STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVIC COMPLETED NAME OF PROVIDER OR SUPPLIER 315312 B. WING 02/10/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 94 STEVENS ROAD HAMPTON RIDGE HEALTHCARE AND REHABILITATION TOMS RIVER, NJ 08755 10 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PROVIDER'S PLAN OF CORRECTION SHOULD BE COM	PROVE	FORM APPE					MENT OF HEALTH AN	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING COMPLETED C 02/10/20 A BUILDING COMPLETED COMPLE		OMB NO. 0938						
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THE FACILITY IS IN COMPLIANCE WITH THE							CENSUS: 179	
SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.						CFR PART 483, FERM CARE	REQUIREMENTS OF SUBPART B, FOR LC FACILITIES BASED (
Electronically Signed 02/13	ATE.	(X6) DAT		TITLE		ER REPRESENTATIVE'S SIGNATURE	DIRECTOR'S OR PROVIDER/S	_ABORATORY [

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.

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