New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED					
		j6tdgc	B. WING		12/2	) 9/2021			
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE					
CLARE E	CLARE ESTATE, THE 201 CROSSWICKS STREET BORDENTOWN, NJ 08505								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE			
A 000	Initial Comments		A 000						
		: Complaint 100150665, NJ00150845, 150857, NJ00150860							
	CENSUS: 29								
	SAMPLE SIZE: 8								
A 310	all of the standards Administrative Code Licensure of Assiste Comprehensive Pe Assisted Living Pro submit a plan of concompletion date for that the plan is impledeficiencies may reaccordance with pro Administrative Code Enforcement of Lice 8:36-3.4(a)(1) Administrative Code Inforcement Only I	e 8:36, Standards for ed Living Residences, rsonal Care Homes and grams. The facility must rrection, including a each deficiency and ensure lemented. Failure to correct sult in enforcement action in ovisions of New Jersey e Title 8, Chapter 43E, ensure Regulations.	A 310						
	1. Ensuring the	not limited to, the following: development, d enforcement of all policies including resident rights;							

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

TITLE (X6) DATE

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7.11.0 1 27.11	or obtained	IBERTIN ISTATION TO MIBER.	A. BUILDING:			
		j6tdgc	B. WING		12/2	9/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CLARE	STATE, THE		SSWICKS ST FOWN, NJ 0			
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A 310	Continued From pa	ge 1	A 310			
	This REQUIREMENT by:	NT is not met as evidenced				
	Complaint #: NJ001	150665, NJ00150845, 150857, NJ00150860				
	determined that the to ensure that facilitimplemented to ensure reporting of reporta communication with Registered Nurse (	and record review it was Executive Director (ED) failed ty policies were consistently sure adequate staffing, the ble events, and n Physicians and the RN) occurred when ficient practice was evidenced				
	interview, the Licen stated that the facili administer medicat 12/24/21. The surveyor review Administration Rec 12/24/21 there were	2:45 p.m., during surveyor used Practical Nurse (LPN) ity did not have staff to ions to the residents on wed resident Medication ords and observed that on e omitted signatures, with not the medications were not				
	the ED who confirm	o.m., the surveyor interviewed ned that the facility was unable idminister medications to 21.				
	"STAFFING", which	undated policy titled, n indicated "Adequate staffing ased on all assessed needs of				

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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		j6tdgc	B. WING		_	9/2021
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
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CLARE	ESTATE, THE		TOWN, NJ 0			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	LD BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				,		
A 310	Continued From pa	ige 2	A 310			
	Refer to 8:36-11.5(t	f)				
		2:00 p.m., the surveyor				
	interviewed the ED	and the Regional and both stated that they did				
		ng shortage on 12/24/21 when				
		to administer medications.				
	The RA stated that she did not need to report staffing shortages to the Department of Health. The surveyor reviewed the facility's policy with the RA, who then stated that she would report the					
	event to the DOH.					
	Surveyor review of	an undated policy titled,				
		" indicated that the facility				
		epartment of Health and				
	Senior Services im	mediately by telephone				
		n confirmation within 72 hours				
		ny interruption of three or more				
	hours of basic serv	ices such as site staff."				
	Refer to 8:36-5.10(	a)(1)				
	3. On 12/27/21 the	surveyor reviewed Resident				
		which indicated the resident				
		lity NJ Ex Order 26.4b1 with				
	diagnoses which in	cluded NJ Ex Order 26.4b1				
		. According to				
	a Nurses Note (NN					
		ned from hospital with Order 26.4b1 The surveyor				
		cumentation that the Physician				
		esident #1 had Nexonal was				
	transferred to the h	ospital and diagnosed NI EXOTRET 26				
		, J				
	On 12/27/21 at 12:	45 p.m., the surveyor				
		N who stated that she was on				
		and unaware if the				
	Physician was notif	ied that Resident #1 was				

New Jer	sey Department of F	lealth				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	:	COMPLETED	
					C	
		j6tdgc	B. WING		12/29	9/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, §	STATE, ZIP CODE		
0: ABE I		201 CRO	SSWICKS ST	REET		
CLARE	ESTATE, THE	BORDEN	TOWN, NJ 0	8505		
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IAG	NEODE TOTAL	SO IDENTIFICATION STATE	IAG	DEFICIENCY)	NATE	
A 310	Continued From pa	2 ana 2	A 310			
/(0.0	•	ige 5	/(0.0			
	NJ Ex Order 26.4b1.  On 12/29/2021 at 1:30 p.m., the surveyor					
		vanced Practice Nurse who				
		s unaware that Resident #1				
	NJ Ex Order 26.4b					
	and was unaware to	that the facility did not have ter medications on NU EX Order 28.461				
	anyone to auminist	el medications on				
		yor review of an undated policy				
		ition with Physicians", facility				
		to " inform the Physician				
		in the resident's condition and ident that might result in a				
	resident needing m					
	Tooldon Hooding	cultur atterner.				
	Refer to 8:36-7.5(d	)				
		yor review of Resident #1's				
	medical record on	revealed a NN dated				
		3, "Resident returned from osis of NJ Ex Order 26.4b1 ."				
	The surveyor did no	ot observe documentation that				
		d regarding <sup>NJ Ex Order 26.4b1</sup>				
		, the surveyor				
		ital discharge paperwork dated				
		icated the diagnosis of				
	NJ Ex Order 26.4b					
	On 12/28/21 at 12:	10 p.m., the surveyor				
	interviewed the RN	I via telephone. The RN stated				
		are that Resident #1				
		the hospital and returned with Order 26.4b1 . The RN also				
	stated that staff sho					
		at she can assess the resident				
	•	needs of the resident.				
		an undated policy titled, ith Registered Nurse" revealed				

