## PRINTED: 10/29/2021 FORM APPROVED

New Jersey Department of Health							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		3EGDKS	B. WING		11/0	3/2020	
NAME OF PROVIDER OR SUPPLIER STREET AD			DRESS, CITY, STATE, ZIP CODE				
ORCHARDS AT BARTLEY, THE 100 NORTH COUNTY LINE ROAD JACKSON, NJ 08527							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
A 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		A 000				
						(X6) DATE 01/06/21	

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If continuation sheet 1 of 1