #4's MR which revealed that the resident moved [redacted]	A1433		

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A1433	Continued From page 19 [redacted]. Further review of the MR revealed a "[redacted]" assessment that was dated [redacted] and signed by a LPN. The surveyor also reviewed a [redacted] for Resident #4, dated [redacted] prior to the resident's admission. Further review of the [redacted] revealed that within the MC portion of the [redacted], there was no indication of documentation that reflected the resident was appropriate for an [redacted] community. At 11:01 a.m., the surveyor reviewed Resident #7's MR which revealed that the resident moved [redacted]. In addition, the surveyor reviewed the "[redacted]" assessment dated [redacted], which was also signed by a LPN. At 11:19 a.m., the surveyor reviewed Resident #8's MR which revealed that Resident #8 moved [redacted]. The surveyor also reviewed the "[redacted]" assessment of Resident #8, dated [redacted], which was signed by a LPN. In addition, the surveyor reviewed the H&P for Resident #8 that was dated [redacted], prior to the resident's admission. The surveyor observed that within the MC portion of the [redacted], next to the question, "Is your patient appropriate for an assisted living community?", the medical provider indicated "[redacted]". At 12:58 p.m., the surveyor interviewed a LPN	A1433		

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A1433	Continued From page 20 who identified herself as a DHW who worked at a sister facility. The DHW stated that in the absence of the facility RN she came to the facility to assist with evaluations and assessments at the facility. At 4:00 p.m., the surveyor requested a removal plan from the ED regarding no RN oversight of staff, resident care/assessments, and CMA medication training/review and review at the facility from 2/28/25 through 4/3/25. On 4/4/25 at 12:08 p.m., the surveyor interviewed the CRNS regarding oversight of resident care, CMA medication training/review, and assessments. The CRNS stated that [NJ Exec Order] was her [NJ Ex Order 26, 481] of coverage at the facility as the RN. The surveyor reviewed the facility policy and procedure titled, "Resident Assessment and Re-Assessment Process" that revealed "...All new and existing residents are assessed or re-assessed in accordance with state laws and regulations ..." In addition, the surveyor reviewed the "Certified Caregiver" job description that revealed "...Responsible for assisting with or administering medications under the supervision of registered ...nurses, per state regulations. The surveyor also reviewed the facility policy and procedure titled, "Medication Management Guidelines" that revealed "..Delegation of ...Medication Administration to other qualified personnel is done in accordance with specific state laws and regulations. ..." The surveyor reviewed the facility policy and procedure titled, "Resident Admission Policy" that	A1433		

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A1433	Continued From page 21 revealed "...The Community admits only those persons whose care and physical needs can be met. ...The community does admit residents likely to have a serious mental illness or a developmental disability unless the ...designee has evaluated the individual and determined that the individual needs skilled nursing care or specialized services. ..." On 4/21/25 the facility submitted an acceptable removal plan that included RN oversight of staff, resident care, assessments, and CMA training and medication review, along with correction of resident medical certifications. Reference: N.J.A.C. 8:36 Standards for Licensure of Assisted Living Residences... A0945, 8:36-11.5(b)(5), A0793, 8:36-8.2, A0745, 8:36- 7.2(f), A0783, 8:36-7.5(e), A0471, 8:36-5.1(f), A0310, 8:36-3.4(a)(1), A0703, 8:36-7.2(a).	A1433		
A1443	8:36-22.3(a)(5) Comprehensive Personal Care Homes (a) Each comprehensive personal care home shall, at a minimum: 5. Provide corridor widths of at least 36 inches of clear space. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain the minimum emergency exit corridor width. This deficient practice was evidenced by the following:	A1443		

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A1443	Continued From page 22 On 4/2/25 at 11:15 a.m., in the presence of the facility Director of Maintenance (DOM), the surveyor observed and measured the width of space between the emergency exit access door and the outdoor egress stair railing. The surveyor measured the space, and it was 16 inches instead of the required 36 inches. The surveyor observed another emergency exit door opening to the same location, causing egress from the *NJ Ex Order 26. 4B1* unit to be obstructed if both doors were to be used at the same time. The surveyor interviewed the DOM regarding above concerns. The DOM stated that he was unaware of the above issues and will have the issues resolved.	A1443		

