STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	082462	A. BUILDING: _____ B. WING _____	C 10/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHELSEA AT FORSGATE, THE	**319 FORSGATE DRIVE JAMESBURG, NJ 08831**

(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 #: NJ00128682 CENSUS: 128 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 563	8:36-5.10(a)(2) General Requirements (a) The facility shall notify the Department immediately by telephone at 609-633-9034 (609-392-2020 after business hours), followed within 72 hours by written confirmation, of the following: 2. Any major occurrence or incident of an unusual nature, including, but not limited to, all fires, disasters, elopements, and all deaths resulting from accidents or incidents in the facility or related to facility services. Reports of such incidents shall contain information about injuries to residents and/or personnel, disruption of services, and	A 563		

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A 563	Continued From page 1 extent of damages; This REQUIREMENT is not met as evidenced by: Complaint #: NJ00128682 Based on interview and record review it was determined that the facility failed to notify the Department of Health (DOH) of an elopement incident for [redacted] of [redacted] residents reviewed, Resident [redacted]. This deficient practice was evidenced by the following: On 10/1/19 at 10:00 a.m., the surveyor reviewed the medical record of Resident [redacted] who was admitted to the facility [redacted] with diagnoses which included Executive Order 26, 4.b. [redacted] unit. The surveyor reviewed a document in the medical record titled, "Assessment summary," dated [redacted] which documented that the resident was able to bear full weight, was independent with ambulation but used a wheelchair intermittently and was able to self-propel. The surveyor then reviewed the "General Service Plan dated [redacted] and observed that the resident was [redacted] The surveyor reviewed the "Care Notes" (CNs)	A 563		

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 563	Continued From page 2 dated 9/20/19 at 10:00 p.m., which documented that the resident was found on his/her [redacted] on the Executive Order 26, 4.b. and was [redacted] to the [redacted]. The resident returned from the [redacted] with a diagnosis of [redacted] to the [redacted] Executive Order 26, 4.b. On 10/1/19 at 12:30 p.m., the surveyor interviewed the Registered Nurse (RN) who stated that the resident [redacted] from the [redacted] unit and was found by staff in the [redacted] on the [redacted] The RN informed the surveyor that staff stated that the secured doors did not alarm when the resident went out them. The RN further stated that she was not aware that this [redacted] had to be reported to the DOH since the resident was found within the building. The RN stated that the Executive Director (ED) was on vacation and that she was in charge. The RN also stated that on [redacted] that she told the ED of the incident and that the ED stated that this incident should have been reported to the DOH. At 11:15 a.m., the surveyor interviewed the ED who agreed with the surveyor that the incident should have been reported immediately to the DOH as an [redacted] The ED stated that she had the doors inspected and serviced by a contractor on [redacted]. The surveyor referred to the facility's policy titled, "Missing Resident-Elopement" which documented, "...regulatory agencies defining a missing resident as a reportable incident."	A 563		
A 749	8:36-7.3(a) Resident Assessments and Care Plans	A 749		

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 749	Continued From page 3 (a) The resident general service plan shall be reviewed and, if necessary, revised semi-annually, and more frequently as needed based upon the resident's response to the care provided and any changes in the resident's physical or cognitive status. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00128682 Based on interview and record review it was determined that the facility failed to ensure that the service plan was updated or revised to include specific interventions in order to reduce the risk of falls with injuries and to reduce the risk of elopements for [redacted] out of [redacted] residents reviewed who eloped from memory care unit and sustained a fall, Resident [redacted]. This deficient practice was evidenced by the following: On 10/1/19 at 10:00 a.m. the surveyor reviewed Resident [redacted] medical record which documented that the resident moved into the facility on [redacted] with diagnoses which included [redacted] According to the "Assessment summary" dated [redacted] Resident [redacted] was independent with [redacted] but used a Executive Order 26, 4.b. and required a secured unit while awake. The surveyor reviewed the Care Notes (CNs) and observed documented that on Executive Order 26, 4.b. [redacted], Resident [redacted] was found on his/her [redacted] in the Executive Order 26, 4.b.. Further review of the CNs revealed that the resident had an [redacted]	A 749		

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A 749	Continued From page 4	A 749		

to the Executive Order 26, 4.b. and was transferred to the [redacted]. The CNs also documented that the resident returned to the facility with diagnoses of Executive Order 26, 4.b. Executive Order 26, 4.b. [redacted].

The surveyor continued to review the medical record and observed the, "General Service Plan/Health Service Plan" (GSP/HSP) dated [redacted]. The surveyor observed that there were no updates or changes made to the GSP/HSP, including no interventions put in place upon return from the [redacted] on [redacted], in an effort to prevent further Executive Order 26, 4.b..

