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	13A019	A. BUILDING: _____ B. WING _____	C 08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHELSEA AT SHREWSBURY, THE	515 SHREWSBURY AVENUE SHREWSBURY, NJ 07702

(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: Standard and Complaint COMPLAINT #: NJ00156289 CENSUS: 77 SAMPLE: 13 1. 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. 2. A Life Safety Code Survey was conducted by the State Agency on 08/19/2024. The facility was not in substantial compliance with New Jersey Administrative Code, Chapter 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs.	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	A 310		

This REQUIREMENT is not met as evidenced by:
Complaint #: NJ00156289

Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the Executive Director (ED) failed to ensure the implementation and enforcement of the facility's policy and procedure titled, "Call Bell/Emergency Response System," for 1 of 13 residents reviewed, Resident #1. This deficient practice was evidenced by the following:

1. On 8/19/24 at 11:07 a.m., the surveyor interviewed Resident #1 to inquire how long staff took to respond to his/her pendant call. Resident #1 stated that staff would sometimes answer the pendant call right away, and sometimes staff would take 30-60 minutes to respond. At this time, the surveyor activated Resident #1's pendant to assess the pendant call response time.

At 11:22 a.m., 15 minutes after Resident #1's pendant call was activated, two Certified Home Health Aides (CHHA) responded to the pendant call. CHHA #1, who was assigned to Resident #1, deactivated the pendant. The surveyor

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A 310	Continued From page 2	A 310		

interviewed CHHA #1 and CHHA #2 to inquire how long staff had to answer the pendant calls. Both stated that the pendant calls should be answered within eight minutes. The surveyor then inquired the reason it took them 15 minutes to answer the pendant call, and they both stated that they were busy. Further, the surveyor inquired what a CHHA should do when a resident pressed their call pendant and the CHHA was busy. CHHA #2 stated that if a resident called while a CHHA was busy, the CHHA should request assistance from other staff using their walkie-talkie system.

The surveyor reviewed a document titled, "Resident Event Report," dated NJ ex order 26.4b1 for Resident #1, which documented Resident #1's longest call pendant response time was 134 minutes (2 hours and 14 minutes).

At 4:05 p.m., the ED provided the surveyor with a document titled, "Detailed Event Report," dated NJ ex order 26.4b1, which documented the longest call pendant response time was 498 minutes (8 hours and 18 minutes). The report also documented 89 occurrences where it took staff longer than 15 minutes to answer the pendant calls.

At 4:08 p.m., during continued surveyor interview with the ED, the surveyor inquired how long staff had to answer the pendant calls. The ED stated that the pendant calls should be answered within eight to fifteen minutes. The surveyor then inquired about the protocol a CHHA would follow if a resident pressed their call pendant and the CHHA was busy. The ED stated that staff should use their walkie talkies to request assistance from other staff if they are
too busy when a resident calls for assistance. The surveyor then inquired how staff knew when

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A 310	Continued From page 3	A 310		

a resident called for assistance. The ED further stated that pendant calls went to an [NJ Ex Order 26] carried by the CHHA, which showed them who called and their location. The ED also stated that there were monitors at the front desk, and in the wellness office, that shows when and where there are pendant calls, and the ED and Assisted Living Coordinator also have access to the pendant call program.

Additionally, the surveyor inquired what the process was for responding to the pendant calls, and the ED explained that the CHHA would respond to the pendant call, reset the pendant, and assist the resident. Further, the surveyor inquired the reason the "Detailed Event Report," documented a pendant response time of 498 minutes. The ED stated that the pendant call was from the memory care unit and was likely accidentally pressed and not turned off. The surveyor then inquired about other call bell response times that were long, and the ED stated that she was working with staff to improve call bell response times.

2. On 8/20/24 at 9:50 a.m., another surveyor interviewed Resident #5 to inquire about pendant call response times. Resident #5 stated that response times were longer at dinner time and on the weekends.

The surveyor also reviewed the "Resident Event Report," dated [NJ ex order 26.4b1] for Resident #5, which documented Resident #5's longest call pendant response time was 72 minutes (1 hour and 12 minutes).

