STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED	
						С	
		082462	B. WING		10	/29/2019	
AME OF PF	ROVIDER OR SUPPLIER			ZIP CODE			
HELSEA	AT FORSGATE, THE		RSGATE DRIVE BURG, NJ 08831				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES EY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
A 000	Initial Comments		A 000				
	Initial Comments: TYPE OF SURVEY:	Complaint					
	COMPLAINT #: NJ <sup>2</sup>	129525					
	CENSUS: 134						
	SAMPLE SIZE: 0						
	all of the standards in Administrative Code Licensure of Assisted Comprehensive Pers Assisted Living Progr submit a plan of corre completion date for e that the plan is imple deficiencies may resu	8:36, Standards for d Living Residences, sonal Care Homes and rams. The facility must ection, including a each deficiency and ensure mented. Failure to correct ult in enforcement action in visions of New Jersey Title 8, Chapter 43E,					
A1047	8:36-14.3(d) Emerge Procedures	ncy Services and	A1047				
	hung, kept easily acc examined monthly ar recorded on a tag wh extinguisher. Fire ext inspected and mainta manufacturers' and a requirements and N.	J.A.C. 5:70. Each fire labeled to show the date of					

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

TITLE

116911

(X6) DATE

Vew Jersey Department of Deficient	CIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION		E SURVEY
ND PLAN OF CORRE	CTION	IDENTIFICATION NUMBER:	A. BUILDING:		СОМ	PLETED
		082462	B. WING		10	C )/29/2019
IAME OF PROVIDER	OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
HELSEA AT FOR	SGATE, THE		RSGATE DRIVE BURG, NJ 08831			
	SUMMARY S			PROVIDER'S PLAN (		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	COMPLETE DATE
A1047 Contin	ued From pag	le 1	A1047			
by: Based facility month the tag inspec Associ deficie On 10, confer that th provide identifi At 9:15 facility copies facility Along extingu for Se attache locatio On the 1. At t one AE annua eviden for Se 2. Insi	on observation failed to visual y and keep a is attached to ted, as require ation (NFPA) int practice wal (29/19 at 9:06) ence of the sub e facility's Mail e a copy of the ed the various of a.m. a tour of s MA was per of evacuation the tour the sub uishers that we t 2019. The sub ishers were r otember 2019 ed to the fire end s. 3rd floor: the main entra 3C type fire ex ly inspected A ce of a month otember 2019. de the Physic	T is not met as evidenced on it was determined that the ally inspect fire extinguishers record of the examination on 22 of 22 fire extinguishers ed by National Fire Protection and N.J.A.C. 5:70. This is evidenced by the following: a.m., during the entrance rvey, the surveyor requested ntenance Assistant (MA) e facility lay-out which is rooms in the facility. If the building with the formed. The MA provided a plans for the 3 floors of the urveyor observed 22 fire ere last annually inspected urveyor observed that fire nissing monthly examinations documented on the tags extinguishers in the following nce of the building there was tinguisher that was last ugust 2019, there was no ly examination documented a Therapy room there was tinguisher that was last				

STATEMENT	ey Department of Hea OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY PLETED	
				A. BUILDING:		С	
		082462	B. WING		10	/29/2019	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE			
CHELSEA	AT FORSGATE, THE		BURG, NJ 08831				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES EY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
A1047	Continued From pag	e 2	A1047				
	evidence of a monthl for September 2019.	y examination documented					
	<ul> <li>3. In the corridor to the left of the Beauty Salon there was one ABC type fire extinguisher that was last annually inspected August 2019, there was no evidence of a monthly examination documented for September 2019.</li> <li>4. In the corridor next to stairwell "" there was one ABC type fire extinguisher that was last annually inspected August 2019, there was no evidence of a monthly examination documented for September 2019.</li> </ul>						
	with the ID # 3C that August 2019, there w	the left of resident apartment ABC type fire extinguisher was last annually inspected vas no evidence of a monthly nted for September 2019.					
	annually inspected A	e extinguisher that was last ugust 2019, there was no y examination documented					
	that was last annuall	tinguisher with the ID # 3F y inspected August 2019, ce of a monthly examination					
	extinguisher with the annually inspected A	e was one ABC type fire ID # 3E that was last ugust 2019, there was no y examination documented					

STATEMENT	ey Department of Hea OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			С
		082462	B. WING		10	)/29/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
CHELSEA	AT FORSGATE, THE		RSGATE DRIVE BURG, NJ 08831			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES XY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
A1047	Continued From pag	e 3	A1047			
	On the <sup>NEXOC</sup> floor:					
	there was one , with the ID # 2R that August 2019, there v examination docume 10. In the corridor ne one ABC type fire ex that was last annual	the left of resident apartment ABC type fire extinguisher was last annually inspected vas no evidence of a monthly ented for September 2019. ext to stairwell "" there was tinguisher with the ID # 2S y inspected August 2019, ce of a monthly examination				
	11. In the corridor ne one ABC type fire ex that was last annuall	ext to stairwell ' there was tinguisher with the ID # 2P y inspected August 2019, ce of a monthly examination				
	2M that was last ann	re extinguisher with the ID # ually inspected August 2019, ce of a monthly examination				
	fire extinguisher that August 2019, there v	m there was one ABC type was last annually inspected vas no evidence of a monthly ented for September 2019.				
	chemical fire extingu	en there was one wet isher that was last annually 19, there was no evidence of on documented for				
	refrigerator there was	en next to the walk-in s one ABC type fire s last annually inspected				

STATEMEN	sey Department of Hea T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			С
		082462	B. WING		10	/29/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
CHELSEA	AT FORSGATE, THE		SGATE DRIVE BURG, NJ 08831			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
A1047	Continued From pag	e 4	A1047			
		vas no evidence of a monthly ented for September 2019.				
	type fire extinguisher	•				
	17. In the maintenance shop area there were two (2) ABC type fire extinguishers that were last annually inspected August 2019, there was no evidence of a monthly examination documented for September 2019.					
	there was one ABC t					
	On the 1st. floor:					
		ype fire extinguisher that was ed August 2019, there was nthly examination				
	extinguisher that was August 2019, there v	cross from resident e was one ABC type fire s last annually inspected vas no evidence of a monthly onted for September 2019.				
	extinguisher that was August 2019, there v	m for residents with <sup>e to other 2440</sup> s one ABC type fire s last annually inspected vas no evidence of a monthly ented for September 2019.				

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STATEMEN	EEV Department of Hea TOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		082462	B. WING	B. WING		C 10/29/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
CHELSEA	AT FORSGATE, THE		RSGATE DRIVE BURG, NJ 08831				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
A1047	Continued From page	e 5	A1047				
	extinguishers: - 7.2.1.2 Inspection inspected either man electronic monitoring minimum of 30 day ir - 7.2.4.3 Where at le inspections are condu- inspection was perfor- person performing the recorded - 7.2.4.4 Where man conducted, records for shall be kept on a tag extinguishers, or an in maintained on file, or - 7.3.1.1.1 Maintenan extinguishers shall be	atervals. east monthly manual ucted, the date the manual rmed and the initials of the e inspection shall be hual inspections are or the manual inspections g or label attached to the fire inspection checklist by an electronic method. ince frequency, Fire e subject to maintenance at					
A1123	hydrostatic test. 8:36-16.12(c) Physica (c) When commercial utilized, it shall be ins room. The remainder protected from the lat separation assemblie construction. Opening assemblies shall be p	l type laundry equipment is stalled in a separate laundry of the home shall be	A1123				

STATE FORM

STATEMENT	ey Department of Hea OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC			E SURVEY PLETED	
			A. BUILDING:			С	
		082462	B. WING		10	10/29/2019	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE			
CHELSEA	AT FORSGATE, THE		RSGATE DRIVE BURG, NJ 08831				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
A1123	Continued From pag	e 6	A1123				
	This REQUIREMEN by: Repeat deficiency	Γ is not met as evidenced					
	Based on observation it was determined the facility failed to ensure that the commercial laundry room maintained a fire separation of at least one hour fire rated construction. This deficient practice was evidenced by the following:						
	presence of the facili (MA) conducted the facility surveyor inspected the and observed that the door (clean linen out position with two rub open devices. The set the one hour fire rate	B a.m. the surveyor, in the ty Maintenance Assistant cour of the building. The ne commercial laundry room e one hour fire rated corridor ) was propped in the open ber wedge type door hold urveyor also observed that ed corridor door (dirty linen in) pen position with a 5 gallon cket.					
	propped in the open the tour, this would a poisonous gases to p into the corridor in th commercial laundry n cited during the Marc	hour fire rated corridor doors position, as observed during llow fire, smoke and bass from the laundry room e event of a fire. This same room corridor doors were th 10, 2016 standard survey 2014 standard survey.					
	Fire Hazard						
A1249	8:36-17.7 Housekeeping-Sanita	ation-Safety-Maintenance	A1249				
		unds shall be well es. The interior and exterior be kept in good condition to					

