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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		315467	B. WING	3. WING		06/26/2020	
NAME OF PROVIDER OR SUPPLIER LITTLE BROOK NURSING AND CONVALESCENT HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 78 SLIKER ROAD CALIFON, NJ 07830			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG				(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 000				
	CENSUS: 36						
	SAMPLE SIZE: 0						
	conducted by the Sta The facility was found CFR 483.80 infection implemented the CMS	Infection Control Survey was te Agency on 6/26/2020. It to be in compliance with 42 control regulations and has S and Centers for Disease on (CDC) recommended for COVID-19.					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	1		TITLE		(X6) 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.

Electronically Signed

07/16/2020