STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65A114	A. BUILDING: _____ B. WING _____	C 09/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHELSEA AT TOMS RIVER, THE	1657 SILVERTON ROAD TOMS RIVER, NJ 08753

(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 00133518, NJ 00133427 CENSUS: 118 SAMPLE SIZE: 3 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 753	8:36-7.3(c) Resident Assessments and Care Plans (c) Documentation in the resident's record shall indicate review and any necessary revision of the resident service plan and/or health service plan. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00133518 Based on interview and medical record review it	A 753		

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A 753	Continued From page 1	A 753		

was determined that the facility failed to provide documented evidence that the facility developed and/or updated the resident's service plan after a hot water spill which resulted in multiple injuries for 1 of 3 residents reviewed, Resident #1. This deficient practice was evidenced by the following:

On 9/17/20 at 9:10 a.m., during an interview, the Director of Nursing (DON) stated that on [redacted] at approximately 2 p.m., Resident #1 went to the dining room [redacted]" area and asked for a cup of hot water for tea. She stated that a dietary aide gave the resident hot water in a cup with a lid to take to his/her apartment. The DON explained that the resident placed the cup of hot water on his/her lap and when the resident reached to push the elevator button, the hot water spilled on the resident's [redacted] and [redacted] which resulted in [redacted] to the [redacted] and [redacted]

Further, the DON stated that Resident #1 was assessed immediately and was sent to a local hospital for medical evaluation. In addition, she stated that the resident was discharged back to the facility with [redacted] twice daily to the [redacted] sites. The DON stated that on [redacted], the resident complained of increased [redacted] sites and that the resident was sent to another local hospital for further evaluation. She stated that the resident was admitted to the hospital for [redacted] to the [redacted] and [redacted] and was later discharged to a rehab center and returned to the facility on [redacted]

Surveyor continued interview, asked both the Executive Director (ED) and DON the intervention(s) that were in place to prevent further reoccurrence of the aforementioned incident. The DON stated that the staff were

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A 753	Continued From page 2	A 753		

in-serviced to encourage residents to enjoy their hot beverages in the [redacted] [dining] area; that residents were not allowed to transport their own hot water/hot beverages to their apartments and that dietary staff deliver hot water/hot beverage to the resident's apartment with a lid. The ED added that no resident will be given hot water/hot beverages while ambulating, "No more residents transporting of hot beverages by themselves."

At 10:05 a.m., the surveyor observed Resident #1 self-propelling in a wheelchair in his/her room. The surveyor was not able to obtain full detail of the incident due to the resident's [redacted] and stated, "[redacted] " The surveyor asked the resident about the hot water [redacted] sites and the resident stated that the sites were healed The resident stated that staff deliver hot water to the apartment when needed and had not been down to the dining room as much since the incident.

At 10:55 a.m., surveyor review of Resident #1's medical record revealed that the resident move in date was [redacted] with diagnoses which included but were not limited to [redacted] The "Assessment Summary" dated [redacted] indicated that the resident was alert and oriented to person, place and time.

The surveyor reviewed the "Care Notes" (CN) dated [redacted] and timed at 2 p.m., signed by a Licensed Practical Nurse (LPN), which documented, "Resident [redacted] , ... resident transported to ... for ER [emergency room]evaluation."

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A 753	Continued From page 3 Surveyor review of the local hospital Emergency Department report dated [redacted] at 16:59 [4:59 p.m.] revealed that Resident #1 sustained a [redacted] and a [redacted] to the [redacted] and [redacted] from the hot water spill. In addition, the surveyor reviewed the resident's "General Service Plan/Health Service Plan" (GSP/HSP) dated [redacted] and revised [redacted] which was provided by the DON. However, there was no documented evidence in the resident's GSP/HSP to show that it was updated to reflect intervention(s) to address Resident #1's [redacted] to the [redacted] and [redacted] to the [redacted] and [redacted] from the hot water spill on [redacted]. At 1:30 p.m., the surveyor informed the ED and the DON of the aforementioned and both acknowledged that the GSP/HSP was not updated with the new interventions.	A 753		