

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/19/2024
NAME OF PROVIDER OR SUPPLIER MAJESTIC CENTER FOR REHAB & SUB-ACUT		STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103		
(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	<p>Initial Comments</p> <p>Complaint #: NJ00179135, NJ00181553</p> <p>Census: 110</p> <p>Sample Size : 5</p> <p>The facility is in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities.</p>	S 000		

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

TITLE

(X6) DATE

Electronically Signed

01/15/25