STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	030305	A. BUILDING: _____ B. WING _____	01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE REHABILITATION AND HEALTHCARE C	255 EAST MAIN ST MOORESTOWN, NJ 08057

(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 SURVEY TYPE: State Licensure Certification for a Dementia/Alzheimer's Unit. SURVEY DATE: 1/19/23 DEMENTIA UNIT CENSUS: 54 THE FACILITY WAS IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES, SPECIFICALLY NJAC 8:39 SUBCHAPTER 45 (ALZHEIMER'S/DEMENTIA PROGRAMS) AND 46 (ALZHEIMER'S/DEMENTIA PROGRAMS--ADVISORY STANDARDS). THE FACILITY IS NOT TO ADVERTISE THAT THEY HAVE A CERTIFIED-DEMENTIA UNIT UNTIL LICESNING HAS PROVIDED FINAL APPROVAL OF CERTIFICATION. THE FACILITY IS RESPONSIBLE TO PROVIDE EVIDENCE OF ONGOING COMPLIANCE AT EACH FUTURE STATE LICENSURE RECERTIFICATION SURVEY FOR CONTINUED CERTIFICATION STATUS.	S 000		

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

Electronically Signed | 01/20/23