## DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

PRINTED: 04/24/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315133	B. WING		_	10/06/2022	
NAME OF PROVIDER OR SUPPLIER  WOODCLIFF LAKE HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STA 555 CHESTNUT RIDGE RO WOODCLIFF LAKE, NJ	AD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	(EACH CORRECTIVI CROSS-REFERENCED	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	000 INITIAL COMMENTS		F 0	00			
	COVID-19 Focuse	ed Infection Control Survey					
	Census: 89						
	Sample: 9						
	was conducted by Health. The facility with 42 CFR §483. and has implement Disease Control ar	sed Infection Control Survey the New Jersey Department of was found to be in compliance 80 infection control regulations ted the CMS and Centers for nd Prevention (CDC) ctices for COVID-19.					
LAROPATORY	/ DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGI	ΙΔΤΙΙRE	TITLE			(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

**Electronically Signed** 

10/11/2022