Rcd & accepted 8/1/25

NJ Ex Order 26. 4B1

POC #4

LEISURE PARK

FIVE STAR SENIOR LIVING

State of New Jersey
Department of Health
PO Box 367
Trenton, N.J. 08625

Updated Plan of Correction Survey: 8/1/2025

Regulation 8:36-3.4(a)(1):

1. There were no residents negatively affected by this deficient practice. On 4/7/2025 the NJ Exec Order 26.4b1 created a policy for RN Delegation was put into place on 5/1/2025. RN Delegating Nurse trained current Certified Medication Aides (CMAs) on this policy and completed each of their competencies on 5/1/2025. **Regarding** resident #8, since having a documented NJ Ex Order 26. 4B1, he/she was seen by a certified registered nurse practitioner from his/her primary care physician's office on NJ Ex Order 26. 4B1 with both notes documented in PCC immediately following those visits. Both notes were reviewed and signed off by his/her primary care physician. Resident 8 wa NJ Exec Order 26.4b1 and he/she NJ Exec Order 26.4b1 NJ Ex Or NJ Exec Order 26.4 Maintenance Director checked the NJ Exec Order 2 on 4/4/25 and the NJ Exec Orde was not properly calibrated. Two new scales were ordered and they arrived on 4/14/25. RN assessed resident 8 on NJ Exec Order 26.4b nd there were NJ Exe NJ Exec Order 26.4b1 to address at that time. Resident 8 was NJ Exec Order 26.4b1 and Residents NJ Exec Order 26.4b1 as NJ Ex Or. RN reviewed NJ Exec Order 26.4b with his/her primary care physician along with his/her current status and no new orders were provided.
2. All residents have the potential to be negatively affected by this deficient practice.
3. All newly hired CMAs were trained starting 4/15/2025 during orientation by the Director of Health & Wellness (DHW) . The training will be documented along with the competencies as listed in the policy. Ongoing competencies for current CMAs will also be completed and documented as listed in the policy. All caregivers, CMAs and LPNs were retrained on the Monitoring Resident Weight Changes policy by the DHW.
4. The DHW or RN designee will audit the CMA training binder to ensure current CMAs are up to date with their competencies weekly for 4 weeks then biweekly for 4 weeks then monthly for 1 month to ensure compliance with this regulation. DHW or RN designee will audit 3 residents' weights weekly for 4 weeks then biweekly for 4 weeks then monthly for 1 month to ensure policy is being followed and compliance with this regulation.
5. Completion Date 7/20/2025

Regulation 8:36-10.4(a)(1)

1. There were no residents negatively affected by this deficient practice. Regarding resident #8's documented [redacted] he/she was seen by a certified registered nurse practitioner from his/her primary care physician's office on [redacted] with both notes documented in PCC immediately following those visits. Both notes reviewed and signed off by his/her primary care physician. Resident #8 was [redacted] at which time he/she had documented [redacted] Maintenance Director checked the [redacted] was not properly calibrated. Two new scales ordered which arrived on 4/14/25. RN assessed resident #8 on [redacted] at which time [redacted] were identified. Resident #8 was [redacted] on [redacted] RN reviewed [redacted] with his/her primary care physician along with his/her current status and no new orders were provided. Registered [redacted] reviews all [redacted] on a monthly basis and provides a written report with [redacted] recommendations for any resident identified as having an [redacted] also provides one on one resident counseling for [redacted] changes.
2. All residents have the potential to be negatively affected by this deficient practice.
3. All Care staff will be trained on the Monitoring Weight changes policy. All current caregivers, CMAs, LPNs/RNs will be retrained on the Monitoring Weight Changes policy by 6/15/2025.
4. The DHW, ADHW or RN designee will audit the Nursing training binder to ensure current Care staff are up to date with their competencies weekly for 4 weeks then biweekly for 4 weeks then monthly for 1 month to ensure compliance with this regulation. DHW, RDHW or RN designee will audit 3 resident's weights weekly for 4 weeks then biweekly for 4 weeks then monthly for 1 month to ensure policy is being followed and compliance with this regulation.
5. Completion date 7/20/2025

accepted 8/1/25

Regulation 8:36-10.5(a)

