STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060806	A. BUILDING: _____ B. WING _____	01/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON HEALTH CARE CENTER	535 EGG HARBOR ROAD SEWELL, NJ 08080

(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 Type of Inspection: An on-site Inspection of a facility reportable event where a vehicle hit and entered the building and repair work had been completed was performed. Documents were reviewed. Tour of the 1st. floor (400's unit) and 2nd. floor (500's unit), which included rooms #402 the area effected by vehicle hitting and entering the building. Inspection of rooms #501 and #502 rooms directly above the room involved with the accident. Census: 84. Sample: 0. THE FACILITY IS IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS ON-SITE VISIT.	S 000		

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

Electronically Signed | 02/10/22