New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	j6tdgc	A. BUILDING: ______ B. WING ______	C 02/04/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ 00151144 CENSUS: 25 SAMPLE SIZE: 4 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. 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 provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 363	8:36-4.1(a)(5) Resident Rights (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: 5. The right to make choices with respect to services and lifestyle; This REQUIREMENT is not met as evidenced	A 363		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/25/22

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 363	Continued From page 1 by: Complaint #: NJ 00151144 Based on interview and record review it was determined that the facility failed to respect and comply with a resident's Executive Order 26, 4.b. equest by performing Executive Order 26, 4.b. (Executive O) for Exec of Exe residents, Resident Execu reviewed for Executive Orc. This deficient practice was evidenced by the following: On 2/4/22 at 10:05 a.m., the surveyor reviewed Resident Execu's closed medical record which revealed that the resident was admitted to the facility in Executive Order 26, 4.b. with diagnoses which included Executive Order 26, 4.b. The Executive Order 26, 4.b." dated Executive Order 26 indicated that the resident was Executive Order 26, 4.b. Executive Order 26, 4.b.. Continued surveyor review of the medical record revealed a "New Jersey Executive Order 26, 4.b. for Executive Order 26, 4.b. (Executive Order 26), (a form used to indicate Executive Order 26, 4.b. Executive Order) dated Executive Order 26 which revealed that the resident was a Executive Order 26, 4.b Executive Order 26, 4.b. . According to a "Nursing Notes" (NN) dated Executive Order 26, 4 at Executive Ord., written by a Licensed Practical Nurse (LPN), LPN #1 documented that she was informed by a staff member at Executive Order 26, 4., on arrival to the unit that Resident Execu was Executive Order 26, 4.b. and Executive Executive Executive Orde. Further, LPN #1 documented in the NN that she went into Resident Execu s room and observed that Paramedics were performing Executive O on the resident. LPN #1 documented that she called	A 363		

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A 363	Continued From page 2	A 363		

Resident [Executive] family representative and informed them that the resident was unresponsive. They in turn informed her, LPN #1, that Resident [Execu] was a [Executive O]. LPN #1 informed the Paramedics to stop [Executive O] and provided them with copy of the [Executive Order 2].

At 10:35 a.m., the surveyor interviewed LPN #2 regarding Resident [Execu]'s [Executive Ord] status. LPN #2 stated that she was on vacation on the date of the incident and confirmed that Resident [Executive] [Executive Order 2] status was [Executive Ord], and that the resident received [Executive Order 26] care. The surveyor then inquired from LPN #2 how staff identified resident's [Executive Order 26, 4.b.] status. LPN #2 explained that a red [Executive O] sticker is placed in the front of the residents' charts, however, sometimes the stickers fall off. The LPN then provided the surveyor a list titled, [Executive Ord] [Executive Order]," which was located in the [Executive Order 26, 4.b.] Executive Order 26, 4.b. binder. The surveyor reviewed the documents in the binder and observed that Resident [Execu] was not included on the "[Executive Order 26, 4.b.]" list, additionally, there was not date that indicated when the list was last updated.

During continued interview with LPN #2, the surveyor inquired as to why Resident [Execu] was not included on the [Executive Order 26, 4.b.]" list. LPN #2 stated that the "[Executive Order 26, 4.b.]" list was last updated in 10/2021 by the former Director of Nursing (DON), and Resident [Executi] was not a [Executive O] at that time. However, the surveyor reviewed Resident [Executive] [Executive Order 2] dated [Executive Order 2] and observed that the resident was a [Executive Order 26, 4.b.] at the time the "[Executive O] [Executive Order]" list was last updated.

At 12:15 p.m., the surveyor interviewed the Regional Administrator (RA) and the Executive Director (ED) regarding the aforementioned. Both confirmed that Resident [Executi] was a [Executive Order 26, 4.b.] and acknowledged that [Executive O] should not have been

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A 363	Continued From page 3 performed on the resident. In addition, both agreed that the [Executive Order 26, 4.b.]" list should have been updated to reflect Resident [Executive] [Executive O] [Executive Order] Post survey on 2/9/22 at 10:30 a.m., the surveyor interviewed LPN #1 via telephone regarding Resident [Executive] [Executive Order 26, 4.b.]. LPN #1 stated that she was still new at the facility and on [Executive Order 26, 4] at approximately 7:25 a.m., she placed a telephone call to Resident [Executive] family representative when she [LPN #1] could not locate the resident's [Executive O] status in the medical record, which is the reason that she called the family representative at the that time.	A 363		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
j6tdgc		3/17/2022

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

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0363 Reg. # 8:36-4.1(a)(5) LSC	Correction Completed 02/28/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 2/4/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

The Clare Estate

ID: j6tdgc Complaint Survey Date: 12/29/2021 SOD Date Received 2/4/2022

1. **A 310- Administration**

   a. **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice**

      i. The RN documented in Resident Executive Order 26.4 information & physician notification.
      ii. Resident Execut s record was updated with the RN notification and subsequent assessment.

   b. **How the facility will identify other residents having the potential to be affected by the same deficient practice**

      i. All residents with a change of condition have the capacity of being affected by this deficient practice.

   c. **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur**

      i. The Administrator updated the policy on Staffing to include criteria for temporary staffing.
      ii. The Administrator updated the policy on Physician and RN communication to include a double check and disciplinary consequences. All nursing staff will be inserviced on communication policy
      iii. The Regional Administrator reviewed the NJ DOH reporting requirements for reportable events with the Administrator.

   d. **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.**

      i. The RN/designee shall review all records with a reported change in condition for physician and RN communication each month.
      ii. The Administrator/designee will inservice all staff on the updated policy and procedures for staffing and communication.
      iii. Results of monthly change of conditions records audits will be compiled into a report given to the Administrator and the QAPI Committee for a period of three (3) months and quarterly thereafter.

   e. **Completion Date**: 2/28/2022

The Clare Estate

ID: j6tdgc Complaint Survey Date: 12/29/2021 SOD Date Received 2/4/2022

2. **A 369- Resident Rights**

   a. **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice**

      i. The RN completed a pain assessment for Resident Executive

   b. **How the facility will identify other residents having the potential to be affected by the same deficient practice**

      i. All residents have the potential to be affected by this deficient practice.

   c. **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur**

      i. All staff will be inserviced on resident rights; including the right to receive pain management and the location of posted resident rights within the facility.

   d. **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.**

      i. The RN/designee will review resident records for those residents identified on a pain management plan for a current assessment and updated plan.
      ii. Results of monthly audits will be compiled into a report given to the Administrator and the QAPI Committee.

   e. **Completion Date**: 2/28/2022

3. **A 561- Reportable Events**

   a. **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice**

      i. No residents were affected by the deficient practice.

   b. **How the facility will identify other residents having the potential to be affected by the same deficient practice**

      i. All residents have the potential to be affected by this deficient practice.

   c. **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur**

      i. The Administrator will be inserviced by the Regional Administrator on the phone and written procedure for reporting reportable events.

   d. **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.**

      i. Reportable events will be compiled into a report monthly to be reviewed by the QAPI Committee for proper reporting.

   e. **Completion Date:** 2/28/2022

The Clare Estate

ID: j6tdgc Complaint Survey Date: 12/29/2021 SOD Date Received 2/4/2022

A 751- Resident Assessment and Care Plans

a. **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice**

   i. The RN assessed Resident Executive developed an HSP and updated the GSP

b. **How the facility will identify other residents having the potential to be affected by the same deficient practice**

   i. All residents have the potential to be affected by this deficient practice.

c. **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur**

   i. All resident's experiencing a change in physical or cognitive status will have their HSP plan reviewed quarterly and revised if necessary.

d. **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.**

   i. The RN will spot check HSPs weekly x 3 months and quarterly thereafter to assure the policy is being followed.
   ii. Results of weekly audits will be compiled into a report given to the Administrator and the QAPI Committee

e. **Completion Date:** 2/28/2022

The Clare Estate

A 779- Resident Assessments and Care Plans

a. **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice**

   i. Resident [redacted]s record was updated with the RN notification and subsequent assessment

b. **How the facility will identify other residents having the potential to be affected by the same deficient practice**

   i. All residents have the potential to be affected by this deficient practice.

c. **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur**

   i. The Administrator updated the policy on Physician and RN communication to include a double check and disciplinary consequences. All nursing staff will be inserviced on communication policy.

d. **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.**

   i. The QAPI Committee will be presented with the inservice records and will be reviewed monthly and quarterly thereafter.

e. **Completion Date:** 2/28/2022

A 781- Resident Assessments and Care Plans

a. **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice**

i. Residents [redacted], [redacted], and [redacted] record was updated with the Physician notification and subsequent assessment.

b. How the facility will identify other residents having the potential to be affected by the same deficient practice

i. All residents have the potential to be affected by this deficient practice.

c. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur

i. The RN will review all MARs weekly for proper completion.
ii. The RN will review the 24-hour report and check all records for Physician notification.
iii. All medication administration staff will be oriented to the MAR documentation policies and procedures and inserviced on the required action.
iv. All nursing staff will be inserviced on the facilities fall protocol pertaining to notification of the Physician.

d. 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.

i. The RN/designee will conduct weekly records audits x 3 months, and quarterly thereafter.
ii. Results of weekly/monthly audits will be compiled into a report given to the Administrator and the QAPI Committee.
iii. All inservice records will be presented to the QAPI committee.

e. Completion Date: 2/28/2022

A 963- Pharma Services

a. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice

i. Residents [redacted], [redacted], [redacted], [redacted] and [redacted] records were updated with medication administration rationale.

b. **How the facility will identify other residents having the potential to be affected by the same deficient practice**

   i. All residents have the potential to be affected by this deficient practice.

c. **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur**

   i. The RN will review all MARs weekly for proper completion.
   ii. All medication administration staff will be oriented to the MAR documentation policies and procedures and inserviced on the required action.

d. **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.**

   i. The RN/designee will conduct weekly records audits x 3 months,
   ii. Results of weekly/monthly audits will be compiled into a report given to the Administrator and the QAPI Committee.
   iii. All inservice records will be presented to the QAPI committee.

e. **Completion Date:** 2/28/2022