New Jersey Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOLDING.				
		65A114	B. WING	·	C 09/17/2020		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
CHELSEA	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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE		
A 000	A 000 Initial Comments		A 000				
	Initial Comments: TYPE OF SURVEY: COMPLAINT #: NJ 0 CENSUS: 118 SAMPLE SIZE: 3	Complaint 0133518, NJ 00133427					
A 753	The facility is not in stall of the standards in Administrative Code & Licensure of Assisted Comprehensive Personal Assisted Living Prograsubmit a plan of correcompletion date for eathat the plan is impler deficiencies may result accordance with prove Administrative Code Tenforcement of Licen 8:36-7.3(c) Resident Plans  (c) Documentation in indicate review and a resident service plan	2:36, Standards for Living Residences, conal Care Homes and cams. The facility must cition, including a cach deficiency and ensure mented. Failure to correct lit in enforcement action in cisions of New Jersey Fitle 8, Chapter 43E, sure Regulations.  Assessments and Care the resident's record shall my necessary revision of the and/or health service plan.	A 753				
	Based on interview ar	nd medical record review it					

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

TITLE

11/16/20

(X6) DATE

PRINTED: 03/04/2021 FORM APPROVED

New Jersey Department of Health

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1657 SILVERTON ROD  (PA) ID  (PA)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1657 SILVERTON ROAD  TOMS RIVER, NJ 08753  [PROVIDERS PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION)  A 753  Continued From page 1  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 approximately 2 p.m., Resident #1 went to the dining room  "area and asked for a cup of hot water for tea. She stated that a dietary aide gave the resident to a cup with a lid to take to his/her apartment. The DON explained that the resident's placed the cup of hot water on his/her lap and when the resident reached to push the elevator button, the hot water on his/her lap and when the resident reached to push the elevator button, the hot water on his/her lap and when the resident reached to push the elevator button, the hot water on his/her lap and when the resident reached to push the resident placed the cup of hot water on his/her lap and when the resident reached to push the resident placed that the session was sent to a local hospital for medical evaluation. In addition, she stated that the resident was discharged back to the facility with twice daily to the sites. The DON stated that on twice daily to the sites. The DON stated that on twice daily to the sites. The DON stated for increased	AND PLAN OF CORRECTION		IDENTIFICATION NOMBER.	A. BUILDING:		COMPLETED		
CHELSEA AT TOMS RIVER, THE  SUMMARY STATEMENT OF DEFICIENCIES  PREPIX REGULATORY OR LSG IDENTIFYING INFORMATION)  A 753  Continued From page 1  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 approximately 2 p.m., Resident #1 went to the dining room and asked for a cup of hot water for tea. She stated that a dietary aide gave the resident's paraframent. The DON explained that the resident packed the cented to push the elevator button, the hot water spilled on the resident's paraframent. The DON explained that the resident packed the cached to push the elevator button, the hot water spilled on the resident's resulted in and butter to the dining and when the resident reached to push the elevator button, the hot water spilled on the resident's service plan and which resulted in and butter to the dining and when the resident reached to push the elevator button, the hot water spilled on the resident's service plan and which resulted in and butter to the dining and when the resident reached to push the elevator button, the hot water spilled on the resident's service plan and butter to the dining and which resulted in and butter to the dining and which resident was discharged back to the facility with twice daily to the sites. The DON stated that on the resident complained of increased	65A114		B. WING					
CHELSEA AT TOMS RIVER, THE  TOMS RIVER, NJ 08753  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  A 753  Continued From page 1  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 a paper on the dining room are and asked for a cup of hot water for tea. She stated that a dietary aide gave the resident papartment. 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 and when the resident reached to push the elevator button, the hot water spilled on the resident's and part was assessed immediately and was sent to a local hospital for medical evaluation. In addition, she stated that the resident complained of increased  Turner for the sident was assessed immediately and was sent to a local hospital for medical evaluation. In addition, she stated that the resident complained of increased	•							
### REGULATORY OR LSC IDENTIFYING INFORMATION)  A 753  Continued From page 1  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 a approximately 2 p.m., Resident #1 went to the dining room are rea 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 reached to push the elevator button, the hot water spilled on the resident's and which resulted in and which resulted in mandal to the facility with to the stated that the resident #1 was assessed immediately and was sent to a local hospital for medical evaluation. In addition, she stated that the resident complained of increased	CHELSEA AT TOMS RIVER. THE							
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sent to another local hospital for further evaluation. She stated that the resident was admitted to the hospital for to the and and was later discharged to a rehab center and returned to the facility on  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	A 753	was determined that it documented evidence and/or updated the rehot water spill which it for 1 of 3 residents redeficient practice was On 9/17/20 at 9:10 a. Director of Nursing (Dapproximately 2 p.m., dining room and a hot water for tea. She gave the resident hot take to his/her apartmentat the resident place his/her lap and when push the elevator but the resident's resulted in and a sasessed immediately hospital for medical estated that the resident hospital for medical estated that the resident hospital for medical estated that the resident sites. The same sent to another local levaluation. She state admitted to the hospit to the and was later discharged returned to the facility.  Surveyor continued in Executive Director (Eintervention(s) that we further reoccurrence of the facility of the was later discharged returned to the facility.	the facility failed to provide that the facility developed esident's service plan after a resulted in multiple injuries viewed, Resident #1. This is evidenced by the following:  m., during an interview, the PON) stated that on at a cup of the stated that a dietary aide water in a cup with a lid to ment. The DON explained the cup of hot water on the resident reached to ton, the hot water spilled on and and which to the set of the that the resident was the post of the stated that on complained of increased and that the resident was the spital for further that the tresident was the post of the stated to the prevent of the aforementioned was a forementioned.	A 753				

PRINTED: 03/04/2021 FORM APPROVED New Jersey Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_ С B. WING 65A114 09/17/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1657 SILVERTON ROAD** CHELSEA AT TOMS RIVER, THE TOMS RIVER, NJ 08753 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) A 753 A 753 Continued From page 2 in-serviced to encourage residents to enjoy their hot beverages in the [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 and stated, " The surveyor asked the resident about the hot water 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 with diagnoses which date was included but were not limited to The "Assessment Summary" dated indicated that the resident was alert and oriented to person, place and time.

The surveyor reviewed the "Care Notes" (CN)

Licensed Practical Nurse (LPN), which

transported to ... for ER [emergency

documented, "Resident

room]evaluation."

and timed at 2 p.m., signed by a

, ... resident

dated

PRINTED: 03/04/2021 FORM APPROVED

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

65A114

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CHELSEA	1657 SILVERTON TOMS RIVER, NJ				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM	FULL PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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