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
	061314	A. BUILDING: _____ B. WING _____	12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLAIRE REHAB & NURSING	115 DUTCH LANE ROAD FREEHOLD, NJ 07728

(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 RENOVATED LONG TERM CARE FACILITIES INITIAL INSPECTION DATE: 12/23/2020 NO DEFICIENCIES WERE NOTED DURING THE INSPECTION OF THE FOLLOWING RENOVATED AREAS: REHAB THERAPY GYM, 2ND FLOOR ANNEX UNIT, GROUND FLOOR LOBBY INCLUDING BISTRO AND VISITOR BATHROOMS, TWO SHOWER ROOMS ON THE 2ND FLOOR AND A BARIATRIC SUITE (ROOM 136). 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 | 12/24/20