The surveyor reviewed the facility policy titled, "Call Bell/Emergency Response System," revised on 1/1/2016, which documented, "Employees will

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A 310	Continued From page 4 respond to a Call Bell alert in a timely and appropriate manner..." "...When an emergency call is activated, Resident Attendants will respond..." "...If a Resident Attendant cannot go to the resident, the employee will notify another Resident Attendant to respond..." "...Residents in the Country Cottage [memory care] will be assessed by the RN to determine appropriateness for the use of the emergency call pendant."	A 310		
A 401	8:36-4.1(a)(22) 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: 22. The right to live in safe and clean conditions in a facility that does not admit more residents than it can safely accommodate while providing services and care; This REQUIREMENT is not met as evidenced by: Complaint and Standard Survey Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure all residents right to live in a safe environment by leaving a housekeeping cart unlocked, which contained cleaning chemicals, in the hallway of the facility NJ Ex Order 26.4(b)(1) Community, for which and	A 401		

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A 401	Continued From page 5 Imminent Danger (ID) was identified. This deficient practice was evidenced by the following: On 8/19/24 at 12:36 p.m., the surveyor observed a housekeeping cart in the hallway of the facility NJ Ex Order 26.4(b)(1) Community, and upon further inspection observed that the area of the cart that stored the cleaning chemicals was not locked. The surveyor observed several items in the unlocked housekeeping cart that included, but were not limited to, NJ Ex Order 2 disinfectant, NJ Ex Order 2 toilet bowl cleaner with bleach, Peroxy/Hydox red dilution and Lavender breeze air freshener. Additionally, the surveyor observed a housekeeping staff member who was vacuuming in a common area adjacent to the cart, approximately 8 feet away, with his back to the cart. The surveyor interviewed the housekeeper who stated that he never had a key to the housekeeping cart. The housekeeper further stated that he was told as long as the cart was within eyesight, and the chemicals were kept off the top of the cart, that the cart did not have to be locked. At 1:20 p.m., the surveyor interviewed the facility Maintenance Director (MD), who stated that he also supervised the housekeepers. During surveyor interview, the MD stated that the housekeeping cart should have been locked, and that he would get the housekeeper a key. The ID was reported to the Licensed Assisted Living Administrator on 8/19/24 at 1:00 p.m. The Administrator was presented with the ID template that included information about the concern for the safety of residents. On 8/20/24, the surveyor verified that the Removal Plan was implemented, and that each	A 401		

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A 401	Continued From page 6 housekeeper had a functioning key for their housekeeping cart, to ensure that cleaning chemicals were not accessible to residents who were cognitively impaired. The surveyor additionally verified that education was provided to the facility housekeepers to ensure the safety and wellbeing of the facility residents. The surveyor reviewed the facility policy and procedure titled, "Resident Rights", with a revised date of March 1, 2010, which indicated residents had the right," To live in a safe...Residence that...can safely accommodate while providing personalized services and care to meet each resident's needs."	A 401		
A 891	8:36-10.5(a) Dining Services (a) The facility and personnel shall comply with the provisions of N.J.A.C. 8:24, Retail Food Establishments and Food and Beverage Vending Machines Chapter XII of the New Jersey Sanitary Code. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00156289 Based on observation, interview, and review of facility documents, it was determined the facility	A 891		

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A 891	Continued From page 7	A 891		

failed to consistently store and label food properly, apply hair restraints, and ensure that the ice machine scoop was properly secured and sloped to an outlet that allowed for complete draining, in accordance with the provisions of Chapter 24, N.J.A.C. 8:24. "Sanitation in Retail Food Establishments and Food and Beverage Vending Machines," which placed the highly susceptible population/residents' health and safety at risk for foodborne illnesses. This deficient practice was evidenced by the following:

Reference: Chapter 24, N.J.A.C. 8:24, "Sanitation in Retail Food Establishments and Food and Beverage Vending Machines" read:

1. Reference: Chapter 24, N.J.A.C 8:24-2.4(c)(1) "The following requirements shall apply to hair restraints: Except as provided in (c)2 below, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, linens; and unwrapped single-service and single-use articles."

On 8/19/24 at 9:35 a.m., during a tour of the facility dining room and kitchen, the surveyor, in the presence of the Food Service Director (FSD), observed through the kitchen door window that 2 facility staff members, Server #1 and Server #2, were not wearing hair restraints. The surveyor asked the FSD if employees should be wearing hair restraints while in the kitchen and he stated, "We don't let anyone in without one."

Prior to the surveyor entering the kitchen, the surveyor observed a box labeled "medium vinyl gloves" that contained small beard nets; however,

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A 891	Continued From page 8	A 891		

the surveyor did not observe that hair restraints were available. The FSD stated that he was unsure whether or not he had any hair restraints, but would go to his office to check. The FSD returned with the hair restraints and placed them at the entrance to the kitchen.

The surveyor entered the kitchen and observed a kitchen staff member preparing food, however, he was not wearing a hair restraint and he had facial hair.

At 11:03 a.m., the surveyor interviewed Server #1, who stated that she knew from previous work experience that hair restraints should be worn in the kitchen. Server #1 additionally stated that the FSD had given her instructions about wearing hair restraints as well.

At 11:07 a.m., the surveyor interviewed Server #2 who stated that she was aware that hair restraints should be worn in the kitchen, but that it was not enforced.