STATEMEN	sey Department of Hea T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			С
		082462	B. WING	10	/29/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
CHELSEA	AT FORSGATE, THE		RSGATE DRIVE BURG, NJ 08831			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
A1249	ensure an attractive a pleasant atmosphere deterioration. The bu	appearance, provide a e, and safeguard against ilding and grounds shall be zards and other hazards to	A1249			
	by: Complaint #: NJ001 Based on observatio determined that the f building was kept in g	n and interview it was acility failed to ensure the good condition and provide a the residents. This deficient				
	presence of the facili (MA), the surveyor in	he tour of the building, in the ty's Maintenance Assistant ispected the building and ng building safety hazards:				
	the automatic dishwa NUEX Order, 26451 and paper instruction	MA stated that the				
	floor unit for resident activity area and obs ventilation and air co	surveyor inspected the first s with <mark>NJ EX Order. 264b1</mark> erved inside a heating, nditioning closet a 12 inch section of wall board on the				

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVE COMPLETED		
		082462	B. WING		10	C 10/29/2019	
AME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE			
			RSGATE DRIVE				
HELSEA	AT FORSGATE, THE	JAMESE	BURG, NJ 08831				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETI DATE	
A1249	Continued From page	e 8	A1249				
	left side with a <b>the wallboard</b> .	substance that adhered to					
	Health safety hazard						

New Jerse	ey Department of Hea	lith				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SU COMPLET	
	······································	· · · · · · · · · · · · · · · · · · ·			С	
		082462	B. WING		10/29	/2019
			DDRESS, CITY, STATE			
NAME OF PF	ROVIDER OR SUPPLIER			., 21 0002		
CHELSEA	AT FORSGATE, THE		BURG, NJ 08831			
			<u> </u>	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	COMPLETE DATE
A 000	Initial Comments		A 000			
	Initial Comments: TYPE OF SURVEY:	Complaint				
	COMPLAINT #: NJ	119525				
	CENSUS: 134					
	SAMPLE SIZE: 0					
	The facility is not in	substantial compliance with				
	all of the standards	an the New Jersey 8:36, Standards for				
	Licensure of Assiste	ed Living Residences,				
	Comprehensive Per	sonal Care Homes and				
	Assisted Living Prog submit a plan of cor	grams. The facility must				
		each deficiency and ensure				
	that the plan is impl	emented. Failure to correct				
		sult in enforcement action in				
		ovisions of New Jersey e Title 8, Chapter 43E,				
	Enforcement of Lice					
A1047	8:36-14.3(d) Emerg	ency Services and	A1047			
	Procedures					
	(d) Fire extinguishe	rs shall be conspicuously				
	hung, kept easily a	ccessible, shall be visually				
	examined monthly	and the examination shall be				
	extinguisher Fire e	vhich is attached to the fire xtinguishers shall also be				
		tained in accordance with				
	manufacturers' and					
		N.J.A.C. 5:70. Each fire be labeled to show the date of				
	such inspection an					
L				I		1

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

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(X6) DATE Etecutive Divector IJ If continuation sheet 1 of 9

