

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>80A007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/09/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CHELSEA AT BRIDGEWATER, THE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>680 202/206 NORTH BRIDGEWATER, NJ 08807</b>
--	---

(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	<p>Initial Comments</p> <p>Initial Comments: Type of Survey: Complaint</p> <p>Complaint #: NJ00171594, NJ00171386</p> <p>Census: 65</p> <p>Sample Size: 3</p> <p>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.</p>	A 000		
A 749	<p>8:36-7.3(a) Resident Assessments and Care Plans</p> <p>(a) The resident general service plan shall be reviewed and, if necessary, revised semi-annually, and more frequently as needed based upon the resident's response to the care provided and any changes in the resident's physical or cognitive status.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	A 749		

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

TITLE

(X6) DATE

05/12/24

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>80A007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/09/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CHELSEA AT BRIDGEWATER, THE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>680 202/206 NORTH</b> <b>BRIDGEWATER, NJ 08807</b>
--	---

(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 749	<p>Continued From page 1</p> <p>Complaint #: NJ00171594, NJ00171386</p> <p>Based on observation, interview, record review, and review of pertinent facility documents it was determined that the facility failed to ensure the resident "General Service Plan" (GSP) was updated to include interventions to prevent the risk of <sup>NJ Exec Order 26</sup> or <sup>NJ Exec Order 26</sup> related to prescribed medication for 1 of 3 residents reviewed, Residents #2, as evidenced by the following:</p> <p>On 4/9/24 at 12:00 p.m., the surveyor observed Resident #2 seated in a wheelchair in the common area. The surveyor was not able to interview the resident due to <sup>NJ ex order 26.4b1</sup>.</p> <p>At 12:28 p.m., the surveyor reviewed the medical record (MR) of Resident #2 which revealed that the resident moved into the facility <sup>NJ ex order 26.4b1</sup> of <sup>NJ ex order</sup> with diagnoses which included <sup>NJ ex order</sup> <b>NJ ex order 26.4b1</b></p> <p>According to the Physician Orders dated <sup>NJ ex order 26.4b1</sup> the resident was prescribed <sup>NJ ex order 26.4b1</sup> <b>NJ ex order 26.4b1</b></p> <p>The "Tag Care Note" [Progress Note (PN)] dated <sup>NJ ex order 26.4</sup> at 12:16 p.m., written by a Licensed Practical Nurse (LPN) documented, <sup>NJ ex order 26.4b1</sup></p>	A 749		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>80A007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C <b>04/09/2024</b>
--	---	---	--

NAME OF PROVIDER OR SUPPLIER  <b>CHELSEA AT BRIDGEWATER, THE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>680 202/206 NORTH BRIDGEWATER, NJ 08807</b>
--	---

(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 749	<p>Continued From page 2</p> <p>The PN dated 2/11/24 at 1:49 p.m., written by the Director of Nursing (DON) documented, <b>NJ ex order 26.4b1</b> [REDACTED]</p> <p>The PN dated <b>NJ ex order 26</b> at 4:29 p.m., written by the DON documented, <b>NJ ex order 26.4b1</b> [REDACTED]</p> <p>During surveyor review of Resident #2's MR, the surveyor observed the resident's GSP was last updated <b>NJ ex order 26</b>, and did not include addressing the resident's <b>NJ ex order 26.4b1</b>. Surveyor's further review of resident's record, did not identify interventions to <b>NJ Exec Order 26.4b1</b> the risk of <b>NJ Exec Order 26.4b1</b>.</p> <p>At 3:00 p.m., the surveyor interviewed the DON in the presence of the Executive Director regarding Resident #2's GSP not updated to include the <b>NJ ex order 26.4b1</b>. The DON stated that she does not put <b>NJ Exec Order 26.4b1</b> or <b>NJ ex order 26.4b1</b> [REDACTED]</p> <p>The surveyor reviewed the facility policy and procedure titled, "General Service Plan and Health Service Plan" which revealed, "The GSP will include, at a minimum, the following: Disease Diagnosis ...Medication Use ...Skin Condition ,..."</p>	A 749		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>80A007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R-C <b>06/12/2024</b>
--	---	---	--

NAME OF PROVIDER OR SUPPLIER  <b>CHELSEA AT BRIDGEWATER, THE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>680 202/206 NORTH BRIDGEWATER, NJ 08807</b>
--	---

(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}	<p>Initial Comments</p> <p>Initial Comments: Type of Survey: Complaint</p> <p>Complaint #: NJ00171594, NJ00171386</p> <p>Census: 65</p> <p>Sample Size: 3</p> <p>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.</p>	{A 000}		

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

TITLE

(X6) DATE

**STATE FORM: REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 80A007 <span style="float:right">Y1</span>	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 6/12/2024 <span style="float:right">Y3</span>
NAME OF FACILITY CHELSEA AT BRIDGEWATER, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 680 202/206 NORTH BRIDGEWATER, NJ 08807	

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 A0749	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 8:36-7.3(a)	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	06/07/2024	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 _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 4/9/2024		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <span style="float:right"> <input type="checkbox"/> YES <input type="checkbox"/> NO                 </span>		