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

PRINTED: 02/10/2020 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER GREEN HILL SUMMARY STATEMENT OF DEFICIENCISS (BACH DESCRIPTION MISST SE PRECEDED BY PULL TAGS (BACH DESCRIPTION MISST SE PRECEDED BY PULL TAGS (BACH DESCRIPTION SET OR ANGE, NJ 07652 F 000 INITIAL COMMENTS Standard Survey 12/18/19 Census: 42 Sample Size: 15 The facility is in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities BORNAIONY DIRECTORS ON PROVIDERSUMPHUE REPRESENTATIVE'S SIGNATURE ABBORATORY DIRECTORS ON PROVIDERSUMPHUE REPRESENTATIVE'S SIGNATURE TILL OR DATE 12/18/2019 TO PRESENT VALLEY WAY WEST ORANGE, NJ 07652 (BACH CORRECTIVE ALTON SHOULD BE COMMENTED TO THE ARTHON DATE CROSS REFERENCE TO THE ARPHOPINATE TO T	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Electronically Signed 12/23/2019

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.