

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 062013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/22/2021
NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT WESTFIELD, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1515 LAMBERTS MILL ROAD WESTFIELD, NJ 07090		
(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	<p>Initial Comments</p> <p>Initial inspection for Licensure of New and/or Renovated Long Term Care Facilities</p> <p>Inspection Date: 6/22/2021</p> <p>No deficiencies were noted during the inspection of the the facility adding five (5) ventilator beds.</p> <p>The above noted areas may not be occupied until formal notification by the Certificate of Need and Licensing Division has been received.</p>	S 000		

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

TITLE

(X6) DATE

Electronically Signed

06/24/21