

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>D35007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/12/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>MILLENNIUM MEMORY CARE AT OCEAN</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>111 BOWNE ROAD</b> <b>OCEAN, NJ 07712</b>		
(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	<p>Initial Comments</p> <p>Complaint #: NJ00158560</p> <p>Census: 11</p> <p>Sample: 5</p> <p>THE FACILITY IS IN COMPLIANCE WITH ALL OF THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE N. J. A. C. 8:37 STANDARDS FOR LICENSURE OF DEMENTIA CARE HOMES.</p>	R 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE