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

PRINTED: 06/02/2021 FORM APPROVED OMB NO. 0938-0391

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
315177		B. WING		12/	12/02/2020	
NAME OF PROVIDER OR SUPPLIER  GATEWAY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  139 GRANT AVE  EATONTOWN, NJ 07724	, . <u></u>		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	LD BE COMPLÉTION		
INITIAL COMMENTS		F 00	00			
Survey date: 12/2/2020						
Census: 112						
Sample: 3						
was conducted by the Health. The facility with 42 CFR §483.8 and has implement Disease Control and	he New Jersey Department of was found to be in compliance 30 infection control regulations ed the CMS and Centers for d Prevention (CDC)					
/ DIDECTOR'S OR DROVID	NED/SLIDDLIED DEDDESENTATIVE'S SICK	IATLIDE	TITLE		(X6) DATE	
	PROVIDER OR SUPPLIER  Y CARE CENTER  SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  INITIAL COMMENT  Survey date: 12/2/2  Census: 112  Sample: 3  A COVID-19 Focus was conducted by the Health. The facility with 42 CFR §483.8 and has implement Disease Control an recommended prace	ROVIDER OR SUPPLIER  Y CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  Survey date: 12/2/2020  Census: 112  Sample: 3  A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.	TROVIDER OR SUPPLIER  Y CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  Survey date: 12/2/2020  Census: 112  Sample: 3  A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC)	ROVIDER OR SUPPLIER  315177  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 139 GRANT AVE EATONTOWN, NJ 07724  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  Survey date: 12/2/2020  Census: 112  Sample: 3  A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be in compliance with 42 CPR \$483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.	A BUILDING  315177  B. WING  TOWNIDER OR SUPPLIER  Y CARE CENTER  SUMMAY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  Survey date: 12/2/2020  Census: 112  Sample: 3  A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be in compliance with 42 CPR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.	

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

(X6) DATE

**Electronically Signed** 12/02/2020

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.