

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>02A00</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/09/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>JEWISH HOME ASSISTED LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>685 WESTWOOD AVENUE</b> <b>RIVER VALE, NJ 07675</b>
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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><b>Initial Comments</b></p> <p>Initial Comments: Type of Survey: Complaint Complaint #: NJ00146810 Census: 101 Sample Size: 3</p> <p>A complaint survey was conducted at the facility on 01/09/2024. The facility was found to be 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.</p>	A 000		

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

TITLE

(X6) DATE