2. Reference: Chapter 24, N.J.A.C 8:24- 4.2 (r) "Equipment compartments that are subject to accumulation of moisture due to conditions such as condensation, food or beverage drip, or water from melting ice shall be sloped to an outlet that allows complete draining."

At 9:43 a.m., during continued tour of the kitchen, in the presence of the FSD, the surveyor observed that an ice scoop was stored inside of the ice machine. When the surveyor asked the FSD if the ice scoop was normally stored inside the ice machine, he explained that in the past, the scoop was stored on a hook on the outside of the ice machine, but since the hook had broken off, the scoop was stored inside the machine. The

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A 891	Continued From page 9 surveyor observed the remains of an adhesive strip on the outside of the ice machine without a hook attached to it. 3. Reference: Chapter 24, N.J.A.C 8:24- 6.7(o) "A handwashing facility may not be used for purposes other than handwashing." On 8/19/24 at 11:07 a.m., in the first floor dining room kitchenette, the surveyor observed an open bucket in the left compartment of the sink that contained a liquid. Server #2 stated that the bucket contained bleach and water which the servers used to clean the dining room tables, and that it was easier to have the bucket near. 4. At 9:46 a.m., the surveyor observed a small refrigerator that the FSD identified as the server refrigerator, and the following food items were stored inside without a date: a. A large tray of chocolate pudding b. A large tray of vanilla pudding At 9:50 a.m., the surveyor observed the walk in refrigerator and the following food items were stored without a date: c. A bucket of pickles in liquid open to air d. A clear container of feta cheese crumbles e. Cut fruit uncovered 5. At 10:00 a.m., the surveyor observed multiple black patches above the sink in an area that was being utilized by the dishwasher to wash cookware. The FSD stated that the black substance was likely mildew. The surveyor then observed the dishwasher utilizing the wire sponge that he was using to scrub the cookware with, to wipe off the black patches.	A 891		

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A 939	Continued From page 10	A 939		
A 939	8:36-11.5(b)(1)(i-ii) Pharmaceutical Services (b) The registered professional nurse may choose to delegate the task of administering medications in accordance with N.J.A.C. 13:37-6.2 to certified medication aides, as defined in this chapter. 1. A unit-of-use/unit dose drug distribution system shall be developed and implemented whenever the administration of medication is delegated by the registered professional nurse to a certified medication aide; i. Over-the-counter (OTC) solid and liquid dosage forms may be dispensed in a non unit-of-use or non unit-dose medication distribution system. ii. Prescription liquid medications (that is, conventional bottles, concentrates) may be dispensed in a non unit-of-use, non unit-dose, or conventional medication distribution system. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the Registered Nurse (RN) failed to ensure the Certified Medication Aide (CMA) administered medication in a unit of use/unit dose for 1 of 13 residents, Resident #11. This deficient practice was evidenced by the following: On 8/19/24 at 9:46 a.m., the surveyor interviewed the Licensed Practical Nurse (LPN) regarding	A 939		

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A 939	Continued From page 11	A 939		

medication administration. The LPN stated that the facility used an electronic medication administration record (EMAR). In addition, the LPN stated that the facility used CMAs to administer medication to the residents on the evening shifts. The surveyor then conducted a medication pass observation with the LPN and inspected the facility medication storage cart.

At 10:16 a.m., the surveyor, during inspection of the medication cart, observed a non-unit of use/unit dose prescription bottle that was labeled with Resident #11's name. Upon further review of the medication label, and the medication orders, the surveyor observed that the medication was called NJ ex order 26.4b1 and the resident was prescribed NJ ex order 26.4b1

At 1:15 p.m., the surveyor reviewed Resident #11's EMAR's for the months of NJ ex order 26.4b1, and NJ ex order 26.4 which revealed the instructions for medication administration, the dates and times of medication administration, and the initials and signatures of staff who administered the medication. NJ ex order 26.4b1 .." NJ ex order 26.4b1 According to surveyor review of the EMAR, a CMA initialed and signed out the medication as NJ ex order 26.4b1 of NJ ex order 26.4b1, and NJ ex order 26.4 as follows:
1. The CMA initialed and signed out the medication NJ Ex times to indicate the medication was administered to Resident #11 in NJ ex order 26.4b NJ ex order 2
2. In CMA initialed the EMAR and signed out the medication NJ Ex times in NJ ex order 26.4b1 to indicate that the medication was administered to the resident.
3. The CMA initialed the EMAR NJ Ex times in

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A 939	Continued From page 12 NJ ex order 26.4b1 to indicate the medication was administered to the resident. At 3:24 p.m., the surveyor interviewed the Health Service Director (HSD/RN) regarding the CMA administering the NJ ex order 26.4b1 at 9:00 p.m., which was package in a non-unit of use/unit dose for Resident #11. The HSD/RN stated that the facility used LPNs and CMAs to administer the above medication to the resident. In addition, the HSD/RN stated that the medication must be kept in its original container according to the pharmacy. The surveyor reviewed the facility policy and procedure titled, "Medication Administration" which indicated, "Medications will be administered in accordance with ...State laws and regulations. ...6. An FDA approved unit of dose drug distribution system ...will be utilized ..."	A 939		
A 997	8:36-11.7(d) Pharmaceutical Services (d) No stock supply of medications shall be maintained, unless prior approval is obtained from the Department. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure all supplies, and medications that are not self-administered by residents were securely stored in a safe area and kept locked when not in use. This deficient practice was evidenced by the following:	A 997		

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A 997	Continued From page 13 On 8/19/24 at 11:00 a.m., the surveyor toured the second floor Assisted Living (AL) lounge area, located to the left of the hair salon, and observed a cabinet with several drawers. Upon opening the cabinet drawers, the following unlabeled items were observed: In the top, left side drawer: (3) boxes of Bacitracin First Aid antibiotic ointment In the bottom, left side drawer: (3) boxes of Curad gauze (11) boxes of Equos Alginate Wound dressing In the first, top middle drawer: (2) brown gauze dressings (2) boxes of Unna-Z zinc paste bandages Calamine Lotion (1)box sure prep protection wipes (1) roll of tape gauze In the second, middle drawer: (1) box of abdominal pads-extra absorbent (3) boxes of gauze sponges (12) Demarginate wound dressings (6) Sterile gauze pads In the bottom middle drawer: (1)Curad gauze (1) post-op (operational) sponge (1) box of gauze sponges (1) gauze bandage (2) tapes (1) toilet brush (3) bags of dentips, disposable oral swabs in sealed bags (4) red plastic bags (1) yellow infectious linen plastic bag	A 997		

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A 997	Continued From page 14 At 11:13 a.m., the surveyor observed the following unlabeled items in the cabinet on the second floor outside the hair salon: (7) packs of adult disposible briefs. At 11:20 a.m., the surveyor continued the tour of the AL second floor, the living room area called "The Allen House", and observed the following unlabeled items in the cabinet drawers: On the right side of the cabinet: On the top drawer: (1) package of under pads and on the bottom drawer: (1) package of a prevail adult washcloths. At 4:43 p.m., the surveyor and the Health Service Director (HSD) went to the second floor AL lounge area and the surveyor showed her all the items found in the cabinet drawers including the (3) boxes of Bacitracin First Aid antibiotic ointment, the HSD stated that these items are our overflow of our stock items. During continued interview the HSD confirmed that it was unsafe to store the medication, Bacitracin in the drawer and stated that she would remove it because the medication should not be ingested. The HSD continued to say that there was no storage closet and since the items were overflow of supplies, they were not labeled.	A 997		
A1047	8:36-14.3(d) Emergency Services and Procedures (d) Fire extinguishers shall be conspicuously hung, kept easily accessible, shall be visually examined monthly and the examination shall be recorded on a tag which is attached to the fire extinguisher. Fire extinguishers shall also be	A1047		

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A1047	Continued From page 15 inspected and maintained in accordance with manufacturers' and applicable NFPA requirements and N.J.A.C. 5:70. Each fire extinguisher shall be labeled to show the date of such inspection and maintenance. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure that 16 of 16 portable fire extinguishers were inspected at least monthly. This deficient practice was evidenced by the following: 1. Surveyor review of the "Fire Extinguisher Inspection Report" for 1/2023 to 8/2024 revealed no inspection of 16 fire extinguishers for the month of July 2024. 2. The surveyor observed that on 8/19/2024 at 1:02 p.m., one "ABC" type fire extinguisher on the 1st floor by stairwell A had no monthly inspection for the month of July 2024 documented on the inspection tag. 3. The surveyor observed that on 8/19/2024 at 1:03 p.m., one "K" type fire extinguisher on the 1st floor in the kitchen had no monthly inspection for the month of July 2024 documented on the inspection tag. 4. The surveyor observed that on 8/19/2024 at 1:06 p.m., one "ABC" type fire extinguisher on the 1st floor by resident Room 125 had no monthly inspection for the month of July 2024 documented on the inspection tag.	A1047		

