	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE S	
AND FLAN C	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPL	ETED
		j6tdgc	B. WING		12/1	; 4/2023
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	•	
CLARE ES	STATE, THE		SWICKS STRE			
	· 		OWN, NJ 0850			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
A 000	Initial Comments		A 000			
	Initial Comments: TYPE OF SURVEY:					
	NJ00167715, NJ0016	0169219, NJ00167679, 37751, NJ00169222				
	CENSUS: 16					
	SAMPLE SIZE: 4					
	all of the standards in Administrative Code & Licensure of Assisted Comprehensive Person Assisted Living Programsubmit a plan of correct completion date for eather the plan is impler	3:36, Standards for Living Residences, onal Care Homes and ams. The facility must ection, including a ach deficiency and ensure mented. Failure to correct alt in enforcement action in isions of New Jersey Fitle 8, Chapter 43E,				
A 269	8:36-3.1(a) Administra	ation	A 269			
	alternate shall be des the absence of the ac administrator or a des available at all times a facility on a full-time b or more licensed bed in facilities that have	signated alternate shall be and shall be on-site at the basis in facilities that have 60 s, and on a half-time basis fewer than 60 licensed beds, e definition of "full-time" and				

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

TITLE

(X6) DATE

04/15/24

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		j6tdgc	B. WING		C 12/14/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CLARE ES	STATE, THE		SWICKS STRE OWN, NJ 0850		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
A 269	Continued From page	e 1	A 269		
	by: Based on observation determined that the fa an Alternate Administ writing. This deficient following: On 11/21/2023 at 11:the facility, Surveyor #1 who stated that the 11/21/2023, NJ Ex the facility. During con Administrator #1 was would be designated upon her departure. I	acility failed to ensure that rator was designated in practice evidenced by the 04 a.m., upon entrance to #1 interviewed Administrator e day of the survey, Order 26.4b1 with intinued interview, unable to confirm who as the facility's Administrator addition, Administrator #1 y the facility's designated			
	Independent Living A was not the facility's A	or #1 interviewed the facility's dministrator, who stated she Assisted Living Alternate as she informed that she new Assisted Living			
	an email from the fac Executive Officer (CE facility's Independent	•			
	new Administrator, Adthat the facility's Hum	or #5 interviewed the facility's dministrator #2, who stated an Resources Staffing gnated as the facility's			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURV	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETE	ĒD
			B. WING		С	
		j6tdgc	D. WING		12/14/2	2023
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA			
CLARE ES	STATE, THE		SWICKS STRE			
040.45	CHMMADV CT		OWN, NJ 0850			045)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE ((X5) COMPLETE DATE
A 269	Continued From page	e 2	A 269			
	Alternate Administrate unable to provide the documentation that id facility's designated A On 11/28/2023 at 11:3 conducted a post surwith the facility's Adm who stated that the fathe facility's designate During continued survequested a written dethe facility's designate	or. The Administrator was surveyor team with written dentified and confirmed the Alternate Administrator.				
A 355	8:36-4.1(a)(1) Reside	ent Rights	A 355			
	comprehensive perso assisted living progra to the following rights (a) Each assisted livir distribute a statement residents of assisted 1. The right to re- and care in accordance	onal care homes, and ims. Each resident is entitled ing provider will post and it of resident rights for all living residences, ceive personalized services ce with dividualized general service				
	This REQUIREMENT by: Complaint #'s: NJ001 NJ00169222	is not met as evidenced 69219, NJ00167715,				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _			
		j6tdgc	B. WING		12/1	; 4/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CLARE ES	STATE, THE		SWICKS STRE OWN, NJ 0850			
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
A 355	Continued From page	e 3	A 355			
	Based on interview and determined that the fa and services in according graph of the service Plan Resident #'s 1, 2, 3, a receiving physician proposed was evidenced by the On 11/21/2023, Surve Record (MR) for Resident facility in MJ Ex Order 26.4(b)(1) Used MJ Ex Order 26.4(b)(1) Use	acility failed to provide care dance with the resident's (GSP) for 4 of 4 residents, and 4 reviewed for not rescribed medications. This e following: Eyor #3 reviewed the Medical dent #1, who moved into the with diagnoses which er 26.4(b)(1), Order 26.4(b)(1), and fithe Medication d (MAR) dated (MAR) date				
	Surveyor #3 reviewed who moved into the fawith diagnoses which	d the MR for Resident #3 acility in NJ Ex Order 26.4(b)(1) included NJ Ex Order 26.4(b)(1)				

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
					c	
		j6tdgc	B. WING		12/1	4/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CLADE E	STATE THE	201 CROSS	SWICKS STRE	ET		
CLARE E	STATE, THE	BORDENTO	OWN, NJ 0850	05		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
A 355	Continued From page	• 4	A 355			
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Review of Resident # , showed that no administered to Resident which included signification which included signification with the sorder 26.4(b)(1) used for the sorder 26.4(b)(1) used to tree. Surveyor #3 reviewed moved into the facility diagnoses which including NJ Ex Order 2 and NJ Ex Order 2 Surveyor's review of the sorder so	3's MAR for NJ EX Order 26.4(b)(1) medications were dent #3 on NJ EX Order 26.4(b)(1) cant medications such as I for NJ EX Order 26.4(b)(1) J EX Order 26.4(b)(1) dethe MR of Resident #4 who of in NJ EX Order 26.4(b)(1) with Uded NJ EX Order 26.4(b)(1) 26.4(b)(1) he MAR for NJ EX Order 26.4(b)(1) cications were administered order 26.4(b)(1) in NJ EX Order 26.4(b)(1) with Uded NJ EX Order 26.4(b)(1) cications were administered order 26.4(b)(1) in NJ EX Order 26.4(b)(1) in Use NJ EX Order 26.4(b)(1) in Use O				
	Resident #'s 1, 2, 3, a medications are facility residents' medications authorized staff). How #'s 1, 2, 3, and 4, did medications which we taken to treat each reconditions. The facility provision of personality medication administration plans of Resident #'s Review of the MARs confirmed that on not also receive their significant medication the residents in accorphysician orders and	ty-administered (all s are administered by facility vever, on susceptibility of the process of t				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER	D	PLE CONSTRUCTION G:	(X3) DATE SU COMPLE	
	A. BOILDIN	o	C	
j6tdgc	B. WING			4/2023
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY,	STATE, ZIP CODE		
CLARE ESTATE. THE	201 CROSSWICKS ST			
·	BORDENTOWN, NJ 0			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION	11111111	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
A 355 Continued From page 5	A 355			
and harm.				
A 537 8:36-5.7(a)(1) General Requirements	A 537			
(a) A policy and procedure manual(s) for the organization and operation of the facility or program shall be developed, implemented, an				
reviewed at least annually. Each review of the manual(s) shall be documented, and the	,			
manual(s) shall be available in the facility or program to representatives of the Department	at			
all times. The manual(s) shall include at least following:				
An organizational chart delineating the lines of authority, responsibility, and accountability for the administration a resident care services of the facility or program;				
This REQUIREMENT is not met as evidenced by:				
Based on interview, observation, and review of pertinent documents it was determined that the				
facility failed to ensure that the Policy and Procedure Manual (P&PM) was made availab	ا ما			
to the Department of Health representatives u				
request during an on-site Complaint visit to the				
facility on 11/21 and 11/22/2023. This deficien practice was evidenced by the following:				
On 11/21/2023 at 11:40 a.m., upon entrance conference, the surveyor team asked the administrator, Administrator #1, for the facility' P&PM and in addition requested the facility's staffing policy. Administrator #1 stated that she was not able to locate or provide the P&PM to	e			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUF	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLET	ED
			B. WING		С	
		j6tdgc	B. WING		12/14/	/2023
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA			
CLARE ES	STATE, THE		SWICKS STRE DWN, NJ 0850			
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
A 537	Continued From page	e 6	A 537			
	Licensed Practical Nu not know where the F had access to the fac procedure manual. H requested for the P&F	Parkers (LPN) stated she did Parker (LPN) stated she did Parkers (LPN) stated and only sility's pharmacy policy and dowever, when the surveyor PM at 11:18 a.m., the LPN only find the pharmacy				
	Administrator, Adminishe was unable to locable to access the for	from the newly appointed istrator #2, who stated that cate the P&PM and was not				
	the surveyor team wit	and pharmacy policies at				
A 647	8:36-6.1(a)(3) Reside	ent Care Policies	A 647			
	shall be established, at intervals specified procedures. Each rev procedures shall be of	are policies and procedures implemented, and reviewed in the policies and view of the policies and documented. Policies and ude, but not be limited to, the				
	3. The determinate ensure delivery of ser	ation of staffing levels to rvices and				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		2011	B WING		C
		j6tdgc	J		12/14/2023
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA		
CLARE ES	STATE, THE		SWICKS STRE DWN, NJ 0850		
	CLIMMA DV CT		1		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
A 647	facility or program dureach 24-hour per provided directly by so by the facility or provided with a written contract. This REQUIREMENT by: Complaint #'s: NJ001	eded for each resident of the ring riod. Services may be taff employed program or in accordance t;	A 647		
	determined that the far policy that included the levels for the 24-hour resident received mentheir care needs. This evidenced by the following of the far policy. The far manual (P&PM) and is staffing policy. The Adocate or provide the factor that the surveyors as residenced to t	40 a.m., upon entrance yor team asked the facility's Policy & Procedure in addition, requested the dministrator was not able to P&PM or the staffing policy equested. The Administrator eam that 11/21/2023 was b1			
	reviewed the facility's there were were blank. In addition used for diagnosis su	MARs and observed that on e no initials and the MAR's n, these medications were ch as diabetes, coronary blood pressure, depression,			

INEM JEIS	ey Department of Fleat	<u> </u>				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
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		j6tdgc	B. WING		12/1	4/2023
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NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	I E, ZIP CODE		
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02,	, , , , , , , , , , , , , , , , , , ,	BORDENT	OWN, NJ 0850	05		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	CIATE	DATE
				DEFICIENCY)		
A 647	Continued From page	. o	A 647			
A 047	Continued From page	8 8	A 047			
	On 11/22/2023 at 10:3	34 a.m., the facility's				
		irse (LPN) stated she did				
		P&PM was located and only				
		ility's pharmacy policy and				
		gain, the surveyor requested				
		m., the LPN stated that she				
	could only find the ph	armacy manual.				
	On 11/22/2023 at 12:0	05 p.m., the surveyor				
		ho stated she was employed				
		m an agency. The surveyor				
	inquired about the or	• •				
	NJEX Order 26.4(b)(1)	the transfer of the second of				
	. The RN S	stated she was notified by				
		at the Licensed Practical				
		ed to work a double shift on				
	NJ Ex Order 26.4(b)(1) had an en	nergency and could not				
		t. The RN stated that the				
	•	lled to work a double shift on				
	NJ Ex Order 26.4(b)(1) . The RN	stated she provided				
	coverage for NJ Ex Order 26.4	Stated, Sile provided				
	coverage for	but was unable to				
		^{J Ex Order 26.4(b)(1)} . The RN stated				
	she was not available	to work at the facility on				
	because s	she was scheduled at				
	another job.					
	The RN further stated	I that she called the				
	Executive Director bu	t was unable to reach her				
		o other means of contact.				
		cility's census was 16 with				
	THE IN STATE THE INC	onity o Collous was 10 Willi				
		ospital prior to NUEx Order 26.4(b)(1).				
		at 15 residents did not				
	receive medication or					
	On 11/22/2023 at 3:00	0 p.m., the surveyor				
	requested the P&PM	from the newly appointed				
	•	ated that she was unable to				
	·	was not able to access the				
		s office because the door				
		onioc because the door				
	was locked.					[

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SI COMPLE	
			7. BOILBING.		c	
		j6tdgc	B. WING		_	, 4/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CLARE ES	STATE, THE		SWICKS STRE OWN, NJ 0850			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETE DATE
A 647	Continued From page	9	A 647			
	the surveyor team wit	trator was unable to provide th a staffing policy or a the survey on 11/21/2023				
	appointed Administrate agency contracts. Or	/2023 the facility's newly tor produced via email, 3 n 11/30/2023 Surveyor #5 contracts and revealed 1 of ent and valid.				
	was implemented to e	nsure that a staffing policy ensure that each resident are and assistance they ed such as medication				
A 793	8:36-8.2 Nursing Serv	vices	A 793			
	A facility shall have at professional nurse av					
	by:	is not met as evidenced				
	determined that the far Registered Profession available to the facility the facility's residents accurately and safely . This deficitly by the following:	y at all times to ensure that ' medications were administered on cient practice was evidenced				
	On 11/21/2023 at 12:2 complaint survey, Sur	26 p.m., while conducting a rvevor #1 interviewed				

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SU	
			A. BUILDING: _			
		j6tdgc	B. WING		12/14	4/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CLADE E	STATE THE	201 CROS	SWICKS STRE	ET		
CLARE E	STATE, THE	BORDEN	OWN, NJ 0850	05		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
A 793	Continued From page	e 10	A 793			
	his/her prescribed me At 12:41 p.m., Survey facility's Medication A					
	Certified Home Healt who confirmed that the receive their prescrib NUSCOCKET 2014 (D)(I). CHHA # agency RN was unab	or #1 interviewed the facility's h Aide (CHHA), CHHA #1 he facility's residents did not ed medications on 1 also stated the facility's ble to go into the facility to to the facility's residents on				
	(LPN), LPN #1 who a medications were not as prescribed on LPN#2 was unable to due to a family emerginate all the facility's nattempt to staff the fashift on LPN #2 was unable to the same interview utilized an agency RN to the facility.	y Licensed Practical Nurse also confirmed that the dispensed to the residents are confirmed. LPN #1 stated to work her scheduled shift gency. LPN #1 also stated the urses were contacted in acility's morning and evening the urse unsuccessful. If the LPN stated the facility who was unable to report				
	facility's RN, who stands buring continued into the RN stated although come into the facility medication, she was	unable to do so due to being mployment. In addition, the				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPL	EIED
		j6tdgc	B. WING		12/1	14/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
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CLARE E	STATE, THE	BORDEN	TOWN, NJ 0850)5		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
A 793	Continued From pag	e 11	A 793			
	facility's nurses wher	pped communicating with the nattempting to staff the . The RN also stated the a full-time RN.				
	On 11/22/23, the surveyor made the newly designated Administrator (Administrator #2) the immediacy of the danger and risks of serious harm to residents if they continue to miss their medications which includes significant medications. The surveyor requested a Removal Plan for immediate corrections of the identified risk to residents					
	the new Administrato "The Clare Estate ha contracts with Bayad and Experience Nurs event that the facility staffing for direct resi	oval Plan was submitted by a which read as follows: s established staffing a Home Health, All Shifts, ses Staffing Agency. In the is in need of additional dent care or medication cility has a plan in place to seeds will be fulfilled				
	additional nurses or of administration. If the Administrator will call Nurse or the establis relief is unavailable, Human Resources the Human Resources won-call. If necessary, medication administration commitment for The additional staffing bath demands of the residinterviewing and hiring	Ilist is exhausted, the I the Clare Estate ON-Call hed staffing contracts. If the the Administrator will alert hat the process has begun. iill coordinate the RN backup the RN backup will provide ation It is our Clare Estate to obtain sed on the acuity needs and				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		j6tdgc	B. WING		C 12/14/2023
NAME OF PI	ROVIDER OR SUPPLIER	•	RESS, CITY, STA	TE, ZIP CODE	1
CLARE ES	STATE, THE		SWICKS STRE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
A 793	as they apply" Surveyors reviewed the 11/28/23, surveyor may that the Removal Plarit needed clarifications qualified/authorized son Nurse (RN) for admir medications. On 11/30/23, during a Department's Supervite facility Corporate Presofficer (CEO) stated the Administrator and will calls out or a certified She stated that she won-Call nurse from coor from their affiliated. The facility Administrate Removal Plan with refulzion 12/5/23, 12/7/23,	ne Removal Plan and on ade Administrator #2 aware in was not accepted and that is regarding the availability of taff, including a Registered instration of residents' telephone interview the sor of Inspections, the sident/Chief Operating hat she will be the Alternate be notified when a nurse medication aide (CMA). Tould then contact the ontracted staffing agencies facilities. Ator re-submitted the visions dated 12/4/23, 0/23, and 12/12/23. The Plan on 12/12/23, included schedule with list of pir contact information, staff, Administrator #2, and 12/12/23, included but not gratatements: The property of the vent of an emergency call on numbers are posted as the absence of the	A 793		
	well. As a backup in				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	EIED
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		j6tdgc			1 12/1	4/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
		201 CROS	SWICKS STRE	ET		
CLARE ES	CLARE ESTATE. THE		TOWN, NJ 0850			
	OLUMANA DV OT		<u> </u>			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
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				DEFICIENCY)		
4.700			4.700			
A 793	Continued From page	e 13	A 793			
	direct number to Hum	nan Resources located at				
		rsing office to assi finding				
		ne Administration will verify				
		Management that all staff				
	_	t. If a punch in is missed, the				
	I	ak directly to the Nurse				
	Supervisor ensuring a					
	The Clare Estate has					
		its NJ Ex Order 26.4(b)(1)				
	event that the facility is in need of additional staffing for direct resident care or medication					
	_	cility has a plan in place to				
	ensure the staffing ne					
	_	eas will be fullilled				
	accordingly	he recognible for calling in				
		be responsible for calling in				
	additional nurses or C					
	administration. If the	•				
		the Clare Estate ON-Call				
		ned staffing contract. If the				
		he Administrator will alert the				
	available agency. The					
		ckup on-call. If necessary,				
	the RN backup will pr	ovide medication				
	administration.					
		s in the process of hiring a				
		Il be provided of evidence				
	posted for RN.					
		for The Clare Estate to				
		ing based on the acuity				
	needs and demands					
		and hiring qualified Director				
		nursing and CMA candidates				
	•	sitions, and per diem roles				
	as they apply.					
		s notified and present in the				
		OH Staff. In the absence of				
	the administrator, you	ı could always contact HR				
	Manager at NJ Ex Order 26	^{.4(b)(1)} , Office at				
	NJ Ex Order 26.4(b)(1) and/or	CIS CEO a NJ Ex Order 26.4(b)(1)				
		ied and confirmed of any				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _			
		j6tdgc	B. WING		12/14	4/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
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040.15	CLIMANA DV. CT		OWN, NJ 0850		N. T	0.50
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
A 793	Continued From page	: 14	A 793			
A 935	notify the Department the phone follow in wr. President of CIS and/notified at NJ Ex Order 26.4(t main office at NJ Ex Order 20.4(t main offic	g shortage, the facility will of Health immediately on riting within 72 hours and the or HR Manager will also be or HR Manager will also be or HR Manager will also be or the and NIEX Order 26.4(b)(1) or the urveyors did a revist to verify s implemented. The facility he contact information when the Administrator verified all each shift. At the time of hired a Director of Nursing ing needs were met.	A 935			
	(b) All medications sh qualified personnel in orders, facility or prog requirements, caution	all be administered by accordance with prescriber tram policy, manufacturer's ary or accessory warnings, tate laws and regulations.				
	by: Complaint #'s: NJ001 NJ00169222 Based on observation	i, interview, and record ned the facility failed to				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			`
		j6tdgc	B. WING		12/1	, 4/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
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			OWN, NJ 0850			
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
A 935	Continued From page	e 15	A 935			
A 935	residents by qualified with prescriber orders reviewed for medicati #'s 1, 2, 3, and 12 oth the sample. The defice videnced by the following of the sample. The defice videnced by the following of the sample. The defice videnced by the following of the sample. The defice videnced by the following of the sample. The deficience of the sample. The deficience of the sample of the sa	personnel in accordance is for 3 of 3 residents on administration, Resident iter residents not included in cient practice was owing: 244 p.m., Surveyor #4 who stated that on State of the residents. It has no Nurse present in the inedications to the residents. It has attempted to call it has she attempted to call it has she attempted that she did that there was no cility's Administrator. Tryeyor #4 reviewed Resident (MR). The "Resident Face dent #1 had an admission diagnoses which included (b)(1) NUEX Order 26.4(b)(1) NUEX Order 26.4(b)(1) We conder 26.4(b)(1) Illowing significant in not signed as m., NJ Ex Order 26.4(b)(1) m., NJ Ex Order 26.4(b)(1) m., NJ Ex Order 26.4(b)(1) m., NJ Ex Order 26.4(b)(1)	A 935			
	or NJ Ex Order 26.4(b)(1) at 9:00 a.	m., NJ Ex Order 26.4(b)(1) used				

New Jers	sey Department of Hea	lth				
	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		104.1	B. WING		C	
		j6tdgc			12/1	4/2023
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			TOWN, NJ 0050			
(X4) ID		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
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"."		•	1,	DEFICIENCY)		
: 005			+			
A 935	Continued From page	∍ 16	A 935			
	NJ Ex Order 26.4(b)(1) for NJ	Ex Order 26.4(b)(1)				
		m., NJ Ex Order 26.4(b)(1)				
ļ	used as NJ Ex Order 2	26.4(b)(1)				
	NJ Ex Order 26.4(b)(1) at 9:00 a.m					
	for NJ Ex Order 26.4(b)(1)	1.				
		m.,NJ Ex Order 26.4(b)(1)				
	with NJ Ex Order 2					
	NJ Ex Order 26.4(b)(1)					
	NJ Ex Order 26.4(b)(1) at 9:00 a.	m., 12 p.m., and 5:00 p.m.,				
	NJ Ex Order 26.4(b)((1) 2 tablets for total of				
	used for NJ Ex Orde	er 26.4(b)(1)				
	NJ Ex Order 26.4(b)(1) at 11:30 a	a.m., NJ Ex Order 26.4(b)(1)				
	NJ Ex Order 26 fo	or ^{NJ Ex Order 26.4(b)(1)} greater than				
	used for NJ Ex Orde	er 26.4(b)(1)				
	NJ Ex Order 26.4(b)(1) at 9:00 a.	m., and 5:00 p.m. NJ Ex Order 26.4(b)				
	used as NJ Ex Order 26.	for NJ Ex Order 26.4(b)(1)				
	NJ Ex Order 26.4(b)(1) at 9:00 a.	m., and 5:00 p.m.,				
	NJ Ex Order 26.4(b	o)(1) used for NJ Ex Order 26.4(b)(1)				
	NJ Ex Order 26.4(b)(1) at 9:00 a.	m., and 5:00 p.m., NEX Order 2				
		used to promote NJ Ex Order 26.4(t				
		· <u>—</u>				
	NJ Ex Order 26.4(b)(1) at 9:00 a.	m., and 5:00 p.m.				
	NJ Ex Order 26.4(b)((1) used as an NJ Ex Order 26.4(b)(1)				
	NJ Ex Order 26.4(b)(1) at 5:00 p.	m., NJ Ex Order 26.4(b)(1) used				
	for NJ Ex Order 26.4(b)(1)					
	NJ Ex Order 26.4(b)(1) at 5:00 p.	m. NJ Ex Order 26.4(b)(1)				
	used for NJ Ex Order 26.4(b					
	NJ Ex Order 26.4(b)(1) at 9:00 p.	NJ Ex Order 26.4(b)(1)				
	, NJ Ex Order 26.4 used for	NJ Ex Order 26.4(b)(1)				
	NJ Ex Order 26.4(b)(1) at 9:00 p.	m. NJ Ex Order 26.4(b)(1)				
	capsules for total of	JEX Order 26.4 used for NJ Ex Order 26.4(b)(1)				
	at 9:00 p.	m., NJ Ex Order 26.4(b)(1) used to				
	NJ Ex Order 26.4(b)(1)					
	On 11/21/2023 at 12:					
		#1 who stated that he/she				
	did not receive medic					
		it #1 stated he/she was				ı
	informed there was n	o Nurse present in the				

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _			,
		j6tdgc	B. WING		12/1	4/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	·	
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A 935	Continued From page	e 17	A 935			
A 935	building to administer Resident #1 further so receive physician premorning or the evening of the	r medications on tated that he/she did not escribed medications in the eng which included his/her reveyor #4 reviewed Resident ent Face Sheet" revealed admission date of included superior with secondar 26.4(b)(1) and NJ Ex Order 26.4(b)(1). The esident #2's MAR dated hich revealed the following as were not signed as m., 2:00 p.m., and 10 p.m., and for NJ Ex Order 26.4(b)(1) m., 11:30 a.m., 4:30 p.m., 3.4(b)(1) per NJ Exest Order 26.4(b)(1) m., NJ Ex Order 26.4(b)(1) used 1) m., NJ Ex Order 26.4(b)(1) used 3. (Order 26.4(b)(1) used 4. (Order 26.4(b)(1) used 4. (Order 26.4(b)(1) used 5. (Order 26.4(b)(1) used 6. (Order 26.4(b)(1) used 7. (Order 26.4(b)(1) us	A 935			
	for NJ Ex Order 26.4(b)(1) at 9:00 a for NJ Ex Order 26.4(b)(1) at 9:00 a used for NJ Ex Order 26.4(b)(1) at 9:00 a	m., NJ Ex Order 26.4(b)(1) used m., NJ Ex Order 26.4(b)(1) m., NJ Ex Order 26.4(b)(1) m., and 5:00 p.m.,				
	NJ Ex Order 26.4(b)	(1) mg used for NJ Ex Order 26.4(b)(1)				

STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _			
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OLAKE E	JIAIL, IIIL	BORDEN	TOWN, NJ 0850	05		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
A 935	Continued From page	e 18	A 935			
A 933	NJ Ex Order 26.4(b)(1) At 9:00 a. p.m., NJ Ex Order 26.4(b)(1) at 9:00 p. Used foll NJ Ex Order 26.4(b)(1) at 9:00 p. NJ Ex Order 26.4(b)(1) at 9:00 p. NJ Ex Order 26.4(b)(1) The provider 26.4(b)(1) The provider 26.4(b)(1) The provider 26.4(b)(1) NJ Ex Order 26.4(b)(1) The provider 26.4(b)(1) The	m., and 5:00 p.m. Ex Order 26.4(b)(1) m., and 5:00 p.m. Used for MJ Ex Order 26.4(b)(1) Exporter 26.4(b)(1) E	Asso			
	stated that during the began to experience					
		esident #2 MR document epartment Documentation"				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		j6tdgc	B. WING		12/14/2023
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA		
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A 935	Continued From page		A 935		
	revealed a NJ Ex Order				
	NJ00169222 Based on observation review it was determinensure medications w				
	residents by qualified personnel in accordance with prescriber orders for 3 out of 3 residents reviewed for medication administration, Resident #'s 1, 2, and 3. The deficient practice was evidenced by the following:				
	Record (MR) of Reside facility in NJEX Order of NJEX Order NJ EX Order NJ EX Order 28.4(b)(1) Nursing Notes dated "On NJEX Order 28.4(b)(1), media pt [patient] NJEX Order 28.4(b)(1), media pt [patient] NJEX Order 28.4(b)(1)	iny and family			
	Review of the Medica (MAR) showed that no administered to Resid Medications were not 3. Surveyor's review of the Medications were not (NJ EX Order 26.4(b)(1), reversed regions that were not the medications that were not the medication to the medication that the med	tion Administration Record o medications were lent #4 on [MEXICATE ACCUPATION OF Resident #3's MAR dated saled the following			

New Jersey Department of Health		itn				
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
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				,		
A 935	Continued From page	e 20	A 935			
		b)(1) once tablet every 12				
	hours at 9 a.m. and 9	p.m. used for				
	N I F.: O-d 20 4/5/4/					
	NJ EX Order 26.4(b)(1)	tablets daily on Tuesday,				
		Sunday at 9 a.m. used for				
	NJ Ex Order 26.4(b)(1)					
	NJ EX Order 26.4(b)(1) Or	nce daily at 9 a.m. used for				
	NJ Ex Order 26.4(b)(1)					
	NJ Ex Order 26.4(b)(1) once	e daily at 9 a.m. used for				
	NJ Ex Order 26.4(b)(1)					
	one tal	blet daily at 9 a.m. used to				
	NJ Ex Order 26.4(b)(1)	or Markoter 2				
	NJ Ex Order 26.4(b)(1) Or	ne tablet at 5 p.m. used for				
	NJ Ex Order 26.4(b)(1)					
	NJ Ex Order 26.4(b)(1) one t	tablets three times daily at 9				
	a.m., 12 p.m., 5 p.m.	used for week and the state of				
	NJ Ex Order 26.4(b)(1) one	tablets every 12 hours at 9				
	a.m. and 9 p.m. used	for NJ Ex Order 26.4(b)(1)				
	NJ Ex Order 26.4(b	o)(1) one capsule every 12				
	hours at 9 a.m. and 9	p.m. used for NJ Ex Order 26.4(b)(1)				
	NJ Ex Order 26.4(b)(1)	one capsule every 12 hours				
	at 9 a.m. and 9 p.m. ı	used for NJ Ex Order 28.4(b)(1)				
	NJ Ex Order 26.4(b)(1)	one capsule daily at 9 p.m.				
	used for NJ EX Order 25.4(b)(1)					
	IN I Ev Order 26 /	·(b)(1) once daily				
	at 9 a.m. used for NJEX	c Order 26.4(b)(1)				
	NJ EX Order 26.4(b)(1) onc	ce daily at 9 a.m. used for				
	NJ Ex Order 26.4(b)(1)					
	NJ Ex Order 26.4(b)(1) once	daily at 9 a.m. used for				
		_				
	NJ Ex Order 26.4(b)(1) once	daily at 9 p.m. used to				
	NJ Ex Order 26.4(b)(1)					
	NJ Ex Order 26.4(b)(1) on	e table three times daily at 9				
	a.m., 12 p.m., 5 p.m.	used for NJ Ex Order 26.4(b)(1)				
	NJ Ex Order 26.4(b)(1)	one table daily at 6 a.m.				
	used for NJ Ex Order 28.4(b)(1)	-				
	NJ Ex Order 26.4(b)(1)	tablets (NJ Ex Order 25.4(b)) three				
		12 p.m., 5 p.m. used for				
	NJ Ex Order 26.4(b)(1)					
	NJ Ex Order 26.4	(b)(1)] once				

New Jers	ey Department of Hea	itn				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
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			5 14/110			
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(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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A 935	Continued From page	e 21	A 935			
	. •					
	daily at 9 a.m. used for	or 13 Ex Grael 20.4(0)(1)				
	At 12:44 p.m., the sur					
	Certified Home Healt	h Aide #1 (CHHA) who				
	indicated on NJ Ex Order 26.4					
		was not in, when a resident				
		iving out medications. CHHA				
		the Administrator, but that				
		not answer the phone.				
	CHHA#1 stated that	she called the Administrator				
	several times but no	one answered. CHHA #1				
	further stated she had	d the number for the				
	corporate office; how	ever, offices were closed on				
	Sundays. In addition	, CHHA#1 confirmed that				
	she did not have the	number to contact the				
	agency Registered N	urse.				
	On 11/22/2023 at 10:	34 a.m., Surveyor #3				
	interviewed Resident	#3 in their apartment who				
	confirmed, 'NJ Ex Order 26.4 t	here was no Nurse. I didn't				
	get medications on N	J Ex Order 26.4(b)(1) "				
	At 11:13 p.m., the sur	rveyor interviewed the				
		urse (LPN #1) who stated				
		made by her to provide				
	coverage for the doub	ble shift for NJ Ex Order 26.4(b)(1) but				
	could not.					
	The facility failed to e	nsure that Resident #'s 1, 2,				
		scheduled medications as				
	prescribed by their ph					
	procention by their pr	ryololario.				
	In addition 12 resider	nts not included in the				
	•	receive their medications on				
		review of their MARs				
	revealed medications					
	administered. Reside	<u> </u>				
		ere significant medications to				
	treat their health cond	ditions such as der 26.4(b)(1), and other health				
	- CAT HO EX OIG	, and other nealth	1		1	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		j6tdgc	B. WING		12/14/2023
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA		
CLARE ES	STATE, THE		SWICKS STRE		
			OWN, NJ 0850		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
A 935	Continued From page	22	A 935		
		cient practice placed all serious harm to their health			
	immediacy of the dan harm to residents if th medications which inc medications. The sur	ator (Administrator #2) the ger and risks of serious ley continue to miss their			
	the new Administrator "The Clare Estate has contracts with Bayada and Experience Nurse event that the facility i staffing for direct resid	a Home Health, All Shifts, es Staffing Agency. In the is in need of additional dent care or medication cility has a plan in place to			
	additional nurses or C administration. If the Administrator will call Nurse or the establish relief is unavailable, the Human Resources the Human Resources with on-call. If necessary, medication administration additional staffing based demands of the resident interviewing and hiring Nurses Full-Time, nur	list is exhausted, the the Clare Estate ON-Call ned staffing contracts. If the he Administrator will alert at the process has begun. Il coordinate the RN backup the RN backup will provide ation It is our Clare Estate to obtain sed on the acuity needs and ents. We continue			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	ZIP CODE	12/14/202		
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CLARE E	STATE, THE		TOWN, NJ 08505				
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A 935	Continued From page	23	A 935				
	as they apply"						
	11/28/23, surveyor mathat the Removal Plai it needed clarification	the Removal Plan and on ade Administrator #2 aware in was not accepted and that is regarding the availability of taff, including a Registered histration of residents'					
	On 11/30/23, during a telephone interview the Department's Supervisor of Inspections, the facility Corporate President/Chief Operating Officer (CEO) stated that she will be the Alternate Administrator and will be notified when a nurse calls out or a certified medication aide (CMA). She stated that she would then contact the On-Call nurse from contracted staffing agencies or from their affiliated facilities.						
	12/5/23, 12/7/23, 12/7 last revised Removal a copy of the staffing available staff and the	visions dated 12/4/23, I0/23, and 12/12/23. The Plan on 12/12/23, included					
	limited to the following " All staff will be give to the administrator a Administrator in the e off. The RN and Physicia well. As a backup in administrator, all staff direct number to Hum	ren a direct phone number nd an alternate for the vent of an emergency call n numbers are posted as					

