

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061206	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/03/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FRANCIS E PARKER MEMORIAL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 501 EASTON AVE AT LANDING LANE NEW BRUNSWICK, NJ 08901
---	--

(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# NJ140907</p> <p>CENSUS: 39</p> <p>SAMPLE SIZE: 4</p> <p>The facility is in compliance with New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities for this Complaint Survey</p>	S 000		

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

TITLE

(X6) DATE