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A1047	Continued From page 16 5. The surveyor observed that on 8/19/2024 at 1:07 p.m., one "ABC" type fire extinguisher on the 1st floor by resident Room 106 had no monthly inspection for the month of July 2024 documented on the inspection tag. 6. The surveyor observed that on 8/19/2024 at 1:08 p.m., one "ABC" type fire extinguisher on the 1st floor by stairwell B had no monthly inspection for the month of July 2024 documented on the inspection tag. 7. The surveyor observed that on 8/19/2024 at 1:11 p.m., one "ABC" type fire extinguisher on the 2nd floor by stairwell A had no monthly inspection for the month of July 2024 documented on the inspection tag. 8. The surveyor observed that on 8/19/2024 at 1:13 p.m., one "ABC" type fire extinguisher on the 2nd floor by the independent living entrance had no monthly inspection for the month of July 2024 documented on the inspection tag. 9. The surveyor observed that on 8/19/2024 at 1:15 p.m., one "ABC" type fire extinguisher on the 2nd floor by resident Room 202 had no monthly inspection for July 2024 documented on the inspection tag. 10. The surveyor observed that on 8/19/2024 at 1:16 p.m., one "ABC" type fire extinguisher on the 2nd floor by the laundry room had no monthly inspection for the month of July 2024 documented on the inspection tag. 11. The surveyor observed that on 8/19/2024 at 1:17 p.m., one "ABC" type fire extinguisher on the 2nd floor by stairwell B had no monthly inspection for the month of July 2024 documented on the	A1047		

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A1047	Continued From page 17 inspection tag. 12. The surveyor observed that on 8/19/2024 at 1:18 p.m. one "ABC" type fire extinguisher on the 3rd floor by stairwell A had no monthly inspection for the month of July 2024 documented on the inspection tag. 13. The surveyor observed that on 8/19/2024 at 1:19 p.m. one "ABC" type fire extinguisher on the 3rd floor by resident Room 305 had no monthly inspection for the month of July 2024 documented on the inspection tag. 14. The surveyor observed that on 8/19/2024 at 1:20 p.m., one "ABC" type fire extinguisher on the 3rd floor by the laundry had no monthly inspection for the month of July 2024 documented on the inspection tag. 15. The surveyor observed that on 8/19/2024 at 1:21 p.m. one "ABC" type fire extinguisher on the 3rd floor by stairwell B had no monthly inspection for the month of July 2024 documented on the inspection tag. 16. The surveyor observed that 8/19/2024 at 1:22 p.m. one "ABC" type fire extinguisher on the 3rd floor by resident Room 323 had no monthly inspection for the month of July 2024 documented on the inspection tag. 17. The surveyor observed that on 8/19/2024 at 1:36 p.m., one "ABC" type fire extinguisher in the basement floor by stairwell A had no monthly inspection for the month of July 2024 documented on the inspection tag. During an interview on 8/19/2024 at 1:52 p.m., the Building Service Director (BSD) stated that	A1047		

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A1047	Continued From page 18 fire extinguishers should be inspected monthly, and he was responsible for ensuring the fire extinguishers were inspected monthly. He said he missed inspecting the fire extinguishers for the month of July 2024. He said all fire extinguishers in the building for the month of July 2024 were not inspected. During an interview on 8/19/2024 at 2:03 p.m., the ED stated that the fire extinguishers should be inspected monthly, and the BSD was responsible for ensuring the fire extinguishers were inspected monthly. She stated that she expected the fire extinguisher to be inspected monthly. The surveyor interviewed the ED on 8/19/2024 at 2:49 p.m., who stated that the facility did not have a policy on inspecting the fire extinguishers. During surveyor interview on 8/19/2024 at 2:54 p.m., the Health Service Director stated that the BSD was responsible for ensuring the fire extinguishers were inspected monthly.	A1047		
A1051	8:36-15.2 Resident Records The records required by this subchapter shall be maintained for all residents and shall be kept available on the premises for review at any time by representatives of the Department. This REQUIREMENT is not met as evidenced by: Complaint#: NJ00156289 Based on interview, and record review it was	A1051		

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A1051	Continued From page 19 determined that the facility failed to ensure requested medical records were available for review to the New Jersey Department of Health surveyors upon entry into the facility for 8 of 13 residents reviewed, Resident #'s 1, 2, 3, 4, 5, 6, 7, & 13. This deficient practice was evidenced by the following: On 8/19/24 at 9:26 a.m., during the entrance conference, the surveyor requested full access to the facility's Electronic Medical Record (EMR). The surveyor said aloud the letters- E M R. At that time, the facility's Administrator stated that the system used was called ECP - Extended Care Professional. In the same interview, the Health Services Director (HSD) stated that she had to check with the Regional Nurse, and then the HSD could print out the records for us. When the surveyor continued to request full computer access, the HSD stated that she was unsure if there was a specific code for surveyor access and that she would have to check. At 12:09 p.m.., the surveyor again requested full access to the EMRs. The HSD stated that she could give the surveyors individual access to the records but not the full access per her Regional Nurse in the corporate office, and she continued to state that the surveyors would have to use her computer to gain this access. At this time, the surveyor requested the phone number for the Regional Nurse. At 12:15 p.m., the surveyor interviewed the HSD who stated that she has surveyor full access on her computer, but the surveyor must use her computer to get it, so she went to get her computer. At 12:20 p.m., the surveyor asked again about full	A1051		

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A1051	Continued From page 20	A1051		

individual access, the HSD stated that the Regional Nurse would not give full individual access.

At 12:24 p.m., the HSD tried the corporate office computer login and it did not work.

At 12:27 p.m., the surveyor called the Regional Nurse at the corporate office, on the main office number and left a message for a return call as soon as possible.

At 12:33 p.m., when the surveyors still had not received EMR access, the surveyor asked the HSD if the Regional Nurse had a main phone number. The HSD stated that she only the main office phone number.

At 12:39 p.m., the HSD stated that she obtained access for the surveyor login, but it did not work, so she left a message for the Regional Nurse.

At 12:57 p.m., the HSD asked the surveyor if the Regional Nurse called back the surveyor. The surveyor informed the HSD that the Regional Nurse had not yet called back.

At 1:07 p.m., the Administrator asked the surveyor if access had been granted, and at that time she gave logins a 3rd time, but the password stated no patient access. She continued to say that the computer can only be accessed by one person at a time.

At 1:10 p.m., another surveyor gained EMR access to the ECP on the HSDs computer for Resident #s 8, 9, 10, 11 & 12, for medications only.

At 1:19 p.m., the HSD stated that she had 3 other

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A1051	Continued From page 21	A1051		

computer logins for the surveyors, but documents were not able to be printed from them.

At 1:25 p.m., the Assisted Living Coordinator stated that the EMR system, ECP, was only used for medications, and the chart had the care plans and face sheets.

At 2:13 p.m., the surveyors were still not granted full access to the EMRs for the residents reviewed, except for the residents reviewed during the medication pass observation. The facility was supposed to provide paper copies of the requested documents from the EMRs.

On 8/20/24 at 9:49 a.m., the surveyor asked the Administrator about clarification on the EMR system, stating when the surveyor asked her yesterday morning about the electronic medical record, she stated ECP, there was no mention of another system, the Administrator replied that the ECP was only used for medications, and that the Wellsky system was used for documentation of nurse's notes, assessments, and the plan of care. The Administrator continued to state that any updates to the care plans were done on paper.

In the same interview, when the surveyor asked the Administrator, why was this EMR information not provided yesterday, she did not reply.

At 10:50 a.m., the HSD confirmed the only access the surveyors were given was to ECP was for the medications only, there still was no access to Wellsky.

At 11:09 a.m., the Administrator stated that she was still working on the login for [redacted] and the other paperwork was in the chart.

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A1051	Continued From page 22 At 11:19 a.m., the Administrator was still working on getting a different login for Wellsky and she stated that she would provide copies of the records requested the day before. At the time of the survey, the surveyors were not granted full access to the EMRs for the residents reviewed, however; after many delays, the facility provided paper copies of the requested documents.	A1051		
A1149	8:36-16.13(b)(11) Physical Plant (b) The facilities shall provide, at a minimum, the following: 11. A janitor's closet; This REQUIREMENT is not met as evidenced by: Complaint #: NJ00156289 Based on observation, and interview it was determined the facility failed to ensure that the dietary department had a janitor's closet adequate to house the kitchen cleaning equipment. This deficient practice was evidenced by the following: On 8/19/24 at 9:35 a.m., before entering the kitchen with the Food Service Director (FSD), the surveyor observed an open area, with shelving, to the right of the kitchen entrance doors that contained cases of soda, cups, ketchup containers, mustard containers, a box labeled "[redacted] and other items. Within this same area, the	A1149		

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A1149	Continued From page 23 surveyor observed 2 vacuum cleaners, 2 brooms, a dust pan, and a yellow wet floor caution sign. On 8/19/24 at 10:03 a.m., the surveyor observed a machine that was located on the floor, several feet across from the clean and dry cookware shelving. The surveyor additionally observed that the machine, and it's cord, had a covering of shiny black grime. The FSD identified the machine as a "wet vac" that was used to dry the floors, and further stated that was where the machine was kept. On 8/20/24, at 9:52 a.m., the surveyor observed the same machine in the same spot, across from the clean and dry cookware shelving; however, additionally there was a smaller fan, 2 brooms, 1 dustpan on the floor, and an additional dust pan hanging on the outside of a single door metal cabinet in the same area. When the surveyor asked the FSD if there was a designated janitor closet for the cleaning tools, he stated that the metal cabinet served as the kitchen's "cleaning closet." The cleaning tools observed were not contained within a closet.	A1149		
A1179	8:36-17.1(a) Housekeeping-Sanitation-Safety-Maintenance (a) The facility shall provide and maintain a sanitary and safe environment for residents. This REQUIREMENT is not met as evidenced by: Based on observation, and interview it was determined that the facility failed to ensure a safe	A1179		

