New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061419	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW JERSEY FIREMEN'S HOME	565 LATHROP AVE BOONTON, NJ 07005

(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	Initial Comments INITIAL INSPECTION FOR LICENSURE of NEW or RENOVATED LONG TERM CARE FACILITIES INITIAL INSPECTION DATE: 10/13/2021 THE FACILITY IS IN SUBSTANTIAL COMPLIANCE WITH THE BUILDING REQUIREMENTS FOR LONG TERM CARE FACILITIES REGARDING THE NEW CONSTRUCTION OF A 10 BED MEMORY CARE UNIT. THE BUILDING MAY NOT BE OCCUPIED UNTIL YOU RECEIVE FORMAL NOTIFICATION BY THE LICENSING PROGRAM.	S 000		

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