## PRINTED: 07/09/2020 FORM APPROVED

(X5) COMPLETE DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	55A008	B. WING		0	6/15/2020	
SUPPLIER	STF	REET ADDRESS, CITY, ST	ATE, ZIP CODE			
LIVING OF W	ALL					
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CC		(X5 COMPL DAT	
D Initial Comments		A 000				
Initial Comments: Census: 55 A Covid-19 Focused Infection Control Survey was conducted by the State Agency on 6/15/20. The facility was found to be in compliance with the New Jersey Administrative Code 8:36 infection control regulations standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.						
	CIES DN SUPPLIER LIVING OF W SUMMARY STI CH DEFICIENC SULATORY OR I nments nments: 55 9 Focused I d by the Sta s found to b ey Administi gulations sta Living Resid Care Home: and Center n (CDC) rec	IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         SUPPLIER         SUMMARY STATEMENT OF DEFICIENCIES         CH DEFICIENCY MUST BE PRECEDED BY FULL         SULATORY OR LSC IDENTIFYING INFORMATION)         Inments         nments:         55         9 Focused Infection Control Survey was         by the State Agency on 6/15/20. The         s found to be in compliance with the         ey Administrative Code 8:36 infection         gulations standards for Licensure of         Living Residences, Comprehensive         Care Homes and Assisted Living         and Centers for Disease Control and         n (CDC) recommended practices to	ICIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPL         IDENTIFICATION NUMBER:       A. BUILDING:         SUPPLIER       STREET ADDRESS, CITY, ST         IVING OF WALL       2600 ALLAIRE ROAD         WALL, NJ       07719         SUMMARY STATEMENT OF DEFICIENCIES       ID         CH DEFICIENCY MUST BE PRECEDED BY FULL       ID         SUMMARY OR LSC IDENTIFYING INFORMATION)       A 000         nmments:       A 000         9 Focused Infection Control Survey was       A 000         oby the State Agency on 6/15/20. The       s found to be in compliance with the         ey Administrative Code 8:36 infection       gulations standards for Licensure of         Living Residences, Comprehensive       Care Homes and Assisted Living         and Centers for Disease Control and       n (CDC) recommended practices to	CIES       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A BUILDING:         SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         LIVING OF WALL       2600 ALLAIRE ROAD WALL, NJ 07719         SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL SULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLANC (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE         nments       A 000       PREFIX       CROSS-REFERENCED DEFICIE         9 Focused Infection Control Survey was d by the State Agency on 6/15/20. The s found to be in compliance with the ey Administrative Code 8:36 infection gulations standards for Licensure of Living Residences, Comprehensive Care Homes and Assisted Living and Centers for Disease Control and n (CDC) recommended practices to       III TIPLE CONSTRUCTION	CIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION       (X3) DAT         SUPPLIER       55A008       B. WING       0         SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       0         SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       0         SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION         CH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX       (EACH CORRECTIVE ACTION SHOULD BE         CROSS-REFERENCED TO THE APPROPRIATE       DEFICIENCY)       DEFICIENCY)         nments       A 000       A 000         nments:       55       9         9 Focused Infection Control Survey was       A 000         9 Focused Infection Control Survey was       A 000         9 Focused Infection Control Survey was       A 000         10 type Residences, Comprehensive       Care Homes and Assisted Living         Care Homes and Assisted Living       and Centers for Disease Control and         n (CDC) recommended practices to       ID	

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

New Jersey Department of Health

TITLE

(X6) DATE