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
	D35011	A. BUILDING: _____ B. WING _____	C 12/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX TRAIL MEMORY CARE LIVING CHESTER	115 ROUTE 206 CHESTER, NJ 07930

(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
R 000	8:37-2.1(i) Initial Comments When determining whether an applicant is capable of operating a dementia care home, the Department shall consider any evidence of licensure violations representing serious risk of harm to residents, any evidence of an applicant's violation of any State licensing or Federal standards in connection with an inappropriate discharge or denial of admission of a resident or patient, and an applicant's record of criminal convictions involving fraud, patient or resident abuse or neglect, a crime of violence, a crime of moral turpitude, or any other crime that presents a risk of harm to the safety or welfare of residents. Complaint #: NJ00141589, NJ00141595 CENSUS: 6 SAMPLE SIZE: 3 THE FACILITY IS IN COMPLIANCE WITH ALL OF THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE 8:43, STANDARDS FOR LICENSURE OF RESIDENTIAL HEALTH CARE FACILITIES AND DEMENTIA CARE HOMES, BASED ON THIS COMPLAINT VISIT.	R 000		

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