On 10/1/19 at 12:30 p.m. the surveyor interviewed the Registered Nurse (RN) who stated that when the Certified Home Health Aide (CHHA) was ready to provide evening care she [CHHA] was unable to locate Resident [redacted]. The RN stated that staff then searched for Resident [redacted], who was found in the Executive Order 26, 4.b..

The RN stated that staff reported the alarm did not sound when the resident opened and exited. The RN stated that the Memory Care Coordinator checked the exit doors on [redacted] and they were operational. The RN stated that on [redacted] she checked the exit doors on the [redacted] unit and the doors alarmed when opened. The RN informed the surveyor that she did a readmission assessment on [redacted] but did not update the GSP.

The surveyor reviewed the policy titled, "Incident Reports" which documented, "The Nurse will identify specific measures to prevent or reduce the likelihood of recurrent incidents and record these measures...adjusting the care plan as

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 749	Continued From page 5 appropriate."	A 749		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
082462 Y1	A. Building B. Wing Y2	12/6/2019 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CHELSEA AT FORSGATE, THE	319 FORSGATE DRIVE JAMESBURG, NJ 08831

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 A0563 Reg. # 8:36-5.10(a)(2) LSC	Correction Completed 10/02/2019	ID Prefix A0749 Reg. # 8:36-7.3(a) LSC	Correction Completed 11/01/2019	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	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
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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 10/1/2019	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

EVENT ID: NHIM12

State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 367
TRENTON, N.J. 08625-0367

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

www.nj.gov/health

JUDITH M. PERSICHILLI, RN, BSN, MA
Acting Commissioner

November 20, 2019

Ms. Michele Adams, Administrator
Chelsea At Forsgate, The
319 Forsgate Drive
Jamesburg, NJ 08831

Dear Ms. Adams:

This will acknowledge your plan of correction received November 4, 2019, for the deficiencies found during our Complaint Survey of October 1, 2019. Your plan of correction (POC) has been reviewed and was found unacceptable in the following areas:

- St - A - 0563 - 8:36-5.10(a)(2) - General Requirements: Part 1: Each resident mentioned in the deficiency should be referenced in the POC along with the action the facility took in order to correct the problem for that resident. Part 2: Please identify who had the potential to be affected by the same deficient practice. Part 3: What changes was put into place to ensure that the deficient practice would not recur. Part 4: How will you monitor Part 3 and by whom and how often? Please include completion date.
- St - A - 0749 - 8:36-7.3(a) - Resident Assessments And Care Plans: Part 2: Who had the potential to be affected by this deficient practice. Part 3: What will be done differently to ensure that this deficient practice will not recur. Part 4: How often will checks occur.(Part 4 is the monitoring of Part 3).
- Also send the POC on your company's letterhead or type the facility's name and address on each POC. Please only send the POC do not include GSP or in-service records.

Please **email** the revised POC which addresses the above mentioned areas back to Gil at **HFEL.POCAL@doh.nj.gov** within
five (5) business days from receipt of this letter. (Do not mail back the POC)

If you need further clarification do not hesitate to call me at 609-633-8990.

Sincerely,

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 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ00128682 CENSUS: 128 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 563	8:36-5.10(a)(2) General Requirements (a) The facility shall notify the Department immediately by telephone at 609-633-9034 (609-392-2020 after business hours), followed within 72 hours by written confirmation, of the following: 2. Any major occurrence or incident of an unusual nature, including, but not limited to, all fires, disasters, elopements, and all deaths resulting from accidents or incidents in the facility or related to facility services. Reports of such incidents shall contain information about injuries to residents and/or personnel, disruption of services, and	A 563		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Michelle Adams TITLE Executive Director (X6) DATE 11/4/19

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A 563	Continued From page 1 extent of damages;	A 563		

This REQUIREMENT is not met as evidenced by:
Complaint #: NJ00128682

Based on interview and record review it was determined that the facility failed to notify the Department of Health (DOH) of an Executive Order 26, 4.b. incident for [redacted] of [redacted] residents reviewed, Resident [redacted] This deficient practice was evidenced by the following:

On 10/1/19 at 10:00 a.m., the surveyor reviewed the medical record of Resident [redacted] who was admitted to the facility Executive Order 26, 4.b.

Executive Order 26, 4.b.

The surveyor reviewed a document in the medical record titled, "Assessment summary," dated Executive Order 26, 4.b. which documented that the resident was able to [redacted] was independent with Executive Ord... [redacted] but used a wheelchair intermittently and was able to self-propel. The surveyor then reviewed the "General Service Plan dated [redacted] and observed that the resident was not oriented to person, place or time and required ongoing cueing and re-orientation.