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A 310	Continued From pa	ge 4	A 310			
	resident health, info about resident issue Registered Nurse b to indicate any of th	re directly responsible for orm the Registered Nurse es". "The Staff shall notify the by phone or instant messaging the following: Hospitalization Other significant change in "				
	Refer to 8:36-7.5(c)	)				
A 369	8:36-4.1(a)(8) Resid	dent Rights	A 369			
	(a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights:					
		receive pain management as nce with N.J.A.C. 8:43E-6;				
	by: Based on interview determined that the administer NJ Ex O as orde 8 residents reviewe Resident #1. This d evidenced by the fo  According to a docu Nurse) Health Asse	ered by the Physician for 1 of ed for NJ Ex Order 26.4b1, leficient practice was ollowing:  ument titled, "RN (Registered essment" dated [MEX.ORGE 20.50], agnoses which included				

PRINTED: 04/03/2025 FORM APPROVED New Jersey Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_ C B. WING j6tdgc 12/29/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 201 CROSSWICKS STREET **CLARE ESTATE, THE** BORDENTOWN, NJ 08505 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A 369 Continued From page 5 A 369 On 12/27/21 the surveyor reviewed the Medication Administration Record (MAR) for Resident #1 and observed a current order for NJ Ex Order 26.4b1 . However, the MAR failed to identify the times of administration for the NJ Ex Order 26.461 and failed to reflect documented evidence that the medication was administered on NJ Ex Order 26.4b1. On 12/27/21 the surveyor reviewed the MAR and observed that Resident #1 should have received NJ Ex Order 26.4b1, however each dose was not signed as given, and there was no rationale documented as to why they were omitted.

On 12/27/21 the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that she did not administer to Resident #1 because she thought it was ordered to be given as needed, and not routinely. At that time the surveyor and the LPN observed the surveyor and the LPN observed that the box had not been opened, the medication seal was intact. The surveyor observed the label on the box which

On 12/27/21 the surveyor reviewed the medical record of Resident #1 who moved into the facility NJ EX Order 26.4bt with diagnoses which included

According to a Nurses Note (NN) dated NIEx Order 26.4b1, timed 7-3, "Resident returned from hospital with diagnosis of NJ Ex Order 26.4b1. The surveyor observed the hospital discharge paperwork dated NIEX ORDER 26.4b1 which revealed that the resident had a diagnosis of NJ Ex Order 26.4b1.

Further review of the medical record

indicated NJ Ex Order 26.4b1

revealed that the last documented

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A 369	assessment by the There were no other in the medical record in the medical record in the surveyor intervent in the resident hacks and when the resident exhibited in the surveyor review "Pain Assessment" policy of [facility] to properly assessed as	RN was dated ON Ex Order 26.4b1 observed ord.  iewed Resident #1 who was The surveyor observed that Ex Order 26.4b1 with his/her he resident attempted to move surveyor observed that the U Ex Order 26.4b1  wed an undated policy titled, which indicated, "It is the assure all residents are and treated for pain A pain completed when a new pain	A 369			
A 561	Facility Survey and by telephone at (60 after business hour written confirmation	notify the Division of Health Field Operations immediately 9) 633-9034 (609) 392-2020 if s, followed within 72 hours by n, of the following: of employment of the he name and qualifications of	A 561			

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A 561	by: Based on interview determined the faci the Department of I interruption in adeq practice was evider  The surveyor review Administration Reco 2021 and observed where the initial of the medication goes. The morning shift of 12/evening shifts of 12 on 12/29/21 at 11:4 interviewed the Recon the Executive Direction on the Executive Direction of	and record review it was lity failed to immediately notify Health (DOH) of an uate staffing. This deficient need by the following:  wed the facility's Medication ord (MAR) dated December that there were blank spaces the person that administers the his was the case for the 23/21 and on the morning and 1/24/21.  Is a.m., the surveyor gional Administrator (RA) and stor (ED), both explained that ector of Nursing (DON) acility. Both stated that they gagency to staff the facility on 1/21. The ED stated that the offied the facility that on gagency would not be able to	A 561			
	was able to provide some nursing cover unable to get provide	a different nursing agency a replacement DON and rage for 12/23/21, but was de nursing staff coverage for ening shift on 12/24/21 to and medication				
	an undated policy ti indicated, "Adequat	00 p.m., the surveyor reviewed tled, "STAFFING" which se staffing will be provided sed needs of residents."				

