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
	061519	A. BUILDING: _____ B. WING _____	06/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORD HEALTHCARE & REHABILITATION	**963 OCEAN AVE LAKEWOOD, NJ 08701**

(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 or RENOVATED LONG TERM CARE FACILITIES INSPECTION DATE: 6/25/19 NO DEFICIENCIES NOTED DURING THE INSPECTION OF THE RENOVATIONS OF THE PHYSICAL THERAPY GYM. RENOVATIONS INCLUDED THE REMOVAL OF OFFICE SPACE THAT WAS LOCATED IN THE CENTER OF THE GYM TO OPEN UP SPACE. THE BUILDING MAY NOT BE OCCUPIED UNTIL YOU RECEIVE FORMAL NOTIFCATION BY THE LICENSING PROGRAM.	S 000		

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

Electronically Signed | 06/25/19