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
	031901	A. BUILDING: _____ B. WING _____	C 01/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT BRIST	**200 BRISTOL GLEN DRIVE NEWTON, NJ 07860**

(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 Initial inspection for Licensure of New and/or Renovated Long Term Care Facilities Inspection Date: 1/21/2022 No deficiencies were noted during the inspection of Phase two (2) and Phase three (3) renovation project in a section of the Long Term Care building. This inspection included Resident rooms [redacted] and [redacted], Living Room, Dining Room Pantry/Kitchen area and Bathing Spas. The above noted areas may not be occupied until formal notification by the Certificate of Need and Licensing Division has been received.	S 000		

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

Electronically Signed | 02/10/22