STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D35019	A. BUILDING: _____ B. WING _____	07/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX TRAIL MEMORY CARE LIVING PARK RIDGE	103 KINDERKAMACK ROAD PARK RIDGE, NJ 07656

(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. C#: NJ00114912 Census: 9 Sample Size: 9 THE FACILITY IS IN COMPLIANCE WITH THE STANDARDS FOR LICENSURE OF RESIDENTIAL HEALTH CARE FACILITIES CHAPTER N.J.A.C. 8:43.	R 000		

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