

NC DEPARTMENT OF  
**HEALTH AND  
HUMAN SERVICES**

ROY COOPER • Governor

KODY H. KINSLEY • Secretary

MARK PAYNE • Director, Division of Health Service Regulation

January 7, 2022

Ms. Kellie Hardison, Director  
Country Living Guest Home, Inc.  
3052 Markey Street Extension  
Washington, NC 27889

Re: Annual and Follow Up Survey completed December 14, 2021  
Country Living Guest Home #2  
MHL # 007-033  
E-mail Address: [countrylivinginc@yahoo.com](mailto:countrylivinginc@yahoo.com)

Dear Ms. Hardison:

Thank you for the cooperation and courtesy extended during the annual and follow up survey completed 12/14/21.

As a result of the follow up survey, it was determined that all of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

**Type of Deficiencies Found**

- Standard level deficiencies.

**Time Frames for Compliance**

- Standard level deficiencies must be **corrected** within 60 days from the exit of the survey, which is February 12, 2022.

**What to include in the Plan of Correction**

- Indicate what measures will be put in place to **correct** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to **prevent** the problem from occurring again.
- Indicate **who will monitor** the situation to ensure it will not occur again.
- Indicate **how often** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

**MENTAL HEALTH LICENSURE & CERTIFICATION SECTION**

**NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION**

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603  
MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718  
www.ncdhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

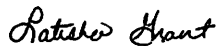
January 7, 2022  
Country Living Guest Home #2  
Ms. Kellie Hardison

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section  
NC Division of Health Service Regulation  
2718 Mail Service Center  
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Ms. Gloria Locklear, Team Leader at (910) 214-0350.

Sincerely,



Latisha Grant  
Facility Compliance Consultant I  
Mental Health Licensure & Certification Section

Cc: Leza Wainwright, Director, Trillium Health Resources LME/MCO  
Fonda Gonzales, Interim Quality Management Director, Trillium Health Resources LME/MCO  
Pam Pridgen, Administrative Assistant

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL007-033</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R <b>12/14/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>COUNTRY LIVING GUEST HOME #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3052 MARKET STREET EXTENSION WASHINGTON, NC 27889</b>
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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
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V 000	INITIAL COMMENTS  An annual and follow up survey was completed on December 14, 2021. Deficiencies were cited.  This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.  The survey sample consisted of audits of 3 current clients.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements  10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and	V 108	V108 - Personnel Requirements  CPR/First Aid and NCI training was conducted in-person on the following dates: January 5, 2022 January 10, 2022  The training was conducted by Bernadine Freeman and every employee at the facility attended.  In the future, all CPR/First Aid will be provided in-person.  The LCSW/Administrator/CP will monitor trainings on a monthly basis. The LCSW/Administrator/CP utilizes a chart to ensure all required trainings are up-to-date.	1/5/22 1/10/22

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Jeffrey Bell*

TITLE

RN/CP

(X6) DATE

1/14/22

Division of Health Service Regulation

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V 108	<p>Continued From page 1</p> <p>implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff were trained in Cardiopulmonary Resuscitation (CPR) and First Aid affecting 1 of 3 staff audited (#2).</p> <p>Review on 12/14/21 of staff #2's personnel record revealed: -A hire date of 5/10/12. -National CPR Foundation training certificate dated 7/20/21 for CPR and first aid. -There was no evidence of a current CPR or First Aid Certification that had been conducted with an in-person instructor.</p> <p>Interview on 12/14/21 staff #2 stated: -She had completed trainings that included CPR and First Aid. -Her CPR and First Aid Training had been completed on-line.</p> <p>Interview on 12/13/21 staff #2 stated: -He had worked at the facility for 6 months. -He had completed trainings that included CPR and First Aid, Medication Administration, and diabetes trainings.</p> <p>Interview on 12/14/21 the Qualified Professional/RN stated: -The National CPR Foundation training was an</p>	V 108		

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V 108	Continued From page 2  online training that was provided to staff because of the on-going pandemic. -He would ensure future CPR and First Aid training provided to staff was with an in-person instructor.	V 108		
V 118	27G .0209 (C) Medication Requirements  10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118	V118 Medication Requirements  Additional training will be provided to staff at the upcoming Quality Assurance Meeting. The training will focus on documentation of medication administration. More specifically, it will emphasize the importance of documenting on the EMAR when the resident is out of the facility. Jett Bell, RN, & P will be responsible for the training. The agency's 2 Quality Assurance Supervisors will monitor the EMARs daily to ensure all documentation related to medication administration is complete. Recurrent issues will be reported to the RN and will be documented in the form of a supervision note.	January 2022

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V 118	<p>Continued From page 3</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to keep the MARs current affecting 3 of 3 audited clients (#3, #4 and #5). The findings are:</p> <p><b>Finding #1</b> Review on 12/14/21 of client #3's record revealed: -35 year old male admitted 7/2/20. -Diagnoses of Schizophrenia and Hypertension.</p> <p>Review on 12/14/21 of client #3's Physician orders dated 7/2/21 revealed: -Lipitor 40mg (milligrams) (cholesterol), 1 tablet at bedtime. -Cogentin 2mg (treats tremors) 1 tablet twice daily. -Clozaril 100mg (antipsychotic) 3 tablets at bedtime. -Dulcolax 100mg (stool softner) 1 twice daily. -Lamictal 100mg (mood disorder) 1 twice daily.</p> <p>Review on 12/14/21 of client #3's November 2021 MAR revealed the following areas in the MAR with no initials to indicate the medication had been administered: -Lipitor 40mg on 11/18/21 at 8:00pm. -Cogentin 2mg on 11/18/21 at 8:00pm. -Clozaril 100mg on 11/18/21 at 8:00pm. -Dulcolax 100mg on 11/18/21 at 8:00pm. -Lamictal 100mg on 11/18/21 at 8:00pm.</p> <p>During interview on 12/14/21 client #3 revealed</p>	V 118		

