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

PRINTED: 03/26/2020 FORM APPROVED OMB NO. 0938-0391

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA	(X3) DATE SURVEY COMPLETED	
	315200	B. WING _			C 08/08/2019	
NAME OF PROVIDER OR SUPPLIER ARISTACARE AT DELAIRE			STREET ADDRESS, CITY, STATE, ZIP CODE 400 W STIMPSON AVE LINDEN, NJ 07036			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
00 INITIAL COMMENTS		F 0	00			
C #: NJ00126818						
Census: 212						
Sample Size: 3						
REQUIREMENTS OF SUBPART B, FOR LC	F 42 CFR PART 483, DNG TERM CARE					
	NIDDI IED DEDDECENTATIVE'S SIGNATU		TITLE		(Y6) DATE	
	ROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE INITIAL COMMENTS C #: NJ00126818 Census: 212 Sample Size: 3 THE FACILITY IS IN REQUIREMENTS OF SUBPART B, FOR LC FACILITIES, BASED	ARE AT DELAIRE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS C #: NJ00126818 Census: 212 Sample Size: 3 THE FACILITY IS IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES, BASED ON THIS COMPLAINT	A. BUILDIN 315200 B. WING ROVIDER OR SUPPLIER ARE AT DELAIRE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS C #: NJ00126818 Census: 212 Sample Size: 3 THE FACILITY IS IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES, BASED ON THIS COMPLAINT	A. BUILDING 315200 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 400 W STIMPSON AVE LINDEN, NJ 07036 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS C#: NJ00126818 Census: 212 Sample Size: 3 THE FACILITY IS IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES, BASED ON THIS COMPLAINT	A BUILDING 315200 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 400 W STIMPSON AVE LINDEN, NJ 07036 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS C #: NJ00126818 Census: 212 Sample Size: 3 THE FACILITY IS IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES, BASED ON THIS COMPLAINT	

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

(X6) DATE

08/27/2019 **Electronically Signed**

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.