DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/26/2023 FORM APPROVED OMB NO. 0938-0391

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	315135	B. WING			C 10/07/2022	
NAME OF PROVIDER OR SUPPLIER CREST POINTE REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COE 1515 HULSE ROAD PT PLEASANT, NJ 08742)E		-
4) ID SUMMARY STATEMENT OF DEFICIENCIES EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL AG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	((EACH CORRECTIVE ACTION S	N SHOULD BE COME APPROPRIATE		(X5) COMPLETION DATE
INITIAL COMMENTS		F0	00			
Complaint: NJ00158178						
CENSUS: 100						
SAMPLE SIZE : 3						
REQUIREMENTS (SUBPART B, FOR	OF 42 CFR PART 483, LONG TERM CARE					
 	DER/SLIPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE			(X6) DATE
	PROVIDER OR SUPPLIER POINTE REHABILITAT SUMMARY STA (EACH DEFICIENCY REGULATORY OR L INITIAL COMMENT Complaint: NJ001 CENSUS: 100 SAMPLE SIZE: 3 THE FACILITY IS I REQUIREMENTS SUBPART B, FOR FACILITIES BASEI VISIT.	PROVIDER OR SUPPLIER POINTE REHABILITATION AND HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS Complaint: NJ00158178 CENSUS: 100 SAMPLE SIZE: 3 THE FACILITY IS IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	DENTIFICATION NUMBER: A. BUILDI 315135 B. WING PROVIDER OR SUPPLIER POINTE REHABILITATION AND HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS Complaint: NJ00158178 CENSUS: 100 SAMPLE SIZE: 3 THE FACILITY IS IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT	IDENTIFICATION NUMBER: 315135 B. WING PROVIDER OR SUPPLIER POINTE REHABILITATION AND HEALTHCARE CENTER SIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LS: DENTIFYING INFORMATION) INITIAL COMMENTS Complaint: NJ00158178 CENSUS: 100 SAMPLE SIZE: 3 THE FACILITY IS IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	A BUILDING 315135 3151313 315135 31513131 3151313	A BUILDING COM 315135 B. WING PROVIDER OR SUPPLIER POINTE REHABILITATION AND HEALTHCARE CENTER POINTE REHABILITATION AND HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS Complaint: NJ00158178 CENSUS: 100 SAMPLE SIZE: 3 THE FACILITY IS IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

10/13/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.