The surveyor reviewed the "Care Notes" (CNs)

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A 563	Continued From page 2 dated Executive Order 26, 4.b. which documented that the resident was found on his/her Executive Order 26, 4 on the Executive Order 26, 4.b. stairwell and was transferred to the hospital. The resident returned from the hospital with a diagnosis of Executive Order 26, 4.b. Executive Order 26, 4.b. On 10/1/19 at 12:30 p.m., the surveyor interviewed the Registered Nurse (RN) who stated that the resident eloped from the Executive Order 26, 4.b Executive O unit and was found by staff in the stairwell on the Executive Order 26, 4.b. The RN informed the surveyor that staff stated that the secured doors did not alarm when the resident went out them. The RN further stated that she was not aware that this elopement had to be reported to the DOH since the resident was found within the building. The RN stated that the Executive Director (ED) was on vacation and that she was in charge. The RN also stated that on Executive Order 2 that she told the ED of the incident and that the ED stated that this incident should have been reported to the DOH. At 11:15 a.m., the surveyor interviewed the ED who agreed with the surveyor that the incident should have been reported immediately to the DOH as an Executive Order 26, 4.b. The ED stated that she had the doors inspected and serviced by a contractor on Executive Order 26. The surveyor referred to the facility's policy titled, "Missing Resident-Elopement" which documented, "...regulatory agencies defining a missing resident as a reportable incident."	A 563		
A 749	8:36-7.3(a) Resident Assessments and Care Plans	A 749		

A563

THE CHELSEA
AT FORSGATE

1. On 9/26/19 the management team was informed of the failure to report the elopement for resident [redacted]
2. On 10/10/19, staff who care for our residents in Memory Care were educated on the elopement policy.
3. The management team was educated on 9/26/19 on what constitutes an elopement and procedure to report to New Jersey Department of Health.
4. The Executive Director/Designee will check 24 hour report daily, beginning 10/2/19, to ensure that any report of resident elopement was reported to New Jersey Department of Health per regulation.

319 Forsgate Drive, Monroe Twp., New Jersey 08831
Telephone: 732/656-1000 Facsimile: 732/656-9242
www.chelseaseniorliving.com

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A 749	Continued From page 3 (a) The resident general service plan shall be reviewed and, if necessary, revised semi-annually, and more frequently as needed based upon the resident's response to the care provided and any changes in the resident's physical or cognitive status. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00128682 Based on interview and record review it was determined that the facility failed to ensure that the service plan was updated or revised to include specific interventions in order to reduce the risk of falls with injuries and to reduce the risk of elopements for [redacted] out of [redacted] residents reviewed who eloped from Executive Order 26, 4.b. and sustained a [redacted] Resident [redacted] This deficient practice was evidenced by the following: On 10/1/19 at 10:00 a.m. the surveyor reviewed Resident [redacted] medical record which documented that the resident moved into the facility on [redacted] with diagnoses which included [redacted] Executive Order 26, 4.b. According to the "Assessment summary" dated [redacted] Resident [redacted] was independent with [redacted] but used a Executive Order 26, 4.b. and required a secured unit while awake. The surveyor reviewed the Care Notes (CNs) and observed documented that on Executive Order 26, 4.b. Resident [redacted] was found on his/her [redacted] in the Executive Order 26, 4.b. stairwell. Further review of the CNs revealed that the resident had an injury	A 749		

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A 749	Continued From page 4 to the [redacted] of his/he[redacted] and was transferred to the hospital. The CNs also documented that the resident returned to the facility with diagnoses of [redacted] Executive Order 26, 4.b. The surveyor continued to review the medical record and observed the, "General Service Plan/Health Service Plan" (GSP/HSP) dated [redacted] The surveyor observed that there were no updates or changes made to the GSP/HSP, including no interventions put in place upon return from the hospital on [redacted] in an effort to prevent further [redacted] On 10/1/19 at 12:30 p.m. the surveyor interviewed the Registered Nurse (RN) who stated that when the Certified Home Health Aide (CHHA) was ready to provide evening care she [CHHA] was unable to locate Resident [redacted] The RN stated that staff then searched for Resident [redacted] who was found in the [redacted] The RN stated that staff reported the alarm did not sound when the resident opened and exited. The RN stated that the Memory Care Coordinator checked the exit doors on [redacted] and they were operational. The RN stated that on [redacted] she checked the exit doors on the [redacted] unit and the doors alarmed when opened. The RN informed the surveyor that she did a readmission assessment on [redacted] but did not update the GSP. The surveyor reviewed the policy titled, "Incident Reports" which documented, "The Nurse will identify specific measures to prevent or reduce the likelihood of recurrent incidents and record these measures...adjusting the care plan as	A 749		

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A 749	Continued From page 5 appropriate."	A 749		

THE CHELSEA
AT FORSGATE

A749

1. Resident [redacted] Service Plan was updated
2. Residents who reside in Memory Care Service Plans were reviewed by RN for accuracy.
3. Beginning on 10/2/19, the Executive Director/Designee will ensure service plans are accurate, based on information received via the 24 hour report.
4. Executive Director/Health Services Director will check memory care service plans beginning 10/2/19, and then quarterly to ensure accuracy and to maintain compliance.

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