STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315019	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DWELLING PLACE AT ST CLARES	**400 WEST BLACKWELL ST , DOVER, New Jersey, 07801**

(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) COMPLETION DATE
F0000	INITIAL COMMENTS Complaints: 2748974 Survey Date: 7/15/2026 Census 28 Sample: 12 + 1 closed record A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F0000		08/07/2026
F0695 SS = SQC-F	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain and document [NJ Exec Order 26.4b1] care and equipment for a resident who was receivin [NJ Ex Order 26, 4B1] for 12 of 12 residents reviewed (Residents #1, #2, #3, #4, #5, #6, #7, #8, #11, #17, #23, #25). This deficient practice was evidenced by the following: 1.) On 7/6/26 at 10:40 AM, the surveyor observed resident #1 in bed with a [NJ Ex Order 26, 4B1]. The [NJ Ex Order 26,] did not have a dated label or a written date on the [NJ Exec Order 26.4b1].	F0695	1) How will the corrective action be accomplished for those residents found to be affected by the deficient practice? The [U. S. FOIA (b) (2)] immediately educated all staff members on all shifts regarding the revised policy "Ventilator: Standard of Care", documentation requirements and expectations regarding labeling the [NJ Exec Order 26.4b1]. All respiratory therapy staff members will document requirements in the electronic health record when equipment changes are made. 2) How will the facility identify other residents having the potential to be affected by the same deficient practice? The facility recognizes that all our residents on ventilators have the potential to be affected by the same deficient practice. 3) What measures will be put in place or systematic changes made to ensure the deficient practice will not recur? a) All respiratory therapists on all shifts were educated on the revised policy and procedures regarding weekly suction ballard changes and documentation of same for all residents. A monitoring system has been implemented to ensure that confirmation of the changes are documented in	08/07/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315019	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/15/2026

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DWELLING PLACE AT ST CLARES	400 WEST BLACKWELL ST , DOVER, New Jersey, 07801

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F0695 SS = SQC-F	Continued from page 1 On 7/7/26 at 10:00 AM, the surveyor reviewed the medical records for resident # 1, which revealed the following: A review of the admission record (AR) (an admission summary) reflected that the resident was admitted to the facility with a diagnosis that included but was not limited to NJ Ex Order 26, 4B1 [redacted] A review of the Physician Order (PO) Summary Report, dated [redacted], reflected a [redacted] setting order of NJ Exec Order 26.4b1 [redacted] 2.) On 7/6/26 at 10:45 AM, the surveyor observed resident #3, in bed with a [redacted] in place. The [redacted] did not have a dated label or written date on the NJ Ex Order 26, 4B1. On 7/7/26 at 10:15 AM, the surveyor reviewed the medical record for resident # 3, which revealed the following: A review of the admission record reflected that the resident was admitted to the facility with a diagnosis that included but was not limited to; [redacted] A review of the PO Summary Report, dated [redacted] reflected a [redacted] setting order of [redacted] and above. 3.) On 7/6/26 at 10:50 AM, the surveyor observed resident #5, in bed with a [redacted] in place. The [redacted] did not have a dated label or written date on the NJ Ex Order 26, 4B1. On 7/7/26 at 10:30 AM, the surveyor reviewed the medical record for resident # 5, which revealed the following… A review of the admission record reflected that the resident was admitted to the facility with a diagnosis that included but was not limited to: [redacted]	F0695	Continued from page 1 the electronic medical record as well as on the changed equipment. b) All respiratory therapists on all shifts were educated on the revised policy and procedures regarding monthly circuit changes for all residents. A monitoring system has been implemented to ensure that confirmation of the changes are documented in the electronic medical record as well as on the changed equipment. 4) How will facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recure, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes? a). The Director of Respiratory Therapy or designee will conduct weekly equipment and documentation audits for the suction ballard changes to ensure that the policies and procedures are met and followed. Audits will continue weekly for one month, then monthly for three months and periodically thereafter to ensure sustained compliance, safety and infection prevention. The goal is 100% compliance. Any episode of non-compliance will require re-education of the staff involved. The Director of Respiratory Therapy will communicate findings to the Administrator monthly. The Director of Respiratory Therapy will report findings quarterly to The Dwelling Place Quality Assurance Performance Improvement Committee (QAPI) and the system Quality Council Committee, whose reports are communicated to the Medical Executive Committee and the Governing Board. b) The Director of Respiratory Therapy or designee will conduct monthly equipment and documentation audits for the ventilator circuit changes to ensure that the policies and procedures are met and followed. Audits will continue monthly for three months, and then periodically thereafter to ensure sustained compliance, safety and infection prevention. The goal is 100% compliance. Any episode of non-compliance will require re-education of the staff involved. The Director of Respiratory Therapy will communicate findings to the Administrator monthly. The Director of Respiratory Therapy will report findings quarterly to The Dwelling Place Quality Assurance Performance Improvement Committee (QAPI) and to the system Quality Council Committee, whose reports are communicated to the Medical Executive Committee and the Governing Board.	08/07/2026

