STATEMEN	sey Department of H IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	COMI	E SURVEY PLETED	
		082462	B. WING			10/01/2019	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST				
CHELSE	A AT FORSGATE, TH	F	GATE DRIVE JRG, NJ 0883				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
A 000	Initial Comments		A 000				
	Initial Comments: TYPE OF SURVE	7: Complaint					
	COMPLAINT #: N	J00128682					
	CENSUS: 128						
	SAMPLE SIZE: 3						
	all of the standards Administrative Cod Licensure of Assist Comprehensive Per Assisted Living Pro- submit a plan of co completion date for that the plan is imp deficiencies may re accordance with pr Administrative Cod	a substantial compliance with is in the New Jersey le 8:36, Standards for red Living Residences, ersonal Care Homes and ograms. The facility must prection, including a r each deficiency and ensure elemented. Failure to correct esult in enforcement action in rovisions of New Jersey le Title 8, Chapter 43E, rensure Regulations.					
A 563	(a) The facility shal immediately by tele (609-392-2020 afte	neral Requirements I notify the Department ephone at 609-633-9034 er business hours), followed written confirmation, of the	A 563				
	unusual nature, inc limited to, all fin and all deaths resu or incidents in services. Reports o contain informa	ccurrence or incident of an cluding, but not res, disasters, elopements, ilting from accidents the facility or related to facility of such incidents shall ation about injuries to residents disruption of services, and					

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

TITLE

(X6) DATE

New Jei	rsey Department of H	lealth			FORM	APPROVED
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		082462	B. WING			C 01/2019
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CHELSE	A AT FORSGATE, TH		SGATE DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
A 563	Continued From pa extent of dama	-	A 563			
	by: Complaint #: NJ00 Based on interview determined that the Department of Hea incident for of in r . This deficient p following: On 10/1/19 at 10:00 the medical record admitted to the faci which included Exe unit. The surveyor review record titled, "Asses	and record review it was a facility failed to notify the lth (DOH) of an elopement residents reviewed, Resident practice was evidenced by the 0 a.m., the surveyor reviewed of Resident who was lity with diagnoses cutive Order 26, 4.b.				
	able to bear full we ambulation but use and was able to sel reviewed the "Gene and observed that t	umented that the resident was ight, was independent with d a wheelchair intermittently f-propel. The surveyor then eral Service Plan dated the resident was wed the "Care Notes" (CNs)				

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If continuation sheet 2 of 6

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 082462			(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		E SURVEY PLETED C 01/2019	
IAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
HELSE	A AT FORSGATE, TH		SGATE DRIVE URG, NJ 0883			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
A 563	that the resident was on the Executive Order to the with a diag Executive Order 21. The with a diag Executive Order 20.4.1 On 10/1/19 at 12:3 interviewed the Reg stated that the resid unit and was f the Executive Order 20.4.1 That staff stated that se further stated that se further stated that se further stated that se further stated that on the resident was fo RN stated that the on vacation and the also stated that on the incident and that incident should have At 11:15 a.m., the se who agreed with th should have been r DOH as an Executive order 20.4.1 The surveyor referr "Missing Resident- documented, "reg	20:00 p.m., which documented as found on his/her er 26, 4.b and was eresident returned from the nosis of to the to the r 26, 4.b. 20 p.m., the surveyor gistered Nurse (RN) who dent from the surveyor dent from the surveyor ound by staff in the surveyor the secured doors did not ident went out them. The RN she was not aware that this be reported to the DOH since und within the building. The Executive Director (ED) was at she was in charge. The RN that she told the ED of at the ED stated that this re been reported to the DOH. surveyor interviewed the ED e surveyor that the incident reported immediately to the surveyor that the incident reported immediately to the surveyor the ED stated that she ected and serviced by a red to the facility's policy titled,				
	5	'				

New Jer	sey Department of H	lealth			TORMATINOVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		082462	B. WING		C 10/01/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
CHELSE	A AT FORSGATE, TH		GATE DRIVI JRG, NJ 088		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
A 749	Continued From pa	ge 3	A 749		
	 (a) The resident gereviewed and, if new semi-annually, and based upon the resprovided and any cliphysical or cognitive This REQUIREMENT by: Complaint #: NJ00 Based on interview 	neral service plan shall be cessary, revised more frequently as needed ident's response to the care hanges in the resident's e status.			
	the service plan wa include specific inte the risk of falls with of elopements for who eloped from m a fall, Resident . evidenced by the for On 10/1/19 at 10:00 Resident medi	s updated or revised to erventions in order to reduce injuries and to reduce the risk out of residents reviewed emory care unit and sustained This deficient practice was			
	with diagnose "Assessment summ was independen Executive Order 26 unit while awake. The surveyor review observed documen "", Resident " v in the Executive Order	s which included the contract of the According to the Acc			

New Jer	sey Department of H	lealth				TROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SU COMPLET	
		082462	B. WING		C 10/01/2	2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CHELSE	A AT FORSGATE, TH		SGATE DRIV			
		JAMESB	URG, NJ 088			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE	(X5) COMPLETE DATE
A 749	Continued From pa	ige 4	A 749			
	transferred to the documented that the facility with diagnost Executive Order Executive Order The surveyor contin record and observe Plan/Health Service No updates or chan including no interve from the	the resident returned to the ses of Executive Order 26, 4.b. r 26, 4.b. nued to review the medical ed the, "General Service e Plan" (GSP/HSP) dated eyor observed that there were ages made to the GSP/HSP, entions put in place upon return of Executive Order 26, 4.b.				
	interviewed the Reg stated that when th (CHHA) was ready [CHHA] was unable RN stated that staff	D p.m. the surveyor gistered Nurse (RN) who e Certified Home Health Aide to provide evening care she to locate Resident . The f then searched for Resident in the Executive Order 26, 4.0				
	not sound when the The RN stated that checked the exit do operational. The R checked the exit do and the doors alarn	N stated that on the she				
	Reports" which doc identify specific me the likelihood of rec	wed the policy titled, "Incident cumented, "The Nurse will asures to prevent or reduce current incidents and record idjusting the care plan as				

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If continuation sheet 5 of 6

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		082462	B. WING		C 10/01/2019	
AME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, ST			
HELSE	A AT FORSGATE, TH		RSGATE DRIVE BURG, NJ 0883			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
A 749	Continued From pa appropriate."	age 5	A 749			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION			DATE OF REVIS	SIT
IDENTIFICATION NUMBER	A. Building				
082462 _{Y1}	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).

ITEN	N	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix	A0563 8:36-5.10(a)(2)	Correction	ID Prefix	A0749 8:36-7.3(a)	_ Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC		10/02/2019	LSC		11/01/2019	LSC _		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC		_	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
_					_	-		
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC _		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
REVIEWE		REVIEWED BY (INITIALS)	DATE	SIGNATURE O	FSURVEYOR		DATE	
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE			DATE	
FOLLOWUP TO SURVEY COMPLETED ON 10/1/2019				CK FOR ANY UNCORRE ORRECTED DEFICIENC				s 🗆 no



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

www.nj.gov/health

PHILIP D. MURPHY Governor

SHEILA Y. OLIVER Lt. Governor 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,

TATEMENT	ey Department of Hea of DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:	DINSTRUCTION	(X3) DATE COMF	SURVEY	
		082462	B. WING		10	C 10/01/2019	
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE			
	AT FORSGATE, THE		SGATE 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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
A 000	Initial Comments		A 000				
ş	Initial Comments: TYPE OF SURVEY:	Complaint					
	COMPLAINT #: NJC	00128682					
	CENSUS: 128						
	SAMPLE SIZE: 3						
	all of the standards i Administrative Code Licensure of Assiste Comprehensive Per Assisted Living Prog submit a plan of cor	8:36, Standards for d Living Residences, sonal Care Homes and grams. The facility must					
	deficiencies may real accordance with pro	emented. Failure to correct sult in enforcement action in ovisions of New Jersey e Title 8, Chapter 43E, ensure Regulations.					
A 563	3 8:36-5.10(a)(2) Gen	eral Requirements	A 563			÷	
	immediately by tele (609-392-2020 after	notify the Department phone at 609-633-9034 r business hours), followed written confirmation, of the					
	unusual nature, inc limited to, all fin and all deaths resu or incidents in services. Reports of contain information	res, disasters, elopements, lting from accidents the facility or related to facility if such incidents shall ation about injuries to residents lisruption of services, and					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN C	F CORRECTION	IDENTIFICATION NOMBER,	A. BUILDING:		
			1		С
		082462	B. WNG	· · · · · · · · · · · · · · · · · · ·	10/01/2019
	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STAT	IE, ZIP CODE	
NAME OF PI	VALUER ON OUTFLIEN		SGATE DRIVE		
CHELSEA	AT FORSGATE, THE		URG, NJ 08831		
		ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	ON (X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE COMPLETÉ
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	
A 563	Continued From pag	e 1	A 563		ŧ
	extent of domog	10.5'			
	extent of damag	53,			
		T is not mot as ovidor cod			
		T is not met as evidenced		1	
	by: Complaint #: NJ001	28682			
	Gomplant #. Nooo			-	
	Based on interview	and record review it was			
	determined that the	facility failed to notify the			
	Department of Healt	th (DOH) of an executive order 26, 4.6.			
	incident for the for	esidents reviewed, Resident			
		ractice was evidenced by the			
	following:				
	On 10/1/10 at 10:00	a.m., the surveyor reviewed			
		of Resident			
	admitted to the facil	ity Executive Order 26, 4.b.			
		Order 26, 4.b.			
		01061 20, 4.0.			
1	The surveyor review	ved a document in the medical			
	Executive Order 26, 4, bl., c; c,	ssment summary," dated umented that the resident was			
1	able to	was independent with			
		d a wheelchair intermittently			
		f-propel. The surveyor then			
		eral Service Plan dated			
ļ	and observed that t	he resident was not oriented	-		
	to person, place or	time and required ongoing			
	cueing and re-orier	itation.			ł
	· ·				
	The surveyor review	wed the "Care Notes" (CNs)			<u>l</u>
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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ENTIFICATION NUMBER: A. BUILDING:			C	
		082462			10/01/2019		
ME OF PRO	OVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE			
		319 FOF	SGATE DRIVE				
HELSEA /	AT FORSGATE, THE	JAMESE	BURG, 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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETE DATE	
A 563	Continued From pag	e 2	A 563				
	dated Executive Order that the resident was on the to the hospital. The hospital with a diagn EXECUTIVE On 10/1/19 at 12:30 interviewed the Reg stated that the resid the Executive Order 20 417 That staff stated that alarm when the resi further stated that she elopement had to be the resident was for RN stated that the E on vacation and that also stated that on	26, 4.b. which documented stairwell and was transferred resident returned from the osis of executive Order 26, 4.b. Order 26, 4.b.					
	At 11:15 a.m., the s who agreed with the should have been r DOH as an an an an an had the doors inspe contractor on an an an The surveyor referr "Missing Resident- documented, "reg	e been reported to the DOH. urveyor interviewed the ED e surveyor that the incident eported immediately to the The ED stated that she ected and serviced by a det to the facility's policy titled, Elopement" which gulatory agencies defining a					
A 749	missing resident as	a reportable incident."	A 749				
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- 1. On 9/26/19 the management team was informed of the failure to report the elopement for resident
- 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.

A563

STATEMENT	ey Department of Hea OF DEFICIENCIES IF CORRECTION	ITI (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 082462	(X2) MULTIPLE CC A. BUILDING: B. WING			
			ADDRESS, CITY, STATE,	ZIP CODE		
	AT FORSGATE, THE	319 FOI	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
A 749	reviewed and, if nece semi-annually, and n based upon the resid	eral service plan shall be essary, revised nore frequently as needed dent's response to the care anges in the resident's	A 749			
	by: Complaint #: NJ001 Based on interview a determined that the the service plan was include specific inter the risk of falls with of elopements for who eloped from	and record review it was facility failed to ensure that supdated or revised to rventions in order to reduce injuries and to reduce the risk out of residents reviewed cuive Order 26, 4.0 and sustained This deficient practice was				
	Residen medie that the resident mo with diagnose Executive Order 2 "Assessment summ was independen	a.m. the surveyor reviewed cal record which documented oved into the facility on s which included 6, 4.D. According to the hary" dated Second Resident it with Second Second Resident at with Second Second Resident at a secured				
	observed documen	wed the Care Notes (CNs) and ted that on Executive Order 26, 4.b vas found on his/her stairwell. Further review of hat the resident had an injury				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 10/01/2019	
		NAME OF PI				
CHELSEA	AT FORSGATE, THE		RSGATE DRIVE			
			BURG, NJ 08831		E CORDECTION	010
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLET DATE
A 749	Continued From page 4		A 749			
	to the secure one rate of his/he		-			
	transferred to the hospital. The CNs also					
	documented that the facility with diagnor	ne resident returned to the executive Order 26, 4.b.				
		Order 26, 4.b.				
	The survevor conti	nued to review the medical				
	record and observ	ed the, "General Service				
		e Plan" (GSP/HSP) dated				
		eyor observed that there were nges made to the GSP/HSP,				
	including no interv	entions put in place upon return				
	from the hospital o	in an effort to ecutive Order 26, 4.b.				
	prevent further	eculive Order 26, 4.b.				
	On 10/1/19 at 12:3	0 p.m. the surveyor				
		gistered Nurse (RN) who				
		ne Certified Home Health Aide / to provide evening care she				
		le to locate Resident				
	RN stated that sta	ff then searched for Resident				
	who was found	t in the Executive Order 26, 4.b.				Ì
	The RN stated tha	t staff reported the alarm did				
	not sound when th	e resident opened and exited.				
	\$	t the Memory Care Coordinator				
		oors on and they were RN stated that on the state of th				
	checked the exit d					
		med when opened. The RN				
		eyor that she did a readmission				
	GSP.	but did not update the				
		ewed the policy titled, "Incident				
		ocumented, "The Nurse will				
	identify specific m	easures to prevent or reduce				
	the likelihood of re	current incidents and record				
	these measures	adjusting the care plan as	1			

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New Jersey Department of Health												
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING:		(X3) DATE SURVEY COMPLETED							
					С							
		082462	B. WING		10/01/2019							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
CHELSEA AT FORSGATE, THE LAMESBURG, NL 08831												
(X4) ID PREFIX TAG	(FACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETE DATE						
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If continuation sheet 6 of 6



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- 1. Resident 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.