

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>15A115</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/19/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>HARMONY VILLAGE AT CAREONE JACKSON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>11 HISTORY LANE JACKSON, NJ 08527</b>
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(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
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A 000	<p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Renovation and conversion survey from long term care rooms to 34 single Assisted Living Residential units and included inspection of the great room, common corridors, residents laundry, nursing station, medication room, environmental services closet, one unisex bathroom, quiet room and dining room/serving area. This inspection will increase the current 35 licensed beds by 34 licensed beds for a total of 69 licensed assisted living beds.</p> <p>CENSUS: 34</p> <p>The facility is in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs.</p>	A 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE