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 |
|---|---|---|---|
| | D35005 | A. BUILDING: _____ B. WING _____ | C 04/05/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MILLENNIUM MEMORY CARE AT MATAWAN | 447 MATAWAN AVENUE CLIFFWOOD, NJ 07721 |

| (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 |
|---|---|---|---|---|
| R 000 | Initial Comments<br><br>Complaint #: NJ00144297, NJ00144273<br><br>Cenus: 16<br><br>Sample: 3<br><br>THE FACILITY IS IN COMPLIANCE WITH ALL OF THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE 8:37, STANDARDS FOR LICENSURE OF RESIDENTIAL HEALTH CARE FACILITIES AND DEMENTIA CARE HOMES, BASED ON THIS COMPLAINT VISIT. | R 000 | | |

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