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 |
|---|---|---|---|
| | 1EGWIO | A. BUILDING: _____ B. WING _____ | C 08/24/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **WELLINGTON ESTATES** | **2018 HIGHWAY 35 SPRING LAKE, NJ 07762** |

| (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<br><br>Initial Comments:<br>SURVEY TYPE: Complaint<br><br>COMPLAINT #: NJ00166735<br><br>CENSUS: 77<br><br>SAMPLE SIZE: 4<br><br>The facility is in substantial compliance with N.J.A.C. Title 8 Chapter 36- Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs for this Complaint Investigation. | A 000 | | |

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