STATE NAME OF DEPENDENCE     (20) PROVIDENCE     (20) DATE BUNCY A DULDING 3100001229     (20) DATE BUNCY A DULDING BUNCY 30 BUOGRELED ACTION 30	CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391								
31C001229     N.WH3     Oe630/2021       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CTV, STATE, 2/P CODE     333 BLOOMFIELD A/ENDE									
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, 20 COBE       PLICEMENT     STREET ADDRESS, CITY, STATE, 20 COBE       VICUUE     SUMMARY STATEMENT OF DEFICIENCIES     DB       DECRET     SUMMARY STATEMENT OF DEFICIENCIES     DB     PROVIDERS PLAN OF CORRECTION     CORSECUTION       VICUUE     SUMMARY STATEMENT OF DEFICIENCIES     DP     PROVIDERS PLAN OF CORRECTION OF NOTAL SECTION OF NOTABULE     CORSECUTION     <			31C0001229	B. WING					
PLCRIM MEDICAL CENTER     MONTCLAR, NJ 9704       (PAL) DR LEXCONTON TO PERCENCIES     ID REACH DREINSKY MUSICE MESTICE PERCENCIES     D REACH DREINSKY MUSICE MESTICE PERCENCIES     D REACH DREINSKY MUSICE PERCENCIES     D REACH DREINSKY MUSICE PERCENCIES     D REACH DREINSKY MUSICE PERCENCY     D REACH DREACH DR	NAME OF PROVIDER OR SUPPLIER				5	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
PREFX TAG (EACH CORRECTIVE ACTION BOULD BE REGULTORY OR LSC DENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION BOULD BE CROSS-REFERENCE TO THE APPROFINATE DEFICIENCY) COMPLETION ONE   Q 000 INITIAL COMMENTS Q 000   Pligrim Medical Center is in compliance with the requirements of 42 CFR 416 Subpart C Ambulatory Surgical Services for Complaint Q 000	PILGRIM MEDICAL CENTER								
Pilgrim Medical Center is in compliance with the requirements of 42 CFR 416 Subpart C Ambulatory Surgical Services for Complaint #NJ00132573.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREF	PREFIX (EACH CORRECTIVE ACTION SI TAG CROSS-REFERENCED TO THE AP			COMPLETION	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		INITIAL COMMENTS Pilgrim Medical Cent requirements of 42 C Ambulatory Surgical S	er is in compliance with the FR 416 Subpart C			DEFICIENCY)	ATE	DATE	
								(Y6) DATE	

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.

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES