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 11/12/2021

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 #: NJ 00149585 CENSUS: 98 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 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;	A 310		

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A 310	Continued From page 1 This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00149585 Based on interview and record review it was determined that the Administrator failed to implement and enforce the facility policy for the prevention of Abuse when: staff failed to immediately notify the Executive Director (ED) of suspected abuse that occurred on [redacted] until [redacted] develop a policy and procedure to address staff to resident abuse; and failed to implement their "Incident Reports" policy by failing to document the incident in the resident's record for 1 of 3 residents reviewed for abuse, Resident [redacted]. This deficient practice was evidenced by the following: On 11/12/21 at 10 a.m., the surveyor interviewed the Executive Director (ED) and asked if there were any incidents or accidents investigated by the facility in past 3 months. The ED stated that there had been an incident of staff to resident physical abuse that occurred in [redacted] and which was reported to the DOH. There was however, no information provided related to an incident of staff to resident verbal abuse which was alleged to have occurred on [redacted]. At 12:30 p.m. the surveyor reviewed Resident [redacted] medical record and according to the "Resident Information Sheet" the resident moved	A 310		

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into the facility in [redacted] with diagnoses which included [redacted]. The resident's "Assessment" dated [redacted] revealed that the resident was [redacted] to [redacted] and required some assistance with Activities of Daily Living (ADLs).

At 10:30 a.m., during the tour of the Assisted Living [redacted] floor, the surveyor observed Resident [redacted] sitting on a couch in the resident's apartment and asked the resident about the care received at the facility in the past three months. The resident stated that the care was alright and stated that there had been an incident with a medication tech but could not recall his name and date of the incident. The resident stated that the incident occurred a few weeks ago [redacted] and told the surveyor, "I have [redacted]." Resident [redacted] was [redacted] and [redacted]

During continued interview, Resident [redacted] told the surveyor that at approximately 8:15 p.m. on [redacted], Resident [redacted] made a pendant call because it was getting late and the resident had not yet received the evening medications. The resident explained that Certified Medication Aide (CMA) #1 [could not recall name] answered the pendant call and started yelling when the resident told the CMA that the resident needed to be medicated. The resident stated that CMA #1 told the resident that medications could be administered up till 9 p.m. for the evening medications. The resident stated that CMA #1 brought the medications at approximately 8:45 p.m., "with an attitude", yelling and told the resident that no one "liked you, everyone hated you, bitch." The resident stated that he/she reported the incident to a "head person" but could not recall her name/date. The resident stated that management assured the resident that CMA

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A 310	Continued From page 3 #1 would no longer be scheduled to work on the [redacted] floor unless there was an emergency and other arrangement would be made to medicate the resident. At 11:15 a.m., and 12:15 p.m., the surveyor interviewed a Registered Nurse (RN) and the Director of Nursing (DON) regarding the above incident. The RN stated that she was on duty on [redacted] and that at approximately 10:30 a.m., CMA #1 approached her in the office, very upset and stated that Resident [redacted] siblings called him into the resident's room and yelled at him about an incident that occurred on [redacted]. The RN recalled that CMA #1 stated he was not aware that he was not supposed to medicate and provide care to Resident [redacted] The RN stated that she went to Resident [redacted] room to further inquire about the incident. The RN stated that she then asked Resident [redacted] why he/she did not want CMA #1 to medicate him/her. The RN told the surveyor that the resident stated that CMA #1 told the resident that no one, including other residents liked the residents and other "upsetting" words when the resident asked for the evening medications. The RN stated that she told Resident [redacted] that CMA #1 would no longer provide care to the resident. The RN stated that she notified the DON and the ED was already aware of the incident and immediately called the facility. The DON reported that she spoke with Resident [redacted] on [redacted] regarding the above incident and the resident stated that CMA #1 gave him/her an attitude and would prefer CMA #1 no longer provide care to the resident. At 12:25 p.m., the surveyor interviewed CMA #1 regarding his contact with Resident [redacted] and [redacted] CMA #1 stated that on [redacted] at	A 310		

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A 310	Continued From page 4	A 310		

approximately 8:45 p.m., that he received a telephone call from Resident [redacted] that he/she had not received his/her evening medications. CMA #1 stated that he told Resident [redacted] that he was aware and was medicating another resident and would be with the resident. CMA #1 stated that at approximately 9 p.m., he took the medications to the resident and the resident questioned why was he was late with the medications. CMA #1 stated that he explained to the resident that he/she gets medicated at the same time at 9 p.m., and was with another resident. CMA #1 stated that the resident took the medications and told him to "Get out of the room."

CMA #1 reported that on [redacted] at 8 a.m., he medicated Resident [redacted] At 12 p.m., the resident's family member called him into the resident's room and both the resident's siblings started yelling/cursing at him in front of the resident. CMA #1 stated that he immediately left the room and reported the incident to the RN on duty. The surveyor asked CMA #1 if he reported the [redacted] to management. CMA #1 stated that he had not because he did not perceive it as an issue. In addition, CMA #1 explained that he did not know that he was not supposed to medicate the resident on [redacted] when he returned to work. CMA #1 denied being verbally abusive to the resident at any time.

At 1:35 p.m., the surveyor interviewed CMA #2 via telephone regarding the above incident and she stated that she worked on [redacted] on the 3-11 shift. She stated that at approximately 9 p.m., she received a telephone call from Resident [redacted]'s sibling that a male CMA [don't know name] disrespected and called Resident [redacted] names and did not want the male CMA to medicate the resident any longer. CMA #2 stated that she told the resident's sibling that she did not know who

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A 310	Continued From page 5	A 310		

the male CMA was and to call back on [redacted], [redacted] to speak with someone in management. The surveyor inquired from CMA #2 if she reported the allegation to management. The CMA #2 confirmed that she did not report the incident to anyone and explained that the family came to the facility in person on [redacted] morning, [redacted] At 2:15 p.m., the surveyor informed the ED of the above concern. The ED stated that she was not aware or notified by CMA #2 of the above incident until [redacted], [redacted] days after the incident, in order to initiate an investigation of the alleged verbal abuse.

At 12:55 p.m., the surveyor continued the interview with the ED regarding Resident [redacted] allegation of staff to resident verbal abuse that occurred on [redacted] The ED stated that she was not made aware of the allegation until [redacted] when she received a telephone call from the Activity Director (AD) who informed her that Resident [redacted]s family member was at the facility and was very upset because CMA #1 attempted to medicate Resident [redacted] when he was not supposed to do so after the [redacted] incident. The ED stated that she called the facility immediately and spoke with the RN on duty who stated that CMA #1 told her that the resident's family yelled at him and accused him of calling the resident a "Bitch." The ED reported to the surveyor that she met with Resident [redacted] on [redacted] days after the incident, where the resident reported that CMA #1 called the resident a "Pain in the ass."

The ED told the surveyor that the resident stated that someone, whose name the resident did not recall, assured her the next day on [redacted] that CMA #1 would no longer be providing care to the resident. Yet, on [redacted], CMA #1 attempted to administer medications to Resident [redacted]. The

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ED stated that CMA #1 was immediately reassigned to another floor on [redacted] and would not be scheduled to work on the [redacted] floor unless there was an emergency and the resident would be medicated by another CMA or an RN. The surveyor then requested the policy on abuse and Residents' Right.

Surveyor review of the facility policy titled, "Abuse" revised June 26, 2014 provided by the ED revealed:

2.) "All allegations of potential resident abuse will be investigated. The resident(s) involved will continue to be cared for and protected during the course of the investigation." Resident [redacted] had repeated interaction with CMA #1 due to the delay in reporting of the incident.

3.) "The Executive Director will be notified immediately and given a verbal report of the abuse or suspected abuse." The ED was not notified until [redacted] days later of the incident thus delaying the initiation of an investigation and protecting the resident during the course of the investigation.

4.) An incident report (HS-9) will be completed and include all known details regarding the incident." There was no documented evidence of the incident in Resident [redacted]'s medical record.

6.) "Employees that are directly or indirectly involved will be interviewed as soon as possible." Staff interviews were delayed due to the delay in reporting of the incident to the ED.