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F0695 SS = SQC-F	Continued from page 2 A review of the PO Summary Report reflected a [redacted] setting order, dated [redacted], of [redacted] and above. 4.) On 7/6/26 at 10:55 AM, the surveyor observed resident #8 in bed with a [redacted] in place. The [redacted] did not have a dated label (or written date on the NJ Ex Order 26, 4B1. On 7/7/26 at 10:45 AM, the surveyor reviewed the medical records for resident #8, which revealed the following… A review of the admission record reflected that the resident was admitted to the facility with a diagnosis that included but was not limited to: [redacted]. Review of the PO Summary Report reflected a [redacted] setting order, dated [redacted], of [redacted] 5.) On 7/6/26 at 11:00 AM, the surveyor observed resident #17 in bed with a [redacted] in place. The [redacted] did not have a dated label or written date on the NJ Ex Order 26, 4B1. On 7/7/26 at 11:00 AM, the surveyor reviewed the medical records for resident #17, which revealed the following: A review of the admission record reflected that the resident was admitted to the facility with a diagnosis that included but was not limited to: [redacted]. A review of the PO Summary Report reflected a [redacted] setting order, dated [redacted], of [redacted] 6.) On 7/6/26 at 11:10 AM, the surveyor observed resident #25 in bed with a [redacted] in place. The [redacted] did not have a dated label or a written date on the NJ Ex Order 26, 4B1. On 7/7/26 at 11:15 AM, the surveyor reviewed the medical record for resident #25, which revealed the following: A review of the admission record reflected that the resident was admitted to the facility with a diagnosis	F0695		08/07/2026

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F0695 SS = SQC-F	Continued from page 3 that included but was not limited to; NJ Ex Order 26, 4B1 [redacted] A review of the PO Summary Report reflected a NJ Ex Order 26, 4B setting order, dated NJ Ex Order 26 of NJ Exec Order 26.4b1 [redacted] 7.) On 7/6/26 at 11:30 AM, the surveyor observed Resident #23 in his/her room, seated in a chair with a NJ Ex Order 26, 4B in place. The NJ Ex Order 26, 4B did not have a dated label or a written date on the NJ Ex Order 26, 4B1 [redacted] On 7/7/26 at 10:00 AM, the surveyor reviewed the medical record for Resident #23, which revealed the following: A review of the AR reflected that the resident was admitted to the facility with a diagnosis that included but was not limited to; NJ Ex Order 26, 4B1 [redacted] A review of the OSR dated NJ Ex Order 26 reflected a NJ Ex Order 26, 4B setting of NJ Exec Order 26.4b1 [redacted] as tolerated. 8.) On 7/6/26 at 11:35 AM, the surveyor observed Resident #7 in bed with a NJ Ex Order 26, 4B1 in place. The NJ Ex Order 26, 4 r did not have a dated label or a written date on the NJ Ex Order 26, 4B1 On 7/7/26 at 10:15 AM, the surveyor reviewed the medical record for Resident #7, which revealed the following: A review of the AR reflected that the resident was admitted to the facility with a diagnosis that included, but was not limited to, NJ Ex Order 26, 4B1 [redacted]. A review of the OSR dated NJ Ex Order 2 reflected a NJ Ex Order 26, 4B setting order NJ Exec Order 26.4b1 [redacted] 9.) On 7/6/26 at 11:40 AM, the surveyor observed Resident #2 in bed with a NJ Ex Order 26, 4B in place. The NJ Ex Order 26, 4B did not have a dated label or a written date on the NJ Ex Order 26, 4B1. On 7/9/26 at 9:47 AM, the surveyor reviewed the	F0695		08/07/2026

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F0695 SS = SQC-F	Continued from page 4 medical record for Resident #2, which revealed the following: A review of the AR reflected that the resident was admitted to the facility with a diagnosis that included but was not limited to NJ Ex Order 26, 4B1 [redacted] A review of the OSR dated [redacted] reflected a [redacted] setting order NJ Exec Order 26.4b1 [redacted] use PRN (when needed) and per the patient's request. 10.) On 7/6/26 at 11:45 AM, the surveyor observed Resident #6 in bed with a [redacted] in place. The [redacted] did not have a dated label or a written date on the NJ Ex Order 26, 4B1. On 7/7/26 at 10:45 AM, the surveyor reviewed the medical record for Resident #6, which revealed the following: A review of the AR reflected that the resident was admitted to the facility with a diagnosis that included but was not limited to; NJ Ex Order 26, 4B1 [redacted] A review of the OSR dated [redacted] reflected a [redacted] setting of NJ Exec Order 26.4b1 [redacted] every shift. 11.) On 7/6/26 at 11:50 AM, the surveyor observed Resident #11 in bed with a [redacted] in place. The [redacted] did not have a dated label or a written date on the NJ Ex Order 26, 4B1. On 7/7/26 at 11:00 AM, the surveyor reviewed the medical record for Resident #11, which revealed the following: A review of the AR reflected that the resident was admitted to the facility with a diagnosis that included but was not limited to; NJ Ex Order 26, 4B1 [redacted]. A review of the OSR dated [redacted] reflected a [redacted] setting order of NJ Exec Order 26.4b1 [redacted] every shift. 12.) On 7/6/26 at 12:00 PM, the surveyor observed Resident #4 in bed with a [redacted] in place. The	F0695		08/07/2026