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		j6tdgc	B. WING		_	9/2021
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
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2444.15	CUMMADV CTA	TEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTI	ON	(ME)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
A 751	1 8:36-7.3(b) Resident Assessments and Care Plans		A 751			
	reviewed, and if ne as needed, based u	alth service plan shall be cessary, revised quarterly, and upon the resident's response d and any changes in the or cognitive status.				
	This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to develop a Health Service Plan (HSP) and implement comprehensive and/or effective safety measures to [MEXOGER 25:45] for 1 of 8 resident reviewed for Resident #1. This deficient practice was evidenced by the following:					
	revealed that the re in NJ Ex Order 26.4b1 wit NJ Ex Order 26.4b Resident #1 reside unit. Review of the	Resident #1's medical record esident moved into the facility th diagnoses which included 1 d on the NJ Ex Order 26.4b1 Nurses Notes (NN) dated  ***I revealed a NJ Ex Order 26.4b1				
	Executive Director #1's HSP. The ED not have an HSP a a list of residents the	rveyor interviewed the (ED) and asked for Resident stated that Resident #1 did nd provided the surveyor with hat had HSP's. The surveyor d did not observe Resident #1				
		wed in Resident #1's medical titled, "Resident General				

I .			(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
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NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
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A 751	Continued From pa	ige 9	A 751			
	Service Plan" (RGS documented that the Con 12/27/21 at 12:4 interviewed the Response and was The surveyon had NJ Ex Order 26.4b.  On 12/28/21 at 12:7 interviewed the Direct telephone who state facility on Conference of the Confe	A5 p.m., the surveyor sident #1, who was not aware that he/she with his/her with his/her with his/her with his/her population of Nursing (DON) via ed that she contracted with the and unaware that Resident #1 that she would assess the				
A 779	8:36-7.5(c) Resider Plans  (c) The registered particular called at the onset of condition of any resussessment of the	n HSP, and update the RGSP.  Int Assessments and Care  professional nurse shall be of illness, injury or change in sident to arrange for resident's nursing care needs and for needed nursing care lical care.	A 779			
	by: Based on interview	NT is not met as evidenced and record review it was facility failed to provide				

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A 779	Continued From pa	ge 10	A 779			
	(RN) was notified or timely assessment medical needs for 1 Resident #1, who	oce that the Registered Nurse in order to ensure a of the resident's condition and of 8 residents reviewed, J Ex Order 26.4b1.				
	record of Resident	rveyor reviewed the medical #1, who moved into the facility diagnoses which included				
	According to a Nurses Note (NN) dated timed 7-3, which indicated, "Resident returned from hospital with diagnosis of "The surveyor did not observe documentation that the RN was notified that the					
	resident NJ Ex Order 28.461	which NJ Ex Order 26.4b1.				
	interviewed the RN that she signed a considerate at 1:00 p.r responsible for "on emergencies. The funaware that Resid transferred to the head	via telephone. The RN stated ontract with the facility on m. and that she was call" coverage and any RN further stated that she was ent #1				
		der 26.4b1 . The RN stated ve called her so that she could s's medical needs.				
	titled, "Communicat which indicated, "It who are directly res inform the Register issuesThe [facility Nursesto provide regulation, The R	rveyor reviewed the policy tion with Registered Nurse" is the policy of the [facility] ponsible for resident health, to ed Nurse about resident of may hire Licensed Practical resident services required by egistered Nurse is responsible intely, and nurse's notes				

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CLARE	ESTATE, THE	201 CROS	SWICKS ST	REET		
BORDEN			FOWN, NJ 0	8505		
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A 779	Continued From pa	ge 11	A 779			
	should indicate noti staff shall notify the or instant messagin following:hospitali	fications and responses. The Registered Nurse by phone ng to indicate any of the ization, injury from a fallother in residents condition."				
A 781	8:36-7.5(d) Resident Assessments and Care Plans  (d) The resident's physician or the physician's designee, that is, another physician or an advanced practice nurse or physician assistant, shall be notified by the licensed professional nurse of any significant changes in the resident's physical or cognitive/mental condition and any intervention by the physician shall be recorded.  This REQUIREMENT is not met as evidenced by: Complaint #: NJ00150665, NJ00150845, NJ00150850, NJ00150857, NJ00150860		A 781			
	review it was detern notify the Physician were not administer orders for 3 of 8 res medication adminis #2, and Resident #8 Physician when a re 1 of 8 residents rev	ion, interview and record mined that the facility failed to when prescribed medication red according to prescriber's sidents reviewed for stration, Resident #1, Resident 5, and failed to notify the esident NJ Ex Order 26.4b1 for itewed strategy for the was evidenced by the				
		10:30 a.m., Resident #2 was Ex Order 26.4b1 unit with a				

