

New Jersey Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 55A008 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 02/18/2022 |
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| NAME OF PROVIDER OR SUPPLIER SUNRISE ASSISTED LIVING OF WALL | STREET ADDRESS, CITY, STATE, ZIP CODE 2600 ALLAIRE ROAD WALL, NJ 07719 |
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| (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 |
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| A 000 | <p>Initial Comments</p> <p>Initial Comments: Type of Survey: COVID-19 Focused Infection Control</p> <p>Census: 64</p> <p>A COVID-19 Focused Infection Control Survey was conducted by the State Agency on 02/18/2022. The facility was found to be in compliance with the New Jersey Administrative Code 8:36 infection control regulations standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs and Centers for disease Control and Prevention (CDC) recommended practice to prepare for COVID-19.</p> | A 000 | | |

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