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A1179	Continued From page 24	A1179		

environment for its memory impaired residents by leaving a hot coffee machine on, and unattended. This deficient practice was evidenced by the following:

On 8/19/24 at 11:30 a.m., the surveyor observed that a coffee dispensing machine was located in the open kitchenette area of the Memory Care Unit (MCU). The surveyor also observed that the machine was turned to the on position, and coffee could be dispensed. In addition, the surveyor observed that the kitchenette area was unattended, and there was no protective barrier to prevent memory impaired residents from entering the area.

At 12:30 p.m., in the presence of the facility Maintenance/Housekeeping Director, the surveyor conducted a temperature check on the coffee. The surveyor's calibrated thermometer read 172 degrees Fahrenheit.

At 1:00 p.m., the surveyor informed the facility Administrator and presented a Imminent Danger Template, and requested a removal plan from the Executive Director (ED) for the coffee machine being left on, unattended and easily accessible to the memory impaired residents, which placed the residents at risk for harm.

At 3:14 p.m., the surveyor interviewed the Food Service Director regarding the temperature of the coffee machine. The FSD stated that the coffee company presets the temperature to 170 degrees Fahrenheit. In addition, the FSD stated that the coffee machine was installed in the MCU on 10/3/23, and has an on/off switch on the inner side of the machine.

At 3:30 p.m., the surveyor toured the MCU and

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A1179	Continued From page 25 observed that the coffee machine was turned off. On 8/20/24 at 9:49 a.m., the ED submitted a removal plan, and upon surveyor review it was found to be unacceptable. The surveyor discussed the removal plan with the ED and requested that the ED complete revisions to the removal plan. At 11: 39 a.m., the ED submitted a second removal plan, which was also found to be unacceptable. At 3:00 p.m., the removal plan was not implemented upon surveyor departure from the facility.	A1179		
A1217	8:36-17.3(b)(4) Housekeeping-Sanitation-Safety-Maintenance (b) The following safety conditions shall be met: 4. All household and cleaning products used by facility staff shall be identified, labeled, and secured. All poisonous and toxic materials shall be identified, labeled, and stored in a locked cabinet or room. The telephone number of the poison control center shall be conspicuously posted in the facility; This REQUIREMENT is not met as evidenced by: Complaint and Standard Survey Based on observation, interview, and review of pertinent facility documents it was determined the facility failed to ensure that cleaning products and	A1217		

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A1217	Continued From page 26	A1217		

chemicals used by housekeeping staff, were kept secured in a locked compartment of the housekeeping cart, for which an Imminent Danger (ID) was identified. This deficient practice was evidenced by the following:

On 8/19/24 at 12:36 p.m., the surveyor observed a housekeeping cart in the hallway of the facility Memory Care Community, and upon further inspection observed that the area of the cart which stored the cleaning chemicals was not locked. The surveyor observed a housekeeping staff member, who was vacuuming in a common area adjacent to the cart, approximately 8 feet away, with his back to the cart. The surveyor interviewed the housekeeper, who stated that he never had a key to the housekeeping cart. The housekeeper further stated that he was told as long as the cart was within eyesight, and the chemicals were kept off the top of the cart, that the cart did not have to be locked.

At 1:20 p.m., the surveyor interviewed the facility Maintenance Director (MD), who stated that he also supervised the housekeepers. During surveyor interview, the MD stated that the housekeeping cart should have been locked, and that he would get the housekeeper a key.

The ID was reported to the Licensed Assisted Living Administrator on 8/19/24 at 1:00 p.m. The Administrator was presented with the ID template that included information about the concern for the safety.

On 8/20/24, the surveyor verified that the Removal Plan was implemented, and that each housekeeper had a functioning key for their housekeeping cart, to ensure that cleaning

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13A019	A. BUILDING: _____ B. WING _____	C 08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHELSEA AT SHREWSBURY, THE	515 SHREWSBURY AVENUE SHREWSBURY, NJ 07702