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F0695 SS = SQC-F	Continued from page 5 NJ Ex Order 26, 4B did not have a dated label or a written date on the NJ Ex Order 26, 4B1. On 7/7/26 at 11:00 AM, the surveyor reviewed the medical record for Resident #4, which revealed the following: A review of the AR reflected that the resident was admitted to the facility with a diagnosis that included, but was not limited to, NJ Ex Order 26, 4B1 A review of the OSR dated NJ Ex Order 2, reflected a NJ Ex Order 26, 4 r setting order of NJ Exec Order 26.4b1 as tolerated daily. On 7/7/26 at 9:54 AM, the surveyor interviewed the floor U. S. FOIA (b) (2) who stated, if any equipment would be changed the date would be written on the white filter that was attached to the NJ Ex Order 26, 4B. If the enclosed NJ Exec Order setup was changed that would be labeled with a next change date sticker (i.e... change “Sunday” or another specific day of the week) and then would be documented in the electronic medical record (eMR) under equipment change. On 7/7/26 at 10:18 AM, the surveyor interviewed the U. S. FOIA (b) (2) who stated the NJ Exec Order setup is changed weekly and labeled on the closed NJ Exec Order 26.4b1 with the day of the week. Circuits are changed every 28-30 days by the U. S. FO and two supervisors, to alleviate using the U. S. FOIA (b) (2) on the unit. The U. S. FO further stated that they do not document the change in the chart, and do not date the NJ Ex Order because there was a schedule (NJ Exec O 2026 NJ Ex Order 26, 4B Circuit change schedule). On 7/7/26 at 12:25 PM, the survey team met with the U. S. FOIA (b) (2) and the U.S. FOIA U. S. FOIA (b) (2) and were made aware of the surveyor's concern of the NJ Ex Order 26, 4B1 changes. On 07/07/2026 at 11:56 AM, the surveyor interviewed U. S. FO who provided a monthly schedule NJ Exec Order 26.4b1 Circuit Change" and no documentation about the previous month's circuit changes could be provided. A review of the NJ Exec Order 26.4b1 Circuit change schedule", provided by the U. S. FO revealed that NJ Ex Order 26, 4B1 circuits were changed on the following	F0695		08/07/2026

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F0695 SS = SQC-F	Continued from page 6 dates in 2026… February 3rd March 2nd March 30th April 27th May 26th June 22nd A review of the electronic record respiratory progress notes documentation for the [NJ Exec Order 26.4b1] [redacted] Circuit change schedule" dated [NJ Exec Order] [redacted] revealed that circuit changes were not documented in the electronic records, in section "equipment change" or "additional comments", for 12 of 12 residents for [NJ Exec Order 26.4b1] [redacted] Circuit change". (Residents #1, #2, #3, #4, #5, #6, #7, #8, #11, #17, #23, #25). A review of the facility policy, "Ventilator; Standard of Care", revised on 4/28/25, revealed; "3) all ventilator monitoring is to be documented in the electronic record…this shall include but is not limited to, maintain the integrity of the circuit, changing the circuit when soiled and/or every 30 days…g) additional documentation will be performed as dictated by patient status and activities performed." A review of the facility policy, "Ventilator; Hamilton C3 Ventilator", dated 5/6/26 and reviewed on 5/6/26, revealed; "h) attach ventilator to patient…j) continue to monitor and document as per policy." NJAC 8:39-11.2 (b); 27.1(a)	F0695		08/07/2026
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure	F0686	1) How will the corrective action be accomplished for those residents found to be affected by the deficient practice? The [U. S. FOIA (b) (2)] immediately reviewed the " Clean Dressing Change Policy" with the nurse who completed the [NJ Exec Order 26.4b1] [redacted] care treatment during the survey. All nurses on all shifts were also immediately in-serviced on the [NJ Exec Orde] [redacted] care policy and procedure. 2) How will the facility identify other residents having the potential to be affected by the same deficient	08/07/2026

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F0686 SS = D	Continued from page 7 ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to provide a resident with a [redacted], the necessary treatment and services consistent with professional standards of practice, to promote healing, prevent infection and prevent new [redacted] for 1 of 2 residents reviewed for [redacted] (Resident #7). According to the U.S. CDC guidelines Hand Hygiene Recommendations, Guidance for Healthcare Providers (HCP) for Hand Hygiene and COVID-19, page last reviewed 1/8/2021 included that the HCP should perform hand hygiene before and after direct contact with the residents and immediately after glove removal. In addition, when cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers, and this should be done outside the water when rubbing your hands, then rinse your hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Other entities have recommended that cleaning your hands with soap and water should take approximately 20 seconds. Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." On 7/6/26 at 11:40 AM, the surveyor observed Resident #7 in bed with a [redacted]	F0686	Continued from page 7 practice? The facility recognizes that all of our residents on ventilators have the potential to be affected by the same deficient practice. 3) What measures will be put in place or systematic changes made to ensure the practice will not recur? All nurses on all shifts were educated by the Director of Nursing on the wound care policy and procedures, as well as infection control precautions for wounds. A competency skill set has been re-educated to ensure consistent practice based on the policy and procedure. Individual staff observations of proper wound care, correct process for wound treatment, and proper safety measures will be implemented. This checklist will also be incorporated into the new hire orientation of nurses. All corrective actions will be completed by August 7, 2026. 4) How will facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes? The Director of Nursing or designee will conduct weekly wound rounds utilizing the skills checklist, along with return demonstrations by all nurses to ensure that proper wound care procedures and policies are adhered to. Rounds will continue weekly for one month, then monthly for three months and periodically thereafter to ensure sustained compliance, safety and infection prevention. The goal is 100% compliance for adherence to proper wound care, according to policy and procedure. Any episode of non-compliance will require re-education of the staff involved. The Director of Nursing will communicate findings to the Administrator monthly. The Director of Nursing will report findings quarterly to The Dwelling Place Quality Assurance Performance Improvement Committee (QAPI) and the system Quality Council Committee, whose reports are communicated to the Medical Executive Committee and the Governing Board.	08/07/2026

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F0686 SS = D	Continued from page 8 NJ Ex Order 26, 4B1 [redacted] in place. On 7/7/26 at 9:15 AM, the surveyor reviewed the electronic medical record (E-mar) for Resident #7. A review of the Admission Record reflected that the resident was admitted to the facility on [redacted] with diagnoses that included but were not limited to; NJ Ex Order 26, 4B1 [redacted] A review of the quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], reflected that resident #7 had a brief interview for mental status (BIMS) score of [redacted] indicating [redacted]. The MDS further assessed that Resident #7 had a NJ Ex Order 26, 4B1 [redacted] and had NJ Ex Order 26, 4B1 that included but were not limited to; [redacted]. A review of the current Order Summary Report (OSR) reflected Resident #7 had a physician's order (PO) to NJ Ex Order 26, 4B1 with [redacted] apply NJ Ex Order 26, 4B1 [redacted] and cover with NJ Ex Order 26, 4B1) pad daily and prn (when needed). A review of Resident #7's care plan reflected a focus area that indicated the resident had [redacted] with interventions that included, but were not limited to; monitor the [redacted] weekly with recommendations to follow NJ Ex Order 26, 4B1 guidelines and recommendations as ordered; administer treatments to [redacted], specialty mattress, assess effectiveness of treatments, and notify the physician if changes were needed. On 7/7/26 at 10:30 AM, the surveyor observed the U. S. FOIA (b) (2)) perform a NJ Ex Order 26, 4B1 to Resident 7's NJ Ex Order 26, 4B1. The [redacted] disinfected the overbed table and washed her hands using appropriate technique. The [redacted] gathered the supplies, which included [redacted] 2 [redacted] pads, a bottle of [redacted] and a NJ Ex Order 26, 4B1. The [redacted] and	F0686		08/07/2026

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F0686 SS = D	Continued from page 9 NJ Ex Order 26, 4B1 donned gowns and gloves and entered the resident's room. The U. S. FO placed all supplies on top of the overbed table (OBT). The U. S. FO removed the NJ Exec Order 26.4b1, which had NJ Ex Order 26, 4B1. The , with the same gloves (now NJ Ex Order 26, 4B1) sprayed the NJ Ex Order 2 directly into the NJ Exec Order . The U. S. FO cleansed the NJ Exec Orde from the NJ Ex Order 26, 4B1) to the bed NJ Ex Order 26, 4B1). The removed her gloves, applied alcohol-based hand rub (ABHR) and donned a new pair of gloves. The U. S. F removed the NJ Exec Order 26.4b1, tore it in half and handled the NJ Exec Order 26 by touching multiple surfaces rather than using the "no touch" technique (a method used during NJ Exec Order 26.4b1 or NJ Exec Orde care to prevent microbial contamination). The did not disinfect the OBT after the treatment was completed and she did not remove and discard the trash from the resident's room. On 7/7/26 at 10:45 AM, the surveyor discussed the NJ Ex Order 26, 4 control breaches with the U. S. FO . The U. S. FO acknowledged that she should have changed her gloves and performed hand hygiene after removing the NJ Exec Order 26.4b1, handled the NJ Exec Order 26.4b1 using the "no touch technique," and disinfected the OBT when the treatment was completed. On 7/7/26 at 10:55 AM, during an interview with the surveyor, the U. S. FOIA (b) (2)) confirmed the infection control breaches made by the U. S. F during the treatment. On 7/9/26 at 12:08 PM, the survey team discussed the above observations and concerns with the U. S. FOIA On 7/9/26 at 12:51 PM, a review of the facility's "Clean Dressing Change" policy dated 4/7/25 reflected...It is the facility policy to provide wound care in a manner to decrease potential for infection and/or cross-contamination...Set up a clean field on the overbed table...Use no - touch techniques to remove ointments and creams...Liquid solutions should be poured directly onto gauze sponges...Cleanse the wound as ordered, taking care not to contaminate other skin surfaces or other surfaces of the wound...Cleanse the wound from the center of the wound outward...Discard disposable items and gloves into the appropriate trash receptacle... On 7/10/26 at 12:07 PM, the survey team met for the exit conference, no further information was	F0686		08/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315019	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DWELLING PLACE AT ST CLARES	400 WEST BLACKWELL ST , DOVER, New Jersey, 07801

(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) COMPLETION DATE
F0686 SS = D	Continued from page 10 provided. NJAC 8:39-19.4(a); 27.1 (a)	F0686		08/07/2026
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure the appropriate management of [redacted]. This deficient practice was identified for 1 of 3 residents (Resident #11) reviewed for [redacted] and was evidenced by the following: On 7/6/26 at 11:50 AM, the surveyor observed Resident #11 in bed with [redacted]. The surveyor observed that the [redacted] was unlabeled and did not include the Resident's name, [redacted] type, date, or [redacted]. On 7/6/26 at 12:00 PM, the surveyor reviewed the medical record for Resident #11.	F0693	How will the corrective action be accomplished for those residents found to be affected by the deficient practice? The [redacted] immediately educated all staff members on all shifts regarding the policy "Feeding Tube Protocol, Care of the Patient," documentation requirements and expectations regarding [redacted] in unmarked ready to hang [redacted]. All nurses will place the required and necessary information found from the dietician and physician order along with the date and the nurse's initials. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? The facility recognizes that all our residents on ventilators have the potential to be affected by the same deficient practice. 3.What measures will be put in place or systematic changes will be made to ensure the deficient practice will not recur? All nurses on all shifts were educated on the "Feeding Tube Protocol, Care of the Patient"policy. A monitoring system has been implemented to ensure that the correct information per the physician's order will be written on a label that is attached to the bag. This skilled competency will also be incorporated into the new hire orientation of nurses. All corrective actions will be completed by August 7, 2026. 4. How will facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recure, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes? The Director of Nursing will conduct an audit every 72 hours for one month, weekly for three months and periodically thereafter to ensure sustained compliance, safety and proper process. The goal is 100% compliance. Any episode of non-compliance will require re-education of the staff involved. The	08/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315019	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DWELLING PLACE AT ST CLARES	400 WEST BLACKWELL ST , DOVER, New Jersey, 07801

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F0693 SS = D	Continued from page 11 A review of the Admission Record (AR) reflected that Resident #11 was admitted to the facility on [redacted] with diagnoses that included but were not limited to; [redacted] A review of the quarterly Minimum Data Set (MDS) assessment tool dated [redacted] reflected that Resident #11 had a brief interview for mental status (BIMS) score of [redacted], which indicated [redacted]. Further review assessed that the resident's [redacted] was [redacted], he/she had a [redacted] and received [redacted] or [redacted] through [redacted] or [redacted] and an [redacted] of [redacted] or more of [redacted]. A review of the resident's care plan reflected a focus area that included the resident required a [redacted] with interventions that included but were not limited to; the resident needed the [redacted] elevated [redacted] degrees during and [redacted] minutes after the [redacted] and that the resident was [redacted] with [redacted] and [redacted] ...see [redacted] orders for current [redacted] orders dated [redacted]. A review of the current physician order summary included a physician's order (PO) for a standard [redacted] every shift for [redacted] for a total [redacted] of [redacted] Start [redacted] at [redacted] and finish at [redacted] for a [redacted] of [redacted] start [redacted] again at 12 noon and finish at 8 PM for a total [redacted] of [redacted]. On 7/7/26 at 9:48 AM, the surveyor showed the above concern to the [redacted] assigned to Resident #11's care. The [redacted] confirmed that the [redacted] should be labeled with the resident's name, type of [redacted] rate, date, time, and the nurse's initials. The [redacted] acknowledged that it was her responsibility to ensure the [redacted] had been labeled according to facility policy. On 7/7/26 at 10:55 AM, during an interview with the surveyor, the [redacted] confirmed that all [redacted] bags and [redacted] should be labeled with the resident's name, type of [redacted] rate,	F0693	Continued from page 11 Director of Nursing will communicate any findings to the Administrator monthly. The Director of Nursing will report findings quarterly to The Dwelling Place Quality Assurance Performance Improvement Committee (QAPI) and the system Quality Council Committee, whose reports are communicated to the Medical Executive Committee and the Governing Board.	08/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315019	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/15/2026

