

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: COGCWM	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/27/2023
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NAME OF PROVIDER OR SUPPLIER SUNRISE ASSISTED LIVING OF LINCROFT	STREET ADDRESS, CITY, STATE, ZIP CODE 734 NEWMAN SPRINGS ROAD LINCROFT, NJ 07738
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(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
A 000	<p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Complaint</p> <p>COMPLAINT #: NJ00141922</p> <p>CENSUS: 58</p> <p>SAMPLE SIZE: 3</p> <p>The facility was in substantial compliance with New Jersey Administrative Code, Chapter 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs, based on this Complaint survey.</p>	A 000		

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