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
	j6tdgc	A. BUILDING: _____ B. WING _____	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARE ESTATE, THE	201 CROSSWICKS STREET BORDENTOWN, NJ 08505

(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
A 000	Initial Comments Initial Comments: SURVEY TYPE: Monitoring CENSUS: 12 A monitoring visit survey was conducted to ensure the safety and wellbeing of the residents as the facility received a shut off notice from the utlity company for non-payment which was set to take place on 7/25/24. The facility paid the bill while surveyors were onsite which prevented the facility from having to enact the emergency closure plan. The facility is in substantial compliance with N.J.A.C. Title 8 Chapter 36- Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs for this Complaint Investigation.	A 000		

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