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
	61517	A. BUILDING: _____ B. WING _____	02/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT MANCHESTER	1770 TOBIAS AVENUE MANCHESTER, NJ 08759

(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 New and/or Renovated Long Term Care Facilities Inspection Date: 2/24/2020 No deficiencies were noted during the inspection of alterations to the business office area which included electrical, three new framed walls, sprinkler head relocations, new wallpaper, carpeting and flooring, ceiling tiles, new lighting and new furniture for 3 offices. No deficiencies were noted during the inspection of renovations to the lobby area included ceiling replacement, sprinkler head relocations and redo of all finishes. The above noted areas may not be occupied until formal notification by the Certificate of Need and Licensing Division has been received.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/28/20