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NAME OF PROVIDER OR SUPPLIER  <b>COUNTRY LIVING GUEST HOME #2</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3052 MARKET STREET EXTENSION WASHINGTON, NC 27889</b>		
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V 118	<p>Continued From page 4</p> <p>he received his medication daily.</p> <p><b>Finding #2</b> Review on 12/14/21 of client #4's record revealed: -70 year old male admitted 10/17/19. -Diagnoses of Major Depressive Disorder, Seizure Disorder, Hypertension and tobacco Use Disorder.</p> <p>Review on 12/14/21 of client #4's Physician orders dated 11/22/21 revealed: -Amantadine 100mg (treats muscle control), 1 tablet at bedtime. -Cilostazol 100mg (treats blood flow problems) 1 tablet twice daily. -Colace 100 (stool softner) 1 twice daily. -Eliquis 5mg (prevent blood clots) 1 twice daily. -Risperidone 1mg (mood disorder) 1 twice at bedtime. -Senna 8.6mg (constipation) 1 at bedtime. -Symbicort 160-4.5 MCG Inhaler (asthma symptoms) 2 puffs twice a day.</p> <p>Review on 12/14/21 of client #4's November 2021 MAR revealed the following areas in the MAR with no initials to indicate the medication had been administered: -Amantadine 100mg on 11/18/21 at 8:00pm. -Cilostazol 100mg on 11/18/21 at 8:00pm. -Colace 100 on 11/18/21 at 8:00pm. -Eliquis 5mg on 11/18/21 at 8:00pm. -Risperidone 1mg on 11/18/21 at 8:00pm. -Senna 8.6mg on 11/18/21 at 8:00pm. -Symbicort 160-4.5 MCG Inhaler on 11/18/21 at 8:00pm.</p> <p>During interview on 12/14/21 client #4 revealed he received his medication daily.</p>	V 118		

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V 118	<p>Continued From page 5</p> <p><b>Finding #3</b> Review on 12/14/21 of client #5's record revealed: -29 year old male admitted 11/8/21. -Diagnoses of Anxiety, Mood Disorder, GERD, Depressive Disorder.</p> <p>Review on 12/14/21 of client #5's Physician orders dated 8/24/21 revealed: -Cogentin 0.5mg (mood) 1 twice daily. -Clonazepam 2mg (anxiety) 1/2 tablet twice daily. -Risperidone 3mg (mood disorder) 1 daily. -Topiramate 100mg (seizures) 1 twice daily.</p> <p>Review on 12/14/21 of client #5's November 2021 MAR revealed the following areas in the MAR with no initials to indicate the medication had been administered: -Cogentin 0.5mg on 11/18/21 at 8:00pm. -Clonazepam 2mg on 11/18/21 at 8:00pm. -Risperidone 3mg on 11/18/21 at 8:00pm. -Topiramate 100mg on 11/18/21 at 8:00pm.</p> <p>During interview on 12/14/21 client #5 revealed he received his medication daily.</p> <p>During interview on 12/15/21 the Qualified Professional stated: -He understood the MAR had to be kept current.</p>	V 118		
V 736	<p>27G .0303(c) Facility and Grounds Maintenance</p> <p>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.</p>	V 736		



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V 736	<p>Continued From page 6</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are:</p> <p>Observation on 12/14/21 at approximately 10:15am revealed: -Client #3 and Client #6's bedroom had a 3 inch hole in the wall and the smoke detector was detached from the ceiling. -The hall bathroom sink was partially detached from the wall and paint was chipping from the ceiling above the sink. -Client #1's ceiling light in his bedroom did not work. -Client #2's bedroom ceiling vent had heavy dust.</p> <p>Interview on 12/14/21 the Qualified Professional stated: -He would ensure the repairs were completed at the facility.</p>	V 736	<p><u>V736 Location and Exterior Requirements</u></p> <p>Client #3 and #6 Bedroom: The smoke detector will be re-attached to the electrical box. The detector remains in working order. The hole in the wall will be repaired and painted. The RN/AP will be responsible for the repairs and the Quality Assurance Supervisor will continue to conduct weekly inspections of each home.</p> <p><u>Hall Bathroom</u> The sink will be re-attached to the wall and the ceiling paint will be sanded and repaired. The RN/AP will be responsible and the Quality Assurance Supervisors will conduct weekly inspections of each home.</p> <p><u>Client #1 Bedroom</u> The bulb will be replaced in ceiling light.</p> <p><u>Client #2</u> - The RN/AP will ensure that the dust is removed from ceiling vent.</p>	<p>1/14/22</p> <p>January 2022</p> <p>1/14/22</p> <p>1/14/22</p>
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**STATE FORM: REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER MHL007-033	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 12/14/2021	Y3
NAME OF FACILITY COUNTRY LIVING GUEST HOME #2			STREET ADDRESS, CITY, STATE, ZIP CODE 3052 MARKET STREET EXTENSION WASHINGTON, NC 27889		

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 <u>V0112</u>	Correction	ID Prefix <u>V0123</u>	Correction	ID Prefix <u>V0366</u>	Correction
Reg. # <u>27G .0205 (C-D)</u>	Completed	Reg. # <u>27G .0209 (H)</u>	Completed	Reg. # <u>27G .0603</u>	Completed
LSC _____	12/14/2021	LSC _____	12/14/2021	LSC _____	12/14/2021
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 <i>Ratsko Grant</i>	DATE 12/14/21
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 7/31/2019		<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		