In addition, the policy and procedure on "Incident Report" revised March 1, 2010 indicated, "The nurse will document in the Resident Record, as appropriate, and include follow-up notes detailing any possible injury, pain, discomfort or

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A 310	Continued From page 7 impairment." There was no documentation of the incident in Resident [redacted] medical record. The delay in the reporting of the potential staff to resident abuse delayed the start of an investigation and prolonged the resident's exposure to the staff member.	A 310		
A 361	8:36-4.1(a)(4) 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: 4. The right to be treated with respect, courtesy, consideration and dignity; This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00149585 Based on interview and record review it was determined that the facility failed to ensure that facility staff communicated with resident in a dignified and respectful manner for 1 of 3 residents reviewed for resident rights, Resident [redacted]. This deficient practice was evidenced by the following: On 11/12/21 at 10:30 a.m., during the tour of the Assisted Living [redacted] floor, the surveyor observed Resident [redacted] in his/her room sitting on a couch and asked the resident about the care the resident received at the facility in the past three months. The resident stated that the care was	A 361		

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A 361	Continued From page 8 alright and stated that he/she had an incident with a medication tech but could not recall his name and date of the incident. The resident stated that the incident occurred a few weeks ago [redacted] and told the surveyor, "I have [redacted] Resident [redacted] was [redacted] and [redacted] During continued interview, Resident [redacted] told the surveyor that at approximately 8:15 p.m., [redacted] that he/she made a pendant call because it was getting late and had not received the evening medications. The resident explained that Certified Medication Aide (CMA) #1 [could not recall name] answered the pendant call and started yelling when the resident told him that he/she needed to be medicated. The resident stated that CMA #1 told the resident that he/she had up till 9 p.m., to receive the evening medications. The resident stated that CMA #1 brought the medications at approximately 8:45 p.m., with an attitude, yelling and told the resident that no one "liked you, everyone hated you, bitch." The resident stated that he/she reported the incident to a "head person" but could not recall her name/date. The resident stated that he/she was told by management that CMA #1 was no longer scheduled to work on the [redacted] floor unless there was an emergency and other arrangement would be made to medicate the resident. At 12:30 p.m. the surveyor reviewed Resident [redacted] medical record and according to the "Resident Information Sheet" the resident moved into the facility in [redacted] with diagnoses which included [redacted] The resident's "Assessment" dated [redacted] revealed that the resident was [redacted] to [redacted] and required some assistance with Activities of Daily Living (ADLs).	A 361		

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A 361	Continued From page 9 At 11:15 a.m., the surveyor interviewed a Registered Nurse (RN) regarding the above incident. The RN stated that she was on duty on [redacted] and that at approximately 10:30 a.m., CMA #1 approached her in the office, very upset and stated that Resident [redacted]'s sibling called him into the resident's room and yelled at him about an incident that occurred on [redacted]. The RN stated that CMA #1 stated that he was not aware that he was not supposed to medicate and/or provide care to the resident. The RN stated that she went to Resident [redacted] room to inquire about the incident. The RN stated that Resident [redacted] reported that CMA #1 should not have medicated him/her after the incident on [redacted]. The RN stated that she then asked Resident [redacted] why he/she did not want CMA #1 to medicate him/her. The RN told the surveyor that the resident stated that CMA #1 told the resident that no one, including other residents liked the residents and other "upsetting" words when the resident asked for his/her evening medications. The RN stated that she told Resident [redacted] that CMA #1 would no longer provide care to him/her. At 12:25 p.m., the surveyor interviewed CMA #1 regarding his contact with Resident [redacted] and [redacted]. CMA #1 stated that on [redacted] at approximately 8:45 p.m., that he received a telephone call from Resident [redacted] that he/she had not received his/her evening medications. CMA #1 stated that he told Resident [redacted] that he was aware and was medicating another resident and would be with the resident. CMA #1 stated that at approximately 9 p.m., he took the medications to the resident and the resident questioned why he was late with the medications. CMA #1 stated that he explained to the resident that he/she gets medicated at the same time at 9 p.m., and was	A 361		

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A 361	Continued From page 10 with another resident. CMA #1 stated that the resident took the medications and told him to "Get out of the room." CMA #1 denied any form of abuse to the resident. The surveyor informed the ED of above concern and she stated that she had not been made aware of the verbal abuse until [redacted] when she was notified by an Activity Director that Resident [redacted]'s family was at the facility with a complaint of alleged verbal abuse. Refer to 8:36-3.4(a)(1)	A 361		
A 565	8:36-5.10(a)(3) 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: 3. All suspected cases of resident abuse, neglect, or misappropriation of resident property, including, but not limited to, those which have been reported to the State of New Jersey Office of the Ombudsman for the Institutionalized Elderly for residents over 60 years of age; This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00149585	A 565		

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A 565	Continued From page 11 Based on interview and record review it was determined that the facility failed to notify the Department of Health (DOH) of staff to resident alleged verbal abuse that occurred at the facility on [redacted] and was reported to the Executive Director (ED) on [redacted] for 1 of 3 residents reviewed, Resident [redacted] This deficient practice was evidenced by the following: On 11/12/21 at 12:55 p.m., the surveyor interviewed the ED regarding Resident #3's alleged staff to resident verbal abuse that occurred on [redacted]. The ED stated that she was not aware of the allegation until [redacted] when she received a telephone call from the Activity Director (AD) when Resident [redacted] family was at the facility. The ED stated that the AD informed her that Resident [redacted]s sibling was very upset because CMA #1 medicated Resident [redacted] on [redacted] and that he was not supposed to do so after the [redacted] incident. The ED stated that she called the facility immediately and spoke with the RN on duty who stated that CMA #1 told her that the resident's family yelled at him and accused him of calling the resident a "Bitch." Further, the ED stated that she met with Resident [redacted] on [redacted] regarding the incident that occurred [redacted] days earlier and that the resident reported that CMA #1 called him/her a "Pain in the ass." The ED stated that CMA #1 was immediately reassigned and continued to work on another floor on [redacted] and would not be scheduled to work on the [redacted] floor unless there was an emergency and the resident would be medicated by another CMA or an RN. The surveyor then asked the ED if the alleged staff to resident verbal abuse was reported to the DOH. The ED confirmed that she did not report the staff to resident verbal abuse to the DOH because she did not consider it as an abuse.	A 565		

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A 565	Continued From page 12 At 10:30 a.m., during the tour of the Assisted Living [redacted] floor, the surveyor observed Resident [redacted] in his/her room sitting on a couch and asked the resident about the care he/she received at the facility in the past three months. The resident stated that the care was alright but there had been an incident with a medication tech but could not recall his name and the date of the incident. The resident stated that the incident occurred a few weeks ago [redacted] and told the surveyor, "I have [redacted] #3 was [redacted] During continued interview, Resident [redacted] told the surveyor that at approximately 8:15 p.m., [redacted] that he/she made a pendant call because it was getting late and had not received the evening medications. The resident explained that Certified Medication Aide (CMA) #1 [could not recall name] answered the pendant call and started yelling when the resident told him that he/she needed to be medicated. The resident stated that CMA #1 told the resident that he/she had up till 9 p.m., to receive the evening medications. The resident stated that CMA #1 brought the medications at approximately 8:45 p.m., with an attitude, yelling and told the resident that no one "liked you, everyone hated you, bitch." The resident stated that he/she reported the incident to a "head person" but [could not recall her name/date]. The resident stated that he/she was told by management that CMA #1 was no longer scheduled to work on the [redacted] floor unless there was an emergency and other arrangement would be made to medicate the resident. At 12:30 p.m. the surveyor reviewed Resident [redacted]'s medical record and according to the	A 565		

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 11/12/2021

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 565	Continued From page 13 "Resident Information Sheet" the resident moved into the facility in [redacted] with diagnoses which included [redacted]. The resident's "Assessment" dated [redacted] revealed that the resident was [redacted] to [redacted] and required some assistance with Activities of Daily Living (ADLs). At 12:25 p.m., the surveyor interviewed CMA #1 regarding the [redacted] incident. CMA #1 stated that on [redacted] at approximately 8:45 p.m., that he received a call from Resident [redacted] that he/she had not received his/her evening medications. CMA #1 stated that he told Resident [redacted] that he was aware and was medicating another resident and would be with the resident. CMA #1 stated that at approximately 9 p.m., he took the medications to the resident and the resident questioned why was he late with the medications. CMA #1 stated that he explained to the resident that he/she gets medicated at the same time at 9 p.m., and was with another resident. CMA #1 stated that the resident took the medications and told him to "Get out of the room." CMA #1 denied any form of abuse towards the resident. At 2:15 p.m., the surveyor informed the ED of above concern and the ED acknowledged that she did not report the suspected staff to resident verbal abuse to the DOH. Surveyor review of the facility policy titled, "Abuse" provided by the ED revealed, "The Executive Director will be notified immediately and given a verbal report of the abuse or suspected abuse." In addition, "All suspected cases of resident abuse will be reported to the N.J. Department of Health immediately by phone at 1-800-792-9770 and followed up within 72 hours in writing."	A 565		

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 565	Continued From page 14 Refer to 8:36-3.4(a)(1)	A 565		