1. All opened, unlabeled, undated, unsealed, unwrapped and expired food was discarded on 4/2/2025. Can opener was discarded on 4/2/2025. New can opener was ordered on 4/2/2025 and was received 4/6/2025.Cleaning schedule for can opener was implemented 4/2/2025 which is after every use and at the end of day. The staff was in serviced on 4/8/2025 on proper use of hair nets and the cleaning schedule for the can opener. The Food Service Director, Executive Chef and Dining room Supervisor will monitor the dishwasher temps 3 times a day. Diversey was called 4/2/2025 and the thermometer was repaired on 4/3/2025.

2. All Residents have the potential to be negatively affected by this deficient practice.

3. All kitchen staff and newly hired staff shall be trained in accordance with policy 5.4 Food Expiration & rotation policy, 5.3 Dating & Labeling of Food in Production Policy, 6.6 Maintaining Sanitary Condition Policy and 2.4 Uniform policy by the Executive Chef. In-service's were completed on all these policies on 4/10/2025 by the FSD and Executive Chef with all dining staff which were documented. Daymark temperature stickers were purchased through Compass to adhere to cookware as an extra precaution with dish washer temperature. Plastic lids were purchased as an extra precaution for all ice cream lids on 4/10/2025 and received on 4/15/2025. The FSD or designee will do daily and weekly checks to ensure all food and condiments are labeled and dated correctly, this will continue to ensure all labeling and dating are done per Policy and Procedure. Diversey (Maintenance Company) will do Monthly routine maintenance to make sure dishwashers running properly. All food will be checked daily for any expiration dates by the Food Service Director and Executive Chef.

4. Executive Chef or designee will monitor weekly and Monthly checks to ensure plan of correction is being followed and to ensure there are no reoccurrences of deficient practices. Executive Chef will also do random checks for hairnet compliance.

8/1/25 accepted.

5. Completion 7/20/2025

Regulation 8:36-17.3(b)(8)(i-ii) Physical Plant

1. There were no Residents negatively affected by this deficient practice. The Facilities Director immediately notified [NJ Exec Order 26.4b1] of the missed yearly inspection on 4/3/2025.

2. All Residents have the potential to be impacted by this deficient practice.

3. The Facilities Director had the 2025 Yearly Electrical Inspection done on 4/11/2025 and has planned for Inspection to be done yearly, an email reminder will be sent to the Facilities Director with the date they will be doing the yearly inspection. The Facilities Director has an online (maintenance check) system [NJ Exec Order 26] that has a checklist of tasks that need to be completed by him and is reviewed by the ED and his regional facility director in order to ensure compliance.

4. This will be completed yearly.
5. Completion Date 4/11/2026

8/1/25 accepted.

Regulation 8:36-17.7 Housekeeping-Sanitation-Safety-Maintenance

1. There were no Residents negatively affected by this deficient practice .On 4/2/2025 during the DOH site visit in the presence of the Facilities Director, the surveyor tested the smoke barrier double doors by the laundry room in Memory Care and observed the smoke double doors did not close and latch.
2. All Residents have the potential to be impacted by this deficient practice.

3. The Facility Director repaired door latch and doors are fully functional as of 4/10/2025, doors were Tested with the Fire Alarm to ensure they are working correctly.

4. Facilities Director and Maintenance Team will monitor all fire doors weekly
5. Completion date 4/10/2025

accepted 8/11/25

Regulation 8:36-22.2:

1. There were no residents negatively affected by this deficient practice. There were no residents negatively affected by this deficient practice. On 4/7/2025 the [NJ Exec Order 26.4b] created a policy for RN Delegation was put into place on 5/1/2025. RN Delegating Nurse trained current Certified Medication Aides (CMAs) on this policy and completed each of their competencies on 5/1/2025 . Regional Clinical Specialist (who is an RN licensed in the state of New Jersey) was in the community from 4/4/25 through 5/2/25 providing RN oversight. Community contracted with an agency RN licensed in the state of New Jersey to cover as the interim Director of Health & Wellness as of 5/1/25. That RN is still in place and will remain in place until [NJ Ex Order 26. 4B1] A permanent DHW who is an RN licensed in the state of New Jersey has been hired and will start on [NJ Ex Order 26. 4B1]. These RNs have been and will continue to provide delegation and oversight of Certified Medication Aides, medication review and training as well as completing resident assessments. At the time of the survey, the LPN/DHW who was assisting from another New Jersey community was informed she could no longer complete [NJ Ex Order 26. 4B1] assessments. After being made aware of the [NJ Ex Order 26. 4B1] evaluation for resident #2 which is dated [NJ Exec Order 26.4b1] being signed by an LPN, the evaluation was reviewed and signed by the Clinical RN Specialist (CRNS). Resident #2 also had a [NJ Ex Order 26. 4B1] evaluation which was completed on [NJ Exec Order 26.4b1] reviewed and signed by the CRNS. After being made aware of the [NJ Ex Order 26. 4B1] evaluation for resident #3 which is dated [NJ Exec Order 26] being signed by an LPN, the evaluation was reviewed and signed by the Clinical RN Specialist (CRNS). Resident #3 also had a [NJ Ex Order 26. 4B1] evaluation which was completed on [NJ Exec Order 26.4b1] reviewed and signed by the CRNS. Resident #5 was evaluated in the community and had a [NJ Exec Order 26.4b1] completed by a certified registered nurse practitioner (CRNP) from his/her primary care physician's (PCPs) office on [NJ Ex Order 26. 4B1] CRNP reviewed data with resident #5's PCP. PCP agreed with [NJ Exec Order 26.4b1] exam and plan as documented by CRNP. Resident #6 was evaluated in the community and had a [NJ Exec Order 26.4b1] completed by his/her PCP on [NJ Ex Order 26. 4] His/her PCP documented he/she does [NJ Exec Order 26.4b1] continuous skilled nursing care and he/she is [NJ Exec Order 26.4b1] to reside in a secured [NJ Ex Order 26. 4B1] unit in an assisted living community. After being made aware of the [NJ Ex Order 26. 4B1] evaluation for resident #4 which is dated [NJ Exec Order 26.4b1] being signed by an LPN, the evaluation was reviewed and signed by the Clinical RN Specialist (CRNS). Resident #4 also had another [NJ Ex Order 26. 4B1] evaluation which was completed on [NJ Exec Order 26.] reviewed and signed by the CRNS. Resident #4 was evaluated in the community and had a [NJ Exec Order 26.4b1] completed by a certified registered nurse practitioner (CRNP) from his/her primary care physician's (PCPs) office on [NJ Ex Order 26. 4B1] CRNP reviewed data with resident #4's PCP. PCP agreed with [NJ Exec Order 26.4b1] exam and plan as documented by CRNP. After being made aware of the [NJ Ex Order 26. 4B1] evaluation for resident #7 which is

dated 3/26/25 being signed by an LPN, the evaluation was reviewed and signed by the Clinical RN Specialist (CRNS). Resident #7 also had a NJ Ex Order 26. 4B1 evaluation which was completed on NJ Exec Order 26.4b1 reviewed and signed by the CRNS. After being made aware of the NJ Ex Order 26. 4B NJ Ex Order 26. 4B1 evaluation for resident #8 which is dated NJ Exec Order 26.4 being signed by an LPN, the evaluation was reviewed and signed by the Clinical RN Specialist (CRNS). Resident #8 was evaluated in the community and had a NJ Exec Order 26.4b1 completed by a certified registered nurse practitioner (CRNP) from his/her primary care physician's (PCPs) office on NJ Ex Order 26. 4B1. CRNP reviewed data with resident #8's PCP. PCP agreed with NJ Exec Order 26.4b1 and plan as documented by CRNP which stated the Resident was NJ Exec Order 26.4b1 for Assisted Living.

