New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	060405		07/17/2019

NAME OF PROVIDER OR SUPPLIER

LAUREL MANOR HEALTHCARE AND REHABILITATIO

STREET ADDRESS, CITY, STATE, ZIP CODE

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 LONG TERM CARE FACILITIES INSPECTION DATE: 7/17/19 NO DEFICIENCIES NOTED DURING THE INSPECTION OF 5 RESIDENT ROOMS ADDING A PRIVATE BATHROOM FOR EACH ROOM (PREVIOUSLY, 2 BEDROOMS WOULD SHARE A BATHROOM; THE EXISTING BATHROOMS REMAINED AS IT) THE BATHROOMS 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 | | 08/22/19