

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>12009</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/15/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN ERA MEDICAL ADULT DAY CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>23 NEVSKY STREET</b> <b>EDISON, NJ 08820</b>		
(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
M 000	<p>Initial Comments</p> <p>Type of Survey: Relocation, requested increase from 90 to 170 slots</p> <p>Census: 0</p> <p>Sample Size: 0</p> <p>The facility was in substantial compliance with all of the standards in the New Jersey Administrative Code, Chapter 8:43F, Standards for Licensure of Adult Day Health Services.</p>	M 000		

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

TITLE

(X6) DATE