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F0693 SS = D	Continued from page 12 date, time, and nurse's initials. At that time, the surveyor requested the facility's [U. S.] policy and procedure. On 7/9/26 at 12:08 PM, the survey team discussed the above observations and concerns with the [U. S. FOIA] [redacted] and the [redacted] U. S. FOIA (b) (2) [redacted]. A review of the facility's "Feeding Tube Protocol, Care of the patient" policy dated 1/30/24 reflected…It is the policy of this facility to outline the nursing management of patients with an indwelling feeding tube…If the product is in a ready-to-hang bottle, the nurse should label it with the patient's name, date, and time hung.… The policy did not address the labeling of products that were not in ready to hang bags… NJAC 8:39-27.1(a)	F0693		08/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11402L	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S0000	Initial Comments The facility was not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations	S0000		08/07/2026
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interviews and review of other facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This deficient practice was identified for 1 out of 14 evening shifts. Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. "Direct care staff member" means any registered professional nurse, licensed practical nurse, or certified nurse aide who is acting in accordance with that individual's authorized scope of practice and pursuant to documented employee time schedules. The following ratio(s) were effective on 02/01/2021: One CNA to every eight residents for the day shift.	S0560	1. How the corrective action will be accomplished for those residents found to be affected? The Director of Nursing and Administrator reviewed all schedules and all shifts to determine and calculate shifts as well as hours and acuities on a daily basis to determine the necessary coverage. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? The facility recognizes that all residents have the potential to be affected by the same deficient practice. 3. What measures will be put in place or systematic changes made to ensure the deficient practice will not recur? " The schedule will be posted for all shifts for all staff 4 weeks in advance to proactively fill positions. " Acuities will be reviewed daily along with the nursing schedule to ensure proper coverage and treatment needs. " Work with the staff to fill positions with 8 and 12 hours shifts. " Shift focus on treatment areas regarding clinical needs, focusing on ventilator and trach care clinical management, working in conjunction with the full time Respiratory Therapy department that has full coverage on all shifts. Continue to work with Human Resources to increase the per diem pool of for all positions, all shifts to maintain a consistent level of staff. 4. How the facility will monitor its corrective actions	08/07/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11402L	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S0560	Continued from page 1 One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nursing Staffing Report" completed by the facility as documented below: For the 2 weeks of staffing prior to survey from 6/11/2026 to 7/4/2026, the facility was deficient in CNA staffing for residents on 1 of 14 overnight shifts as follows: -6/24/2026 had 3 CNAs to 8 total staff on the evening shift, required at least 4 total staff. On 7/10/2026 at 10:35 AM, the surveyor interviewed the Director of Nursing (DON), who acts as the staffing coordinator for the nursing staff, who stated that she was aware of the staffing ratios of one CNA to eight residents on the day shift, one CNA to 10 residents on the evening shift, and one CNA to fourteen residents on the night shift. She further stated that the facility does not use agency and that she was able to meet the ratios most of the time when she could not meet the ratios, it was due to call outs. On 7/10/2026 at 11:00 AM, the surveyor reviewed the facility's policy, "Staffing Policy" with a date of 10/2025, revealed that the facility meets or exceeds the staffing levels mandated by state and federal staffing requirements…with qualified personnel, 24hours/day, seven days/week on each shift to assure that residents are safe and their needs are met…	S0560	Continued from page 1 to ensure that the deficient practice is being corrected and will not recur, i.e, what program will be put into place to monitor the continued effectiveness of the systemic changes? " Schedule will be reviewed daily, and each shift reviewed by Director of Nursing and Administrator. " Maintain open communication with the Human Resources to continue to actively hire staff, continue to work with all new staff " A monthly audit of all open positions, prospects, and new ways of hiring staff. A review of the monthly audits will be reviewed quarterly at Quality Assurance Performance Improvement (QAPI).	08/07/2026
S1680	Mandatory Nurse Staffing CFR(s): 8:39-25.2(b)(1)&(2) (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more	S1680	1. How the corrective action will be accomplished for those residents found to be affected? The Director of Nursing and Administrator reviewed all schedules and all shifts to determine and calculate shifts as well as hours and acuities on a daily basis to determine the necessary coverage. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice?	08/07/2026

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S1680	Continued from page 2 than the minimum hours required at N.J.A.C. 8:39-25.1(a)) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on a review of the Nurse Staffing Reports for the 2 weeks of 05/31/2026 to 06/13/2026, it was determined that the facility was deficient in staffing for required resident services for 11 of 14 days as follows: For the week of 06/21/2026, required staffing hours was 159. On 6/21/26 had 152 actual staffing hours, for a difference of -7 hours. On 6/22/26 had 152 actual staffing hours, for a difference of -7 hours. On 6/23/26 had 144 actual staffing hours, for a difference of -15 hours.	S1680	Continued from page 2 The facility recognizes that all residents have the potential to be affected by the same deficient practice. 3. What measures will be put in place or systematic changes made to ensure the deficient practice will not recur? " The schedule will be posted for all shifts for all staff 4 weeks in advance to proactively fill positions. " Acuities will be reviewed daily along with the nursing schedule to ensure proper coverage and treatment needs. Focus on treatment areas regarding clinical needs, focusing on ventilator and trach care clinical management, working in conjunction with the full-time Respiratory Therapy department that has full coverage on all shifts caring for the needs of the ventilator. Continue to work with Human Resources on the hiring process. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes? " Schedule will be reviewed daily, and each shift reviewed by Director of Nursing and Administrator. " Maintain open communication with the Human Resources to continue to actively hire staff. " A daily review of acuities on the unit in A review of the monthly audits will be reviewed quarterly at Quality Assurance Performance Improvement (QAPI). The Director of Nursing will report findings quarterly to The Dwelling Place Quality Assurance Performance Improvement Committee (QAPI) and the system Quality Council Committee, whose reports are communicated to the Medical Executive Committee and the Governing Board.	08/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11402L	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/15/2026