(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
A1217	Continued From page 27 chemicals were not accessible to residents who were cognitively impaired. The surveyor additionally verified that education was provided to the facility housekeepers, to ensure the safety and wellbeing of the facility residents. The surveyor reviewed a facility housekeeping policy titled, "Cart and Equipment Cleaning," with a revised date of March 1, 2010, which indicated,..."Carts and equipment must be kept locked and in view at all times when in use."	A1217		
A1249	8:36-17.7 Housekeeping-Sanitation-Safety-Maintenance The building and grounds shall be well maintained at all times. The interior and exterior of the building shall be kept in good condition to ensure an attractive appearance, provide a pleasant atmosphere, and safeguard against deterioration. The building and grounds shall be kept free from fire hazards and other hazards to resident's health and safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, it was determined that the facility failed to maintain a set of smoke barrier doors to prevent the passage of smoke for 1 of 7 smoke barrier door sets. This deficient practice was evidenced by the following: During surveyor observation and interview on	A1249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13A019	A. BUILDING: _____ B. WING _____	C 08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A1249	Continued From page 28 8/19/24 at 10:49 a.m., the surveyor observed that a double smoke door located on the 3rd floor, when tested, the right leaf of the door failed to close and dragged on the carpet when released from the automatic hold-open device. The set of smoke barrier doors did not fully close to meet the other door to form a smoke-tight barrier. The Building Service Director stated that the door did not close into frame when tested and the right leaf of the door was caught on the carpet. He stated that he checked the doors weekly but the carpet underneath the door was recently cleaned and that could have been why the right leaf dragged on the carpet and kept it from closing. He also stated that he was responsible for ensuring the doors were maintained and closed when released from their hold-open device. He stated that he expected the smoke doors to close completely. During an interview on 8/19/24 at 2:01 p.m., the Executive Director (ED) stated that she observed the fire barriers doors during monthly fire drills, and that she had no knowledge of any issues with the door sets on the 3rd floor. She also stated that the Building Service Director was responsible for checking and maintaining the smoke door sets, and that she too expected the doors to close completely. During continued interview at 2:49 p.m., the ED stated that the facility did not have a policy on inspection, testing, and maintenance the fire or smoke barrier doors. At 2:52 p.m., the surveyor interviewed the facility Health Service Director who stated that she was not aware of any issues with any of the smoke doors in the facility, and she indicated that she too expected the smoke barrier doors to be maintained in proper working order and close completely.	A1249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13A019	A. BUILDING: _____ B. WING _____	C 08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHELSEA AT SHREWSBURY, THE	515 SHREWSBURY AVENUE SHREWSBURY, NJ 07702

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STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
13A019 Y1	A. Building B. Wing Y2	11/14/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CHELSEA AT SHREWSBURY, THE	515 SHREWSBURY AVENUE SHREWSBURY, NJ 07702

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 A0310	Correction	ID Prefix A0401	Correction	ID Prefix A0939	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(22)	Completed	Reg. # 8:36-11.5(b)(1)(i-ii)	Completed
LSC	11/14/2024	LSC	11/14/2024	LSC	11/14/2024
ID Prefix A0997	Correction	ID Prefix A1047	Correction	ID Prefix A1051	Correction
Reg. # 8:36-11.7(d)	Completed	Reg. # 8:36-14.3(d)	Completed	Reg. # 8:36-15.2	Completed
LSC	11/14/2024	LSC	11/14/2024	LSC	11/14/2024
ID Prefix A1149	Correction	ID Prefix A1179	Correction	ID Prefix A1217	Correction
Reg. # 8:36-16.13(b)(11)	Completed	Reg. # 8:36-17.1(a)	Completed	Reg. # 8:36-17.3(b)(4)	Completed
LSC	11/14/2024	LSC	11/14/2024	LSC	11/14/2024
ID Prefix A1249	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-17.7	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/14/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
8/20/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
13A019 Y1	A. Building B. Wing Y2	11/14/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CHELSEA AT SHREWSBURY, THE	515 SHREWSBURY AVENUE SHREWSBURY, NJ 07702

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0401	Correction	ID Prefix A0891	Correction	ID Prefix A0939	Correction
Reg. # 8:36-4.1(a)(22)	Completed	Reg. # 8:36-10.5(a)	Completed	Reg. # 8:36-11.5(b)(1)(i-ii)	Completed
LSC	11/14/2024	LSC	11/14/2024	LSC	11/14/2024
ID Prefix A0997	Correction	ID Prefix A1047	Correction	ID Prefix A1149	Correction
Reg. # 8:36-11.7(d)	Completed	Reg. # 8:36-14.3(d)	Completed	Reg. # 8:36-16.13(b)(11)	Completed
LSC	11/14/2024	LSC	11/14/2024	LSC	11/14/2024
ID Prefix A1179	Correction	ID Prefix A1217	Correction	ID Prefix A1249	Correction
Reg. # 8:36-17.1(a)	Completed	Reg. # 8:36-17.3(b)(4)	Completed	Reg. # 8:36-17.7	Completed
LSC	11/14/2024	LSC	11/14/2024	LSC	11/14/2024
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	

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	
8/20/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO