

New Jersey Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>65A114</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>07/01/2020</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>CHELSEA AT TOMS RIVER, THE</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1657 SILVERTON ROAD</b><br><b>TOMS RIVER, NJ 08753</b> |
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| (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              | <p>Initial Comments</p> <p>Initial Comments:<br/>TYPE OF SURVEY: Complaint</p> <p>COMPLAINT #: NJ 00118414</p> <p>CENSUS: 119</p> <p>SAMPLE SIZE: 3</p> <p>The facility was in substantial compliance with New Jersey Administrative Code, Chapter 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs, based on this Complaint survey.</p> | A 000         |   |                    |

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

TITLE

(X6) DATE