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S1680	Continued from page 3 On 6/26/26 had 144 actual staffing hours, for a difference of -15 hours. On 6/27/26 had 152 actual staffing hours, for a difference of -7 hours. For the week of 06/28/2026, the required staffing sours was 168. On 6/28/26 had 152 actual staffing hours, for a difference of -16 hours. On 6/29/26 had 160 actual staffing hours, for a difference of -8 hours. On 6/30/26 had 160 actual staffing hours, for a difference of -8 hours. On 7/01/26 had 160 actual staffing hours, for a difference of -8 hours. On 7/02/26 had 152 actual staffing hours, for a difference of -16 hours. On 7/03/26 had 152 actual staffing hours, for a difference of -16 hours. On 7/10/2026 at 10:35 AM, the surveyor interviewed the Director of Nursing (DON) who acts as the staffing coordinator for the nursing staff, stated that she was aware of the staffing ratios. She further stated that the facility was able to meet the ratios most of the time and when the facility does not it was because of staff calling out and that the facility did not use agency staff. On 7/10/2026 at 11:00 AM the surveyor reviewed the facility's policy, "Staffing Policy" with a date of 10/2025, revealed that the facility meets or exceeds the staffing levels mandated by state and federal staffing requirements…with qualified personnel, 24hours/day, seven days/week on each shift to assure that residents are safe and their needs are met…	S1680		08/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315019	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/18/2026

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F0000	INITIAL COMMENTS An on-stie revisit was conducted on 8/18/2026 to verify the facility's Plan of Correction for the 7/15/2026 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **11402L**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/18/2026**

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S0000	Initial Comments An on-stie revisit was conducted on 8/18/2026 to verify the facility's Plan of Correction for the 7/15/2026 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities	S0000		

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315019	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **07/15/2026**

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K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 07/14/2026 and 07/15/2026,was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy Dwelling Place at St. Claire's is a 4-story building that was built in 1960's, It is composed of Type II (222) construction. The facility is divided into 5-smoke zones and occupies floor 3 (east-wing). The generator powers approximately 50% of the building.	K0000		08/07/2026
K0353 SS = F Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by:	K0353	How the corrective action will be accomplished for those residents found to be affected by the deficient practice? The town water department has confirmed that the hydrants were tested and flowed during the annual check in September of 2025 (see attached email). We have arranged with our sprinkler vendor to conduct a test and document same while onsite by August 7th How will the facility identity other residents having the potential to be affected by the same deficient practice? The facility recognizes that all residents have the potential to be affected by this deficient practice. What measures will be put in place or systematic changes made to ensure the deficient practice will not recur? Flowing of the outside hydrants will be added to the yearly contract and will be conducted by our licensed vendor, in addition to the town continuing	08/07/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315019	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 07/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DWELLING PLACE AT ST CLARES	400 WEST BLACKWELL ST , DOVER, New Jersey, 07801

(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) COMPLETION DATE
K0353 SS = F Bldg. 01	Continued from page 1 Based on observations, documentation review and interviews on 07/14/2026 and 07/15/2026 in the presence of the facility's U. S. FOIA (b) (2) the U. S. FOIA (b) (2) it was determined that the facility failed to maintain the sprinkler system in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition). This deficient practice had the potential to affect all residents and was evidenced by the following: On 07/14/2026 at approximately 1:31PM, during the exterior building tour, the Surveyor, the U. S. FOIA, and the U. S. observed two fire hydrants located outside the facility. Documentation review on 07/15/2026 at 1:33PM of facility's annual fire sprinkler reports dated 07/29/2025, revealed that annual Fire hydrants flow test was not completed. No further documents were provided for annual fire hydrants flow test. In an interview at 12:13PM, the U. S. FOIA stated that the fire hydrant annual flow test was completed in September 2025. The facility's U. S. FOIA (b) (2) were informed of the deficient practices at the Life Safety Code exit conference on 07/15/2026 at 2:15 PM. N.J.A.C 8:39-31.1(c), 31.2 (e) NFPA 25.	K0353	Continued from page 1 their annual flow tests and inspections every September. How will facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recure, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes? The Director of Facilities will obtain the document from the vendor and town confirming completion of the work and report completion at the EOC/Safety committee and QAPI committee annually. a) Date sprinkler system last checked: July 6th, 2026 b) Who provided system test: Oliver Fire Protection and Security c) Water system supply source: Town of Dover Water Supply	08/07/2026
K0531 SS = F Bldg. 01	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best	K0531	How the corrective action will be accomplished for those residents found to be affected by the deficient practice? The Director of Facilities arranged for the inhouse IT phone tech check and verify the phone line, and once that was confirmed the elevator tech was contacted to reprogram the phone. The phone was then tested and verified that it was operational and connected to the switchboard. See attached work orders. How will the facility identity other residents having the potential to be affected by the same deficient practice?	08/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315019	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 07/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DWELLING PLACE AT ST CLARES	400 WEST BLACKWELL ST , DOVER, New Jersey, 07801

