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
	61517	A. BUILDING: _____ B. WING _____	11/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT MANCHESTER	1770 TOBIAS AVENUE MANCHESTER, NJ 08759

(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
S 000	Initial Comments INITIAL INSPECTION FOR LICENSURE of a RENOVATED LONG TERM CARE FACILITIES INSPECTION DATE: 11/24/2020 NO DEFICIENCIES NOTED DURING THE INSPECTION OF THE FINAL PHASE OF A 3-PHASE PROJECT. THE PROJECT INCLUDED A RENOVATED PHYSICAL THERAPY GYM, ADDITION OF A NEW POOL AND NEW FINISHES THAT INCLUDED MEP FIXTURES, CEILING GRID, FLOORING AND CEILING TILES. THE BUILDING MAY NOT BE OCCUPIED UNTIL YOU RECEIVE FORMAL NOTIFICATION BY THE LICENSING PROGRAM.	S 000		

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

Electronically Signed | 11/25/20