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STATE FORM 6899 0J2J11 If continuation sheet 13 of 23

MAR and also observed that on NJ Ex Order 26.4b1

On 12/29/21 at 1:30 p.m., Surveyor #1 and

not administered.

that there were blanks where there should have been initial to indicate medications were administered. There was no documented evidence in the medical record that the Physician was notified as to reason the medications were

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	NAME OF PROVIDER OR SUPPLIER  CLARE ESTATE, THE  STREET A  201 CRC BORDEN					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
A 781	Practice Nurse (AP aware that the above not administered or APN stated that she residents had not rethe above dates.  Refer to 8:36-11.5(f. 3. On 12/27/21 the #1's Medical Recording to a Nurse timed 7-3, "Resident diagnosis of NJ Ex did not observe dowas notified that Resident #1's MAR NJ Ex Order 26.4b's were initialed as gived documentation regawere not given.  On 12/27/21 at 12:4 interviewed the Lice who stated that she unaware if the Phys Resident #1 was NJ further stated, the fa administer medication 12/24/21.  On 12/29/2021 at 1	ewed the residents' Advanced N) and inquired if she was be residents medications were a NJ Ex Order 26.4b1  The ewas not aware that the exceived their medications on surveyor reviewed Resident (MR), which indicated that into the facility NJ Ex Order 26.4b1  Sees Note (NN) dated NJ Ex Order 26.4b1  Sees Note (NN) dated NJ Ex Order 26.4b1  The surveyor reviewed Resident with Order 26.4b1  Sees Note (NN) dated NJ Ex Order 26.4b1  Sees Note (NN) dated NJ Ex Order 26.4b1  The surveyor reviewed and observed that on medications ren. Additionally, there was no arding the rationale why they have on vacation and was sician was notified that Ex Order 26.4b1. The LPN accility did not have staff to ions to the residents on 130 p.m., the surveyor 130 p.m.	A 781			
	interviewed the APN	N who stated that she was				

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					С	
		j6tdgc	B. WING		12/2	9/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CLARE	CLARE ESTATE, THE 201 CR			REET		
CLARE	STATE, THE	BORDENT	TOWN, NJ 0	8505		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
A 781	Continued From pa	ge 14	A 781			
	unaware that Resident that the facility did remedications to the supplicy titled, "Commonwhich indicated that	ent #1 had , and was unaware not have anyone to administer residents on 12/24/21.  rveyor reviewed an undated nunication with Physicians" t staff were to "informing changes in the resident's				
	condition and any a result in a resident the [facility] will mai all communications Nurse's notes.	ccident or incident that might needing medical attention ntain written documentation of with Physicians in the				
A 963	and documented by	aceutical Services  Il be accurately administered  properly authorized  rdance with prescribed orders.	A 963			
	by: Complaint #: NJ00 NJ00150850, NJ00 Based on observati review it was deterr ensure medications	NT is not met as evidenced 150665, NJ00150845, 150857, NJ00150860 on, interview and record mined that the facility failed to swere administered to				
	and failed to docum medications were n residents reviewed,	ance with prescriber's orders nent the rationale why ot administered for 6 out of 8 Residents #1, Resident #2, ent #5 and Resident #6, as				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		j6tdgc	B. WING		12/2	) 9/2021	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE			
CLARE	ESTATE, THE		SWICKS ST FOWN, NJ 0				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
A 963	Continued From pa	ge 15	A 963				
	evidenced by the fo	llowing:					
	Record (MR) of Refacility in NJ Ex Order 26 included NJ Ex Order 26 included NJ Ex Order 26 Service Plan (GSP) Resident #1 require services.  On 12/27/21 the su Medication Adminis	surveyor reviewed the Medical sident #1, who moved into the with diagnoses which er 26.4b1  According to the "General form dated ** According to the "General ad medication administration rveyor reviewed the tration Record (MAR) for d observed the following					
	medications were n NJ Ex Order 26.4b <sup>o</sup> 2. On 12/27/21 at 1 observed Resident	0:30 a.m., the surveyor #2 on the NJ EX Order 26.461 unit valker. Resident #2 was					