2. All residents have the potential to be negatively affected by this deficient practice.
3. On 5/1/25, RN designee was trained by the Regional RN (RRN) on the requirements within this regulation. New DHW who is starting on NJ Ex Order 26. 4B1 will be trained on the requirements of this regulation during day one onboarding. Moving forward, all resident care, medication administration, assessments, and physician certifications will be implemented and overseen by an RN to ensure compliance with this regulation.
4. The DHW or RN designee will audit 3 residents' records, including eMARs, to ensure care, medication administration, assessments, and physician certifications have been implemented and overseen by an RN weekly for 4 weeks then biweekly for 4 weeks then monthly for 1 month to ensure compliance with this regulation.
5. Completion date 7/20/2025

accepted 8/1/25

Regulation 8:36-22.3(a)(5) Comprehensive Personal Care Homes

1. There were no Residents negatively affected by this deficient practice. On 4/2/2025 the surveyor observed and measured the width of space between the emergency exit access door and the outdoor egress stair railing. The measured space was 16 inches instead of the required 36 inches. The surveyor observed another opening to the same location, causing egress from the Memory Care unit to be obstructed if both doors were to be used at the same time.

2. All residents have the potential to be negatively affected by this deficient practice.

3. With regards to the observation the Facility Director has contacted NJ Exec Order 26.4b1 homes on 4/4/2025 to replace the emergency door, have it open to the left and build a staircase with rails to the opposite side for safety clearance. Project will start on 6/19/2025

4. Completion date 7/19/2025

accepted 8/1/25 NJ Ex Order 26. 4B1

Regulation 8:36-16.6 Physical Plant

1. There were no Residents negatively affected by this deficient practice. On 4/2/2025 the surveyor inspected rooms ([redacted]) in [redacted] and observed there were no sprinklers in the closets.

2. All Residents have the potential to be impacted by this deficient practice.

3. The Facilities Director will adhere to the life safety concerns and will open all closets per code for the sprinkler system to function properly with 18" with no obstruction.

4. Faciality Director had 2 contractors come out to give quotes on 4/9/2025 on adding sprinkler heads into the closets. The Facilities Director ordered the material on May 2025 and has begun the work which started on 6/2/2025.Work will be completed by 8/2/2025.

5. Completion date 8/2/2025

[redacted]

NJ Exec Order 26.4b1

Executive Director
Leisure Park Special Care Center
1400 Route 70
Lakewood, N.J. 08701
732-370-0444

accepted 8/1/25

[redacted]

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65C003	A. BUILDING: _____ B. WING _____	R 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE PARK SPECIAL CARE CENT	1400 ROUTE 70 LAKEWOOD, NJ 08701

(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}	Initial Comments Initial Comments: Type of Survey: Standard Census: 18 on 4/2 and 4/3/25 Sample Size: 8 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.	{A 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/13/25

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
65C003 Y1	A. Building B. Wing Y2	4/3/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE PARK SPECIAL CARE CENT	1400 ROUTE 70 LAKEWOOD, NJ 08701

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 A0887	Correction	ID Prefix A0891	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-10.4(a)(1)	Completed	Reg. # 8:36-10.5(a)	Completed
LSC	07/20/2025	LSC	07/20/2025	LSC	07/20/2025
ID Prefix A1097	Correction	ID Prefix A1225	Correction	ID Prefix A1249	Correction
Reg. # 8:36-16.6	Completed	Reg. # 8:36-17.3(b)(8)(i-ii)	Completed	Reg. # 8:36-17.7	Completed
LSC	08/02/2025	LSC	04/11/2025	LSC	04/10/2025
ID Prefix A1433	Correction	ID Prefix A1443	Correction	ID Prefix	Correction
Reg. # 8:36-22.2	Completed	Reg. # 8:36-22.3(a)(5)	Completed	Reg. #	Completed
LSC	07/20/2025	LSC	07/19/2025	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	
4/3/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO