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
	060405	A. BUILDING: _____ B. WING _____	04/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL MANOR HEALTHCARE AND REHABILITATIO	18 W LAUREL ROAD STRATFORD, NJ 08084

(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
S 000	Initial Comments INITIAL INSPECTION FOR LICENSURE of NEW or RENOVATED CONSTRUCTION LONG TERM CARE FACILITIES INSPECTION DATE: 4/22/19 NO DEFICIENCIES NOTED DURING THE INSPECTION OF THE FACILITY ADDING A BED TO ROOM [redacted] AND [redacted]. ROOMS WERE CHANGED FROM PRIVATE TO SEMI-PRIVATE. THE BEDS MAY NOT BE OCCUPIED UNTIL YOU RECEIVE FORMAL NOTIFICATION BY THE LICENSING PROGRAM.	S 000		

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

Electronically Signed | 05/06/19