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 | (X4) DATE SURVEY COMPLET

		Jolage		<u> </u>	12912021
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE	
CLARE E	ESTATE, THE		ROSSWICKS ST ENTOWN, NJ 0		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 963	Continued From pareceived at the facil "Resident Face She admitted to the facil diagnoses which in the sum of the facil diagnoses which in the sum of the facil diagnoses which in the sum of the facil diagnoses which included sum of the facil which included sum of the facil diagnoses which included sum of the facil diagnose	Indicated that he/she was lity in NJ Ex Order 26.4b1 with cluded NJ Ex Order 26.4b1 with cluded NJ Ex Order 26.4b1 and the following medications administered: NJ Ex Order 26.4b1 mouth at bedtime for sleep as administered to the 0:30 a.m., surveyor reviewed of Resident #3, who was lity on NJ Ex Order 26.4b1 with diagnose	A 963		DAIL
	interview with Resident #3 stated his/her morning and	00 a.m., during surveyor dent #3 in his/her apartment, that he/she did not receive d evening medication this pa half days. Resident #3 furth	st		

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		C	
		j6tdgc	B. WING			, 9/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CLARE	ESTATE, THE		SSWICKS ST FOWN, NJ 0			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
A 963	Continued From pa	ge 17	A 963			
	explained that he/sl but was informed b	he was not sure of the dates, y the Nurses Aides that not swas due to staff being on				
	interviewed the Lice who explained to the returned from vacal agency staff in her	15 a.m., the surveyor ensed Practical Nurse (LPN) be surveyor that she had just tion and that the facility used absence. The LPN confirmed Ex Order 26.4b1 his/her				
	On 12/29/21 at 11:30 a.m., the surveyor reviewed Resident #3's MAR dated which indicated that medications were not initialed as being administered on the following dates and times: NJ Ex Order 26.4b1  the 9:00 a.m. and the 9:00 p.m. doses were not initialed as					
	administered.  On NJ Ex Order 26. tablet 1 tablet once as administered. O	daily for was not initialed n NJ Ex Order 26.4b1  . dose was not gadministered on was not gadmin				

PRINTED: 04/03/2025

STATE, ZIP CODE  TREET  08505  PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)	(X5) COMPLETE DATE
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETE

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 | (X3) DATE SURVEY COMPLETED | (X4) DATE SURVEY COMPLETED | (X5) DATE SURVEY COMPLETED | (X5) DATE SURVEY COMPLETED | (X6) DATE SURVEY COMPLET

	PROVIDER OR SUPPLIER ESTATE, THE	201 CROSS	SWICKS STR DWN, NJ 08		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM	ES Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
A 963	Continued From page 19		A 963		
	At 12:55 p.m., the surveyor interviewed who stated that she was on vacation du week of Christmas and returned today. The LPN stated that she was informed residents and staff that there was no Ni cover some of the shifts when she was vacation.	uring the [12/27/21]. by urse to			
	At 1:20 p.m., the surveyor reviewed Remedical record and according to the "Reface Sheet", the resident was admitted facility in NJ Ex Order 26.4b1 with diagnoses wincluded NJ Ex Order 26.4b1	esident I to the			
	Further review of Resident #5's MAR, re that on medications were not initialed as admin NJ Ex Order 26.4b1	g			

and

PRINTED: 04/03/2025 FORM APPROVED New Jersey Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_ C B. WING j6tdgc 12/29/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 201 CROSSWICKS STREET **CLARE ESTATE, THE** BORDENTOWN, NJ 08505 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A 963 Continued From page 20 A 963 NJ Ex Order 26.4b1 at 5 p.m. and 9 p.m., the following evening medications were not initialed as administered to Resident #5: NJ Ex Order 26.4b1 [4:30 p.m. and 9 p.m.]. On 12/29/21 at 11:45 a.m., during interview with the Administrator and the Regional Administrator (RA), both acknowledged that medications were not administered to the residents on 12/23/21 and 12/24/21. The RA explained that the facility was not able to secure Nurses through a nursing agency for those days. Surveyor review of the facility policy and procedure titled, "General Medication Administration Guidelines", revised 3/29/16 provided by the Administrator revealed, "The nurse or CMA (certified medication aide) will sign for each medication administered by initialing on the MAR in the appropriate space allotted immediately following medication administration for each resident." In addition, the policy indicated, "The nurse or CMA (certified

STATE FORM 6899 0J2J11 If continuation sheet 21 of 23

medication aide) will document any medications that are held or refused on the back of the MAR and notify physician if necessary, per facility

6. On 12/27/21 the surveyor reviewed the MR of Resident #6 who moved into the facility in with diagnoses which included NJEXO

According to the GSP dated

policy."

INEW JEI	sey Department of I	icaili i				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	·	COMPLETED	
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		j6tdgc	B. WING		12/2	9/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, 9	STATE, ZIP CODE		
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CLARE	STATE, THE		TOWN, NJ 0			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
A 963	Continued From pa	ge 21	A 963			
	Resident #6 require services.	ed medication administration				
	and observed were not initialed as  On 12/27/21 at 12:4	wed the MAR for NJ Ex Order 28.451 the following medications is administered: NJ Ex Order 28.451 45 p.m., the surveyor was N that the facility did not have				
	staff to administer r 12/24/21.	nedications to the residents on				
	the Executive Direct	.m., the surveyor interviewed stor (ED) who stated that the to provide staff to administer dents on 12/24/21.				
	interviewed the Reg she was aware that to administer medic	10 p.m., the surveyor gistered Nurse who stated that the facility did not have staff eations but that she had other lld not come into the facility to ications.				
	interviewed Reside did not receive med the facility did not h	20 p.m., the surveyor nt #6 who stated that he/she dications on were because ave enough staff. The resident ne/she was concerned that				

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S	SURVEY LETED
						:
		j6tdgc	B. WING			9/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CLARE	ESTATE, THE		NSSWICKS ST NTOWN, NJ (			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
A 963	Continued From pa	ge 22	A 963			
	he/she did not rece					

New Jersey Department of Health
STATEMENT OF DEFICIENCIES (X1) P

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R-	С
		j6tdgc	B. WING		03/1	0/2022
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CLARE	STATE, THE		SSWICKS ST FOWN, NJ 0			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
{A 000}	Initial Comments		{A 000}			
	Initial Comments: TYPE OF SURVEY CENSUS: 25	: Revisit survey of 12/29/21				
	SAMPLE SIZE: 16					
	all of the standards Administrative Code Licensure of Assiste Comprehensive Pe Assisted Living Pro submit a plan of co- completion date for that the plan is impledeficiencies may re accordance with pro Administrative Code Enforcement of Lice	e 8:36, Standards for ed Living Residences, rsonal Care Homes and grams. The facility must rrection, including a each deficiency and ensure lemented. Failure to correct sult in enforcement action in ovisions of New Jersey e Title 8, Chapter 43E, ensure Regulations.				
{A 963}	and documented by	aceutical Services  Il be accurately administered  y properly authorized  rdance with prescribed orders.	{A 963}			
	by: Deficiency not corre Based on observati review it was detern	NT is not met as evidenced ected on, interview and record mined that the facility failed to of correction (POC) to ensure				

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

TITLE (X6) DATE

STATEMEN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE SURVEY COMPLETED	
			A. BUILDING.		R-	C	
		j6tdgc	B. WING		1	0/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
CLARE E	ESTATE, THE		SWICKS ST				
	-		TOWN, NJ 0			O/E)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
{A 963}	Continued From pa	ge 1	{A 963}				
	medications were a accordance with prodocument the ration administered for 9 of for medication adm 9, 11, 12, 13, 14, 15 practice was evider.  On 3/9/22 at 10:30 the MARs for Residus 15 and 16 for the mand up to NJEX Order survey. The survey the residents mentioned medications were months mentioned	administered to residents in escriber's orders, and failed to hale why medications were not out of 16 residents reviewed inistration, Resident #'s 1, 3, 5, and 16. This deficient need by the following:  a.m., the surveyor reviewed dent #'s 1, 3, 9, 11, 12, 13, 14, nonths of NJ Ex Order 26.4b1, 26.4b1, which is the date of the or observed that for each of oned above that the following not signed as given for the NJ Ex Order 26.4b1 following was observed:					
	medication (mg) by mouth daily For the and up to NJ Ex Order not signed out as a documentation as to administered.  2. Resident #3 was	ordered NJ Ex Order 26.4b1 y mouth daily for NJ Ex Order 26.4b1 n and NJ Ex Order 26.4b1 y foi NJ Ex Order 26.4b1 months of NJ Ex Order 26.4b1 months of NJ Ex Order 26.4b1 these medications were dministered, and there was no o why they were not  ordered NJ Ex Order 26.4b1,					
	applied at 9 a.m T the treatment completed on the M	for NJ Ex Order 26.4b1 to be the surveyor observed that on at was not signed as MAR and there was no it was not completed.					
	mouth daily for that the medication administered to the	ordered NJ Ex Order 26.4b1 by Order 26.4b1 The surveyor observed was not signed out as resident during the months of and up to NJ Ex Order 26.4b1.					

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					R-	С
		j6tdgc	B. WING		03/1	0/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CLARE	CTATE THE	201 CROS	SWICKS ST	REET		
CLARE	ESTATE, THE	BORDEN <sup>*</sup>	TOWN, NJ 0	8505		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
{A 963}	Continued From pa	ge 2	{A 963}			
. ,	-		` ′			
	the medication was	mented rationale as to why not administered.				
	4. Resident #11 was	s ordered NJ Ex Order 26.4b1 mg				
	tablet (for NJ Ex Or	der 26.4b1				
	-	The surveyor observed that on				
	The surveyor observed that on p.m., and 9:00 p.m., these					
	medications were n	ot signed out as administered,				
	and there was no ra not administered.	ationale as to why they were				
	not auministered.					
	5. Resident #12 wa	s ordered a treatment of				
	our cheer about ad	The that on Nexoder 25 through Nexoder 25				
	at 9:00 a.m., the	Was not signed out as				
	applied, and there v	was no rationale as to why it				
	was not administered	ed.				
	6. Resident #13 wa	as ordered NJ Ex Order 26.4b1 mg by				
	mouth daily, a NJ E	x Order 26.4b1 , and				
		y mouth daily. The surveyor				
		ARs that these medications given for the months of				
		and up to NJ Ex Order 26.4b1.				
	There was no ration	nale as to why the medications				
	were not administer	red.				
	7. Resident #14 ha	nd an order for NJ Ex Order 26.4b1				
	by mouth daily	, however the surveyor				
		MARs for NJ Ex Order 26.4b1				
		were not signed as there was no rationale for why				
		re not administered.				
		NIE O L OCH				
		nd an order for NJ Ex Order 26.4b1 the surveyor observed that				

New Jer	sey Department of F	lealth				
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMP	LLTLD
		j6tdgc	B. WING		R- 03/1	.C <b>0/2022</b>
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			SSWICKS ST			
CLARE	ESTATE, THE	BORDEN'	TOWN, NJ 0	8505		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
{A 963}	Continued From pa	nge 3	{A 963}			
	the MARs for NJ Ex	Order 26.4b1 and up to welcomerse igned as given. Additionally, hale for why the medications				
	mcg by mouth daily observed that the Mand up to NJ Ex Order given. Additionally,	ad an order for NJ Ex Order 26.4b1 y, however the surveyor MARs for NJ Ex Order 26.4b1 26.4b1 were not signed as there was no rationale for why ere not administered.				
	Licensed Practical above medications administered. The I given, there was no Assistant (CMA) on the medications."	surveyor interviewed a Nurse (LPN) regarding the that were not signed out as LPN stated, "They were not o Nurse or Certified Medication in the night shift to administer The LPN informed the surveyor tact the residents' physician to to the day shift.				
	interviewed the Dire stated that she was	5 a.m., the surveyor ector of Nursing (DON) who is not aware that the not administered and that she IARs.				
	Executive Director Administrator (RA), arrive at 7 a.m., and administer medicat documented evider administered when	surveyor interviewed the (ED) and the Regional, the RA stated that the Nurses d had a one hour window to tions. However, there was no note that the medications were the Nurse(s) arrived at 7 a.m.				
	the Department of I completion date of	the facility's POC submitted to Health on 3/1/22, with the 2/28/22, revealed that the actions included the following:				

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY							
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED							
		j6tdgc	B. WING		R- 03/1	C <b>0/2022</b>						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
CLARE ESTATE THE 201 CROSSWICKS STREET												
CLARE ESTATE, THE BORDENTOWN, NJ 08505												
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	(X5) COMPLETE DATE							
{A 963}	Continued From page 4		{A 963}									
{A 963}	"The Registered Nu weekly for proper of will conduct weekly The facility failed to the deficient practic last survey conduct ensure that medical administered upon	urse (RN) will review all MARs ompletion. The RN/designee records audits x 3 months."  implement its POC to correct be previously cited during the ted on 12/29/21; and failed to a tions were documented as administration, or circle as not why medications were not	{A 963}									

## STATE FORM: REVISIT REPORT MULTIPLE CONSTRUCTION PROVIDER / SUPPLIER / CLIA / DATE OF REVISIT **IDENTIFICATION NUMBER** A. Building 3/10/2022 B. Wing i6tdgc **Y3** NAME OF FACILITY STREET ADDRESS, CITY, STATE, ZIP CODE 201 CROSSWICKS STREET CLARE ESTATE, THE BORDENTOWN, NJ 08505 This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form). ITEM DATE ITEM DATE ITEM DATE **Y4 Y5** Y4 Y5 Y4 **Y**5 ID Prefix A0310 ID Prefix A0369 ID Prefix A0561 Correction Correction Correction 8:36-5.10(a)(1) 8:36-3.4(a)(1) 8:36-4.1(a)(8) Reg. # Completed Reg. # Completed Reg. # Completed LSC 02/28/2022 LSC 02/28/2022 LSC 02/28/2022 ID Prefix A0751 ID Prefix A0779 ID Prefix A0781 Correction Correction Correction 8:36-7.3(b) 8:36-7.5(c) 8:36-7.5(d) Reg. # Reg. # Completed Reg. # Completed Completed 02/28/2022 02/28/2022 02/28/2022 LSC LSC LSC ID Prefix Correction ID Prefix Correction ID Prefix Correction Reg. # Completed Reg. # Completed Reg. # Completed LSC LSC LSC ID Prefix Correction **ID Prefix** Correction **ID Prefix** Correction Reg. # Completed Reg. # Completed Reg. # Completed LSC LSC LSC **ID Prefix ID Prefix ID Prefix** Correction Correction Correction Reg. # Completed Reg. # Completed Reg. # Completed LSC LSC LSC **REVIEWED BY REVIEWED BY** DATE SIGNATURE OF SURVEYOR DATE STATE AGENCY (INITIALS) DATE TITLE DATE REVIEWED BY **REVIEWED BY** CMS RO (INITIALS) FOLLOWUP TO SURVEY COMPLETED ON CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? 12/29/2021 YES NO

Page 1 of 1

EVENT ID:

0J2J12

## STATE FORM: REVISIT REPORT MULTIPLE CONSTRUCTION PROVIDER / SUPPLIER / CLIA / DATE OF REVISIT **IDENTIFICATION NUMBER** A. Building 3/10/2022 B. Wing i6tdgc **Y3** NAME OF FACILITY STREET ADDRESS, CITY, STATE, ZIP CODE 201 CROSSWICKS STREET CLARE ESTATE, THE BORDENTOWN, NJ 08505 This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form). ITEM DATE ITEM DATE ITEM DATE **Y4 Y5** Y4 Y5 Y4 **Y**5 ID Prefix A0310 ID Prefix A0369 ID Prefix A0561 Correction Correction Correction 8:36-5.10(a)(1) 8:36-3.4(a)(1) 8:36-4.1(a)(8) Reg. # Completed Reg. # Completed Reg. # Completed LSC 02/28/2022 LSC 02/28/2022 LSC 02/28/2022 ID Prefix A0751 ID Prefix A0779 ID Prefix A0781 Correction Correction Correction 8:36-7.3(b) 8:36-7.5(c) 8:36-7.5(d) Reg. # Reg. # Completed Reg. # Completed Completed 02/28/2022 02/28/2022 02/28/2022 LSC LSC LSC ID Prefix Correction ID Prefix Correction ID Prefix Correction Reg. # Completed Reg. # Completed Reg. # Completed LSC LSC LSC ID Prefix Correction **ID Prefix** Correction **ID Prefix** Correction Reg. # Completed Reg. # Completed Reg. # Completed LSC LSC LSC **ID Prefix ID Prefix ID Prefix** Correction Correction Correction Reg. # Completed Reg. # Completed Reg. # Completed LSC LSC LSC **REVIEWED BY REVIEWED BY** DATE SIGNATURE OF SURVEYOR DATE STATE AGENCY (INITIALS) DATE TITLE DATE REVIEWED BY **REVIEWED BY** CMS RO (INITIALS) FOLLOWUP TO SURVEY COMPLETED ON CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? 12/29/2021 YES NO

Page 1 of 1

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New Jersey Department of Health

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY								
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED								
					R-	C							
		j6tdgc	B. WING		05/24/2022								
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE													
CLARE ESTATE, THE 201 CROSSWICKS STREET													
BORDEN TOWN, NJ 08505													
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	(X5) COMPLETE DATE								
{A 000}	Initial Comments		{A 000}										
	Initial Comments: TYPE OF SURVEY 3/10/22	: Revisit from 12/29/21 and											
	CENSUS: 23												
	SAMPLE SIZE: 23												
	New Jersey Admini Standards for Licen Residences, Comp	substantial compliance with istrative Code, Chapter 8:36, insure of Assisted Living rehensive Personal Care ed Living Programs, based on rey.											

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

TITLE (X6) DATE

## STATE FORM: REVISIT REPORT MULTIPLE CONSTRUCTION PROVIDER / SUPPLIER / CLIA / DATE OF REVISIT **IDENTIFICATION NUMBER** A. Building 5/24/2022 B. Wing i6tdgc **Y3** NAME OF FACILITY STREET ADDRESS, CITY, STATE, ZIP CODE 201 CROSSWICKS STREET CLARE ESTATE, THE BORDENTOWN, NJ 08505 This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form). ITEM DATE ITEM DATE ITEM DATE Y4 **Y5** Y4 Y5 Y4 **Y**5 ID Prefix A0963 **ID Prefix ID Prefix** Correction Correction Correction 8:36-11.5(f) Reg. # Completed Reg. # Completed Reg. # Completed LSC 04/18/2022 LSC LSC **ID Prefix ID Prefix ID Prefix** Correction Correction Correction Reg. # Completed Reg. # Completed Reg. # Completed LSC LSC LSC ID Prefix Correction ID Prefix Correction ID Prefix Correction Reg. # Completed Reg. # Completed Reg. # Completed LSC LSC LSC ID Prefix Correction **ID Prefix** Correction **ID Prefix** Correction Reg. # Completed Reg. # Completed Reg. # Completed LSC LSC LSC **ID Prefix ID Prefix ID Prefix** Correction Correction Correction Reg. # Completed Reg. # Completed Reg. # Completed LSC LSC LSC **REVIEWED BY REVIEWED BY** DATE SIGNATURE OF SURVEYOR DATE STATE AGENCY (INITIALS) DATE TITLE DATE REVIEWED BY **REVIEWED BY** CMS RO (INITIALS) FOLLOWUP TO SURVEY COMPLETED ON CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? 12/29/2021 YES NO

Page 1 of 1

EVENT ID:

0J2J13

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Page 1 of 1

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