New Jers	ey Department of Hea	itn					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
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				DEFICIENCY)			
A 935	Continued From page	24	A 935				
71000	Continued From page	5 24	71000				
	other release staff. The	he Administration will verify					
	through UltiPro Time	Management that all staff					
	are present each shif	t. If a punch in is missed, the					
	Administrator will spe	ak directly to the Nurse					
	Supervisor ensuring a	all staff are present.					
	The Clare Estate has						
	contracts with All Shif	fts ^{NJ Ex Order 26.4(b)(1)}). In the					
		is in need of additional					
	staffing for direct resid	dent care or medication					
	administration, the fac	cility has a plan in place to					
	ensure the staffing ne	eeds will be fulfilled					
	accordingly						
	The Administrator will	l be responsible for calling in					
	additional nurses or C	CMAs for medication					
	administration. If the	list is exhausted, the					
	Administrator will call	the Clare Estate ON-Call					
	Nurse or the establish	ned staffing contract. If the					
	relief is unavailable, t	he Administrator will alert the					
	available agency. The	e Administrator will					
	coordinate the RN ba	ckup on-call. If necessary,					
	the RN backup will pr	ovide medication					
	administration.						
	Currently the facility is	s in the process of hiring a					
	RN documentation wi	ill be provided of evidence					
	posted for RN.						
	It is our commitment	for The Clare Estate to					
	obtain additional staff	fing based on the acuity					
	needs and demands	of the residents. We					
	continue interviewing	and hiring qualified Director					
	of Nurses Full-Time,	nursing and CMA candidates					
	for their respective po	ositions, and per diem roles					
	as they apply.						
		s notified and present in the					
	_	OH Staff. In the absence of					
		ı could always contact HR					
	Manager at NJ Ex Order 26						
	NJ Ex Order 26.4(b)(1) and/or	CIS CEO at NJ Ex Order 26.4(b)(1)					
	CIS CEO will be notif	ied and confirmed of any					
	staffing shortage or a	ny other issues.					
	In the event of staffing	g shortage, the facility will					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. Boilesino.			С	
		j6tdgc	B. WING		12/14/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CLARE ES	STATE, THE		SSWICKS STRE			
(X4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	TOWN, NJ 0850	PROVIDER'S PLAN OF CORRECTION	J (V5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
A 935	Continued From page	e 25	A 935			
	notify the Department the phone follow in w President of CIS and notified at main office at MI EX Order. On 12/14/2023, the sto the facility to determ that the Removal Plate Department Of Health correct identified risks to the residents. The the contact information and the Administrator present on each shift survey, the facility hir	t of Health immediately on riting within 72 hours and the for HR Manager will also be and with a condense of the condense of t				
A 937	scope of practice and of the registered profe	n of medications is within the I remains the responsibility	A 937			
	by: Complaint#'s: NJ001 NJ00169222					
	Based on observation	n, interview with staff, and				

New Jers	sey Department of Hea	itn					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
		101.1	B. WING		C 12/14/2023		
		j6tdgc	B: Will 5		12/1	4/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	ATE, ZIP CODE			
		201 CRO	SSWICKS STRE	ET			
CLARE ES	STATE, THE		TOWN, NJ 0850				
	0.11414 D./ 0.7						
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE	
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE	
				DEFICIENCY)			
A 937	Cantinual Francisco	- 20	A 937				
A 931	Continued From page	3 20	A 937				
	review of medication	administration records					
	(MARs), it was deterr	mined that the facility					
	Registered Profession	nal Nurse (RN) failed to					
	ensure that residents	' medications were					
	accurately and safely	administered on					
		ficient practice was					
	evidenced by the follo						
		ŭ					
	Review of the facility'	's MARs on 11/21/2023 at					
		or revealed that medications					
	were not administere						
	NJ Ex Order 26.4(b)(1) . These in	cluded administration of					
	medications with the						
		ictions/precautions that were					
		e medication on an empty					
		edication 1/2 hour before					
	breakfast, take the m						
		R's dated NJ Ex Order 26.4(b)(1)					
		cations used for diagnosis					
		•					
		ronary artery disease, high					
	blood pressure, depre	ession, and pain					
	medications.						
	0= 44/00/0000 =+ 40.	05 m m the aumieure					
		05 p.m., the surveyor					
		who stated she was employed					
		om an agency. The surveyor					
	inquired about the on	nitted medications on					
	. The RN s	stated she was notified by					
		hat the Licensed Practical					
		ed to work a double shift on					
	nad an ci	mergency and could not					
	_	ft. The RN stated that the					
		uled to work a double shift on					
	NJ Ex Order 26.4(b)(1) . The RN	further stated, she provided					
	coverage for NJ Ex Order 26.4	but was unable to					
	provide coverage on	NJ Ex Order 26.4(b)(1) . The RN stated					
	she was not available	e to work at the facility on					
		she was scheduled at					
	another job.						

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
					l c	
		j6tdgc	B. WING		1	4/2023
NAME OF P	ROVIDER OR SUPPLIER	•	DRESS, CITY, STA	TE ZIP CODE	•	
NAME OF T	KOVIDEK OK 3011 EIEK		SWICKS STRE			
CLARE ES	STATE, THE		OWN, NJ 0850			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
A 937	Continued From page	e 27	A 937			
	The RN further stated Executive Director or to reach her via phono of contact. The RN s was 16 with one resid and confinot receive medication. Post survey on 11/28 appointed Administrated agency contracts. Overified such agency 3 contracts were currused April 2020 and sused anymore due to The surveyor request procedure manual or	d that she called the but was unable e and had no other means tated the facility's census dent in the hospital prior to rmed that 15 residents did on on NUEX OTHER 26.4(b)(1) /2023 the facility' newly tor produced via email, 3 n 11/30/2023 Surveyor #5 contracts and revealed 1 of ent, one contract was last the other contract was not				
A 961	the Removal Plan was educated all staff on a call-out occurs and staff were present on the revisit, the facility (DON) to ensure staff 8:36-11.5(e) Pharmac (e) The registered promedication errors and immediately to the propharmacist and/or co	-	A 961			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING			,
		j6tdgc	B. WING		12/1	, 4/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
CLARE ES	STATE, THE		SWICKS STRE			
	· 		OWN, NJ 0850			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
A 961	Continued From page	= 28	A 961			
	by:	is not met as evidenced 169219, NJ00167715,				
	Based on interview and record review, it was determined that the facility Registered Professional Nurse (RN) failed to notify the consultant pharmacist when medications were not administered in accordance with prescriber orders for 2 of 4 saampled residents reviewed, Resident #1 and Resident #2. The deficient practice was evidenced by the following: On 11/21/2023, Surveyor #4 reviewed the Medication Administration Records (MAR) for Resident #1 and Resident #2. The surveyor observed that medications on the date of for Resident #1 and Resident #2 were not signed as given which indicated that medications were not given in accordance with prescriber orders.					
	Record (MR) revealed date of with NLLEY Order 26.40	NJ Ex Order 26.4(b)(1) NJ Ex Orde				
	document titled, "Nur which ind not completed or indicated that the phy notified. Further review	vsician and family were ew of MR indicated no notified the pharmacist or				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					c	;
		j6tdgc	B. WING		12/1	4/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CLARE E	STATE, THE		SWICKS STRE OWN, NJ 0850			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
A 961	#2's MR which reveal in date of included with of with NJ and NJ Ex Order 26.4(b)(1). Further review of Res NN dated pass was not done or further indicated that were notified. Further evidence that the RN consultant pharmacis: On 11/21/2023, at 12: interviewed Resident not receive any medic coverage that is presconditional process of the evening including to administer Resident #1 further streceive prescribed methor the evening including. The facility failed to no or pharmacy consultated administered as presconditions.	yor #4 reviewed Resident ed Resident #2 had a move and diagnoses which EX Order 26.4(b)(1) ident #2's MR revealed a indicating that medication ident #2's MR revealed a indication on Indicated no notified the pharmacist or ident #2's MR revealed a indication and family if review of MR indicated no notified the pharmacist or ident #2's MR revealed a indication and family if review of MR indicated no notified the pharmacist or ident #2's MR revealed a indication and family if review of MR indicated no notified the pharmacist or ident #1 stated he/she did ident #2 become 28.4(b)(1) indications in the morning or ident #1 stated he/she did not redications in the morning or ident #1 indications were not contributed for Resident #1 and intity failed to provide intity failed medications as	A 961			

				STA	ATE FC	RM: RE	VISIT R	EPORT				
	R / SUPPLIER / C		MULTIPLE CONS A. Building	TRUCTION							DATE O	F REVISIT
j6tdgc	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		B. Wing							Y2	3/12/20	24 _{Y3}
NAME OF	FACILITY	•					STREE	TADDRESS, CIT	Y, STATE, ZIF	CODE	•	
CLARE E	STATE, THE						1	OSSWICKS STR				
							BORDE	NTOWN, NJ 085	05			
corrective	e action was acc tion prefix code	omplished	. Each deficiend	y should be	fully ide	ntified us	ing either	the regulation	or LSC prov	and the date such ision number and nent on the surve	the	
ITEI	M		DATE	ITEM				DATE	ITEM			DATE
Y4			Y5	Y4				Y5	Y4			Y5
ID Prefix	A0269		Correction	ID Prefix	A0355			Correction	ID Prefix	A0537		Correction
Reg.#	8:36-3.1(a)		Completed	Reg.#	8:36-4.1	(a)(1)		Completed	Reg.#	8:36-5.7(a)(1)		Completed
LSC			03/12/2024	LSC				03/12/2024	LSC			03/15/2023
									-			<u> </u>
ID Prefix	A0647		Correction	ID Prefix	A0793			Correction	ID Prefix	A0935		Correction
Reg.#	8:36-6.1(a)(3)		Completed	Reg. #	8:36-8.2			Completed	Reg.#	8:36-11.4(b)		Completed
LSC			03/15/2023	LSC				03/12/2024	LSC			03/12/2024
ID Prefix	A0937		Correction	ID Prefix	A0961			Correction	ID Prefix			Correction
Reg. #	8:36-11.5(a)		Completed	Reg. #	8:36-11.	5(e)		Completed	Reg.#			Completed
LSC			03/15/2023	LSC				03/12/2024	LSC			Completed
			00/10/2020	150				00/12/2024	1.50			
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			
REVIEWE	D RV	REVIEWE	ED RV	DATE		SIGNATU	RE OF SU	DVEVOR			DATE	
STATE AG		(INITIALS		DATE		SIGNATU	NE OF 30	NOTEFOR			DATE	
REVIEWE CMS RO	D BY	REVIEWE (INITIALS		DATE		TITLE					DATE	

Page 1 of 1 EVENT ID: TXR312

YES NO

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF

UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

12/14/2023

FOLLOWUP TO SURVEY COMPLETED ON