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 09/13/2019

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	Initial Comments TYPE OF SURVEY: Complaint COMPLAINT #: NJ00125073 CENSUS: 7 SAMPLE SIZE: 3 THE FACILITY IS IN COMPLIANCE WITH ALL OF THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE 8:37, 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