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
	F CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING:			
					C C	
	_	082462	B. WING		10/29/2019	
AME OF PR	ROVIDER OR SUPPLIER		DRESS, CITY, STATE	, ZIP CODE		
	AT CODOCATE THE		SGATE DRIVE			
HELSEA	AT FORSGATE, THE	JAMESB	URG, NJ 08831		N (X	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	BE COMP	LETE
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP	RIATE DA	ΤE
TAG	REGULATORY OR			DEFICIENCY)		
A1047	Continued From pag	e 1	A1047			
		T is not met as evidenced				
	by: Record on observation	on it was determined that the				
	Based on observatio	ally inspect fire extinguishers				
	monthly and keep a	record of the examination on				
	the tage attached to	22 of 22 fire extinguishers				
	increated as require	ed by National Fire Protection				
	Association (NEPA)	and N.J.A.C. 5:70. This				
	deficient practice Wa	as evidenced by the following:				
	On 10/29/19 at 9:06	a.m., during the entrance	- I - I			
	conference of the su	urvey, the surveyor requested				
	that the facility's Ma	iintenance Assistant (MA)				
	provide a copy of th	e facility lay-out which				
	identified the variou	is rooms in the facility.				
	At 0:15 am a tour	of the building with the			1	
	facility's MA was ne	prformed. The MA provided				
	conies of evacuatio	n plans for the 3 floors of the				
	facility.	The product of the pr				
	Along the tour the s	surveyor observed 22 fire				
	extinguishers that v	vere last annually inspected				
	August 2019, The	surveyor observed that fire		1		
	extinguishers were	missing monthly examinations				
	for September 201	9 documented on the tags		ļ		
	attached to the fire	extinguishers in the following				
	locations:	· ·				
	On the 3rd floor:					
	1. At the main ent	rance of the building there was				
	one ABC type fire	extinguisher that was last				
	annually inspected	August 2019, there was no the examination documented				
	for September 201					
		I <b>U.</b>				
	2. Inside the Phys	sical Therapy room there was				
	one ABC type fire	extinguisher that was last	1			
	annually inspected	d August 2019, there was no			·	—

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OW JEISE	by Department of Heal	(X1) PROVIDER/SUPPLIER/CLIA	(X1) PROVIDER/SUPPLIER/CLIA (X2) MOETH EL GONOTATION		(X3) DATE SURVEY COMPLETED	
ID PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		·	с
		082462	B. WING	1	/29/2019	
	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
HELSEA	AT FORSGATE, THE		BURG, NJ 08831	PROVIDER'S PLAN OF CO	RECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLET DATE
A1047	Continued From pag	e 2	A1047			
		ly examination documented				
	there was one ABC	the left of the Beauty Salon type fire extinguisher that was ted August 2019, there was onthly examination otember 2019.				
	one ABC type fire e	ext to stairwell " there was xtinguisher that was last August 2019, there was no hly examination documented 9.				
	#319 there was one with the ID # 3C the August 2019, there	o the left of resident apartment e ABC type fire extinguisher at was last annually inspected was no evidence of a monthly nented for September 2019.				
	was one ABC type	o the left of stairwell "3C" there fire extinguisher that was last August 2019, there was no thly examination documented 9.				
	one ABC type fire	next to stairwell "3D" there was extinguisher with the ID # 3F ally inspected August 2019, ence of a monthly examination eptember 2019.				
	apartment a second the extinguisher with	to the right of resident here was one ABC type fire the ID # 3E that was last d August 2019, there was no hthly examination documented 19.				

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STATEMENT	Y Department of Heal OF DEFICIENCIES F CORRECTION	th (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:	INSTRUCTION	(X3) DATE SURVEY COMPLETED
	···· ··· ··· ··· ··	082462	B. WING		10/29/2019
	NOVIDER OR SUPPLIER	STREET AL 319 FOR	DDRESS, CITY, STATE SGATE DRIVE URG, NJ 08831		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETE
A1047	there was one with the ID # 2R that August 2019, there examination docume 10. In the corridor r one ABC type fire exit that was last annual there was no evider documented for Set 11. In the corridor r one ABC type fire exit that was last annual there was no evider documented for Set 12. In the corridor was one ABC type 2M that was last an there was no evider documented for Set 13. In the dining re fire extinguisher th August 2019, there examination docur 14. In the main kill chemical fire extin inspected August	the left of resident apartment ABC type fire extinguisher t was last annually inspected was no evidence of a monthly ented for September 2019. Next to stairwell there was xtinguisher with the ID # 2S Ily inspected August 2019, nee of a monthly examination obtember 2019. Next to stairwell there was xtinguisher with the ID # 2P Ily inspected August 2019, nee of a monthly examination ptember 2019. Next to stairwell there fire extinguisher with the ID # 2P Ily inspected August 2019, nee of a monthly examination ptember 2019.	A1047		
	refrigerator there	tchen next to the walk-in was one ABC type fire was last annually inspected			

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TATEMENT	ey Department of Heal of DEFICIENCIES of CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A, BUILDING:			SURVEY
	· · · · · · · · · · · ·	082462	B. WING			C /29/2019
	ROVIDER OR SUPPLIER AT FORSGATE, THE	319 FOR:	DDRESS, CITY, STATE SGATE DRIVE URG, NJ 08831	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
A1047	examination docume 16. In the loading do type fire extinguished last annually inspect no evidence of a mo documented for Sep 17. In the maintena (2) ABC type fire exi annually inspected A evidence of a month for September 2019 18. In the corridor r there was one ABC last annually inspect no evidence of a mo documented for Sep On the 1st. floor: 19. In the corridor r there was one ABC last annually inspect no evidence of a mo documented for Sep On the 1st. floor: 19. In the corridor r there was one ABC last annually inspect no evidence of a mo documented for Sep 20. In the corridor r apartment the extinguisher that wa August 2019, there examination docum	vas no evidence of a monthly ented for September 2019. Dock area there was one ABC r with the ID # 2D that was red August 2019, there was nothly examination tember 2019. Ince shop area there were two tinguishers that were last August 2019, there was no hly examination documented type fire extinguisher that was ted August 2019, there was onthly examination otember 2019.	A1047			
	extinguisher that w August 2019, there	vas one ABC type fire as last annually inspected was no evidence of a monthly nented for September 2019.				

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1. All Fire Extinguishers listed were visually examined and recorded October on 10/29/19. Foremost Fire Protection completed annual fire extinguisher inspection on 11/20/19.

2. The Building Services Director visually examined all fire extinguishers on 10/31/19 to ensure they were visually examined and recorded.

3. The task of visually inspecting and recording fire extinguishers will be placed in our TELS system.

4. The Building Services and/or Executive Director will verify each month via the TELS system that the task is completed.

STATEMENT	y Department of Hea OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	· · · · · · · · · · · · · · · · · · ·	082462	B. WING	10	C 10/29/2019		
	OVIDER OR SUPPLIER AT FORSGATE, THE	319 FOR	DDRESS, CITY, STATE SGATE DRIVE BURG, NJ 08831	ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE	
A1047	Continued From pag	e 5	A1047				
A1123	extinguishers: - 7.2.1.2 Inspection inspected either man electronic monitoring minimum of 30 day i - 7.2.4.3 Where at inspections are cond inspection was perfor- person performing the recorded - 7.2.4.4 Where man conducted, records shall be kept on a tate extinguishers, or an maintained on file, of - 7.3.1.1.1 Maintena extinguishers shall be intervals of not more hydrostatic test. 8:36-16.12(c) Physical (c) When commercial	least monthly manual ducted, the date the manual bread and the initials of the ne inspection shall be anual inspections are for the manual inspections of or label attached to the fire inspection checklist or by an electronic method. ance frequency, Fire be subject to maintenance at the than 1 year, at the time of	A1123				
	room. The remaind protected from the separation assemb construction. Open assemblies shall be	er of the home shall be aundry room by fire lies of at least one-hour rated ings in all fire separation e protected in accordance with uction Code, N.J.A.C. 5:23.					

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If continuation sheet 6 of 9

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# A1123

- 1. The commercial laundry room door was immediately closed on 10/29/19. The rubber wedge door holds were removed and discarded on 10/31/19.
- 2. The community only has one commercial laundry room.
- 3. The housekeeping and maintenance staff will be re-educated by 12/06/19 on the importance of keeping fire rated doors closed.
- 4. Managers will ensure doors are closed as they move through the community daily.

STATEMENT	y Department of Hea DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY
· · · · · ·		A second seco	· · · · · · · · ·		C	
		082462	B. WING		10/29/2019	
	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
			SGATE DRIVE			
CHELSEA	AT FORSGATE, THE	JAMESE	BURG, NJ 08831	PROVIDER'S PLAN OF		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIEN(	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	COMPLETE DATE
A1123	Continued From page	 je 6	A1123			
		T is not met as evidenced				
	by:					
	Repeat deficiency					
	Based on observation	on it was determined the ure that the commercial				
	laundry room maint	ained a fire separation of at				
	least one hour fire r	ated construction. This				
	deficient practice wa	as evidenced by the following:				
	On 10/29/19 at 10:2	28 a.m. the surveyor, in the				
	presence of the fac	ility Maintenance Assistant tour of the building. The				
	surveyor inspected	the commercial laundry room				
	and observed that I	the one hour fire rated corridor				
	door (clean linen ou	ut) was propped in the open bber wedge type door hold				
	onen devices. The	surveyor also observed that				
	the one hour fire ra	ted corridor door (dirty linen in) open position with a 5 gallon				
	chemical product b	bucket.				
	With both of the or	he hour fire rated corridor doors				
	propped in the ope	en position, as observed during d allow fire, smoke and				
	I noisonous dases t	o pass from the laundry room				
	into the corridor in	the event of a fire. This same				
	commercial laund	ry room corridor doors were arch 10, 2016 standard survey				
	and the January 2	4, 2014 standard survey.				
	Fire Hazard					
			A1249			
A12	49 8:36-17.7 Housekeeping-Sa	nitation-Safety-Maintenance				
	The building and	grounds shall be well times. The interior and exterior				
	of the building shi	all be kept in good condition to				

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If continuation sheet 7 of 9

TATEMENT	or Department of Hea	(X1) PROVIDER/SUPPLIER/CLIA	R/SUPPLIER/CLIA     (X2) MULTIPLE CONSTRUCTION       ATION NUMBER:     A. BUILDING:		(X3) DATE COMF	PLETED
ND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:			······································	
		and the second	B. WNG		10	/29/2019
		082462				
AME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE		
			SGATE DRIVE			
CHELSEA	AT FORSGATE, THE		URG, NJ 08831	PROVIDER'S PLAN OF	CORRECTION	(X5)
(X4) ID PREFIX TAG	/EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLET DATE
A1249	Continued From pa	ge 7	A1249			
	pleasant atmosphered	e appearance, provide a re, and safeguard against uulding and grounds shall be lazards and other hazards to id safety.				
	by: Complaint #: NJ00 Based on observa determined that the building was kept safe environment	tion and interview it was e facility failed to ensure the n good condition and provide a for the residents. This deficient				
	On 10/29/19 durin presence of the fa (MA), the surveyo observed the follo	enced by the following: g the tour of the building, in the cility's Maintenance Assistant r inspected the building and wing building safety hazards:				
	the automatic dish NEX Order 20001 subst and paper instruc dishwasher mach interviewed the M	inside the kitchen, to the left of washer machine there was a ance that adhered to the wall tions mounted to the wall on the ine. At that time the surveyor A to ascertain what the The MA stated that the				
	floor unit for resid activity area and ventilation and ai bigh by 20 inch k	the surveyor inspected the first lents with <b>NJEX Order. 264b1</b> observed inside a heating, r conditioning closet a 12 inch ong section of wall board on the substance that adhered to				

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New Jersey Department of Heal STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/GLIA	1	(X2) MULTIPLE CONSTRUCTION A, BUILDING:		
	·······					с
		082462	8. WING		10	/29/2019
	ROVIDER OR SUPPLIER AT FORSGATE, THE	319 FOF	ADDRESS, CITY, STATE, RSGATE DRIVE BURG, NJ 08831	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
A1249	Continued From pag the wallboard. Health safety hazard		A1249			

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ΑТ

# A1249

1. The dish machine and HVAC closet was cleaned on 10/29/19. The wallboard was also removed on 10/29/19 from the HVAC closet.

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- 2. The Building Services Director completed a walkthrough on 10/31/19 to ensure that HVAC closet areas and dish machine are well maintained and in good condition.
- 3. Maintenance and Kitchen employees will be re-educated by 12/6/19 on the importance of keeping HVAC closets and dish machine areas clean. If areas are in need of maintenance they are to notify the concierge so that it could be placed in our TELS system.
- 4. The Building Services and/or Executive Director will verify each month via the TELS system that tasks entered are complete.

### STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
	A. Building		1/27/2020	
082462 <sub>Y1</sub>	B. Wing	Y2	1/2//2020	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).

ITE	м	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix Reg. # LSC	A1047 8:36-14.3(d)	Correction Completed 10/31/2019	ID Prefix Reg. # LSC	A1123 8:36-16.12(c)	Correction Completed 10/31/2019	ID Prefix Reg. # LSC	A1249 8:36-17.7	Correction Completed 10/31/2019
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	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed
REVIEWE STATE AG REVIEWE CMS RO FOLLOWU 10/29/201		REVIEWED BY (INITIALS) REVIEWED BY (INITIALS) DMPLETED ON		SIGNATURE OF S	TED DEFICIENCIES		IMARY OF	DATE