

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: D35007	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/12/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MILLENNIUM MEMORY CARE AT OCEAN	STREET ADDRESS, CITY, STATE, ZIP CODE 111 BOWNE ROAD OCEAN, NJ 07712
--	--

(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>Type of Survey: Complaint</p> <p>Complaint #: NJ00146519</p> <p>Census: 16</p> <p>Sample Size: 16 and one closed record</p> <p>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.</p>	R 000		

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

TITLE

(X6) DATE