(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) COMPLETION DATE
K0531 SS = F Bldg. 01	Continued from page 2 serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 07/14/2026 in the presence of the facility's U. S. FOIA (b) (2), it was determined that the facility failed to maintain elevator emergency communication telephones for 1 of 2 elevator telephones tested in accordance with ASME/ANSI A17.3. This deficient practice had the potential to affect all residents and was evidenced by the following: At 11:51 AM, the U. S. FOIA conducted a test of the emergency communication telephone system for elevator #2. The emergency telephone did not function when the button was activated. In an interview at the time, the U. S. FOIA (b) (2) confirmed the observation. The facility's NJ Ex Order 26, 4B1 were informed of the deficient practices on 07/15/2026 at 2:15 PM. NJAC 8:39-31.2(e) ASME/ANSI A17.3	K0531	Continued from page 2 The facility recognizes that all residents have the potential to be affected by this deficient practice. What measures will be put in place or systematic changes made to ensure the deficient practice will not recur? The phones are checked annually by the elevator vendor. The U. S. FOIA (b) (2) created a monthly work order to check operation and connection of the elevator phones with the elevator vendor. See attached PM work order How will facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recure, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes? The Director of Facilities will monitor the new process of monthly work orders for checking phone operation with the elevator tech. If there are any issues, they can correct the issue immediately. Findings will be reported to the EOC/Safety committee and QAPI committee quarterly.	08/07/2026
K0521 SS = E Bldg. 01	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 07/14/2026 in the presence of the facility's	K0521	How the corrective action will be accomplished for those residents found to be affected by the deficient practice? The HVAC filters are changed on a quarterly basis, the Life Safety inspection was conducted on July 15th, the filters were last changed in May and due to be changed again 2 weeks later at the start of August. Facilities changed the filters that day ahead of schedule, see attached pictures. How will the facility identify other residents having the potential to be affected by the same deficient practice?	08/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315019	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 07/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DWELLING PLACE AT ST CLARES	400 WEST BLACKWELL ST , DOVER, New Jersey, 07801

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K0521 SS = E Bldg. 01	Continued from page 3 U. S. FOIA (b) (2) [redacted], it was determined that the facility failed to ensure that resident room air conditioner (AC) units were maintained in safe operating condition in accordance with the National Fire Protection Association (NFPA) 90A. This deficient practice was identified for 7 of 8 AC units observed, had the potential to affect all 7 of 27 residents and was evidenced by the following: Observations on 07/14/2026 revealed the following At 9:15AM, the surveyor observed filter for Room# 390 AC unit was dirty and clogged. At 9:17AM, the surveyor observed filter for Room# 391 AC unit was dirty and clogged. At 9:22AM, the surveyor observed filter for Room# 392 AC unit was dirty and clogged. At 9:25AM, the surveyor observed filter for Room# 393 AC unit was dirty and clogged. At 9:33AM, the surveyor observed filter for Room# 394 AC unit was dirty and clogged. At 9:37AM, the surveyor observed filter for Room# 395 AC unit was dirty and clogged. At 9:41AM, the surveyor observed filter for Room# 396 AC unit was dirty and clogged. At 9:55AM, the surveyor observed filter for Room# 390 AC unit was dirty and clogged. In an interview at time the U. S. FOIA (b) (2) confirmed the observations. The facility's U. S. FOIA (b) (2) were informed of the deficient practices at the Life Safety Code exit conference on 07/15/2026 at 2:15 PM. N.J.A.C 8:39-31.2(e) NFPA 90A	K0521	Continued from page 3 The facility recognizes that all residents have the potential to be affected by this deficient practice. What measures will be put in place or systematic changes made to ensure the deficient practice will not recur? The timing of filter changes has been changed since the filters on the bottom of the units are close to the floor and could get dirty faster. The Preventative maintenance work order for the filter changes has been changed from quarterly to bi-monthly. How will facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recure, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes? The Director of Facilities or designee will monitor this new schedule to determine if this more frequent change is effective. If filters are noticed to need a change sooner, the preventative maintenance work order will be changed from bi-monthly to a monthly basis. Findings will be reported to the EOC/Safety Committee and QAPI committee quarterly.	08/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315019	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DWELLING PLACE AT ST CLARES	**400 WEST BLACKWELL ST , DOVER, New Jersey, 07801**

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 07/14/2026 and 07/15/2026. The facility was found to be in compliance with 42 CFR 483.73.	E0000		08/07/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315019	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **08/18/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DWELLING PLACE AT ST CLARES	**400 WEST BLACKWELL ST , DOVER, New Jersey, 07801**

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K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 8/18/2026 in relation to the 7/15/2026 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.	K0000		

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