New Jersey Department of Health

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 12/02/2025

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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A 000	Initial Comments Initial Comments: COMPLAINT #: NJ179422, NJ189349 CENSUS: 80 SAMPLE SIZE: 5 TYPE OF SURVEY: Standard, Life Safety Code, and Complaint Survey of 89 residential units The facility is not in substantial compliance with all the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations. A Life Safety Code Survey was conducted by the State Agency on 10/16/2025 - 10/17/2025 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 609	8:36-5.15(a)(2) General Requirements (a) The resident's family, guardian, and/or designated responsible person or community agency shall be notified, when known, and with the resident's consent, immediately after the occurrence, in the event of the following: 2. Any serious accident, criminal act or	A 609		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/30/26

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A 609	Continued From page 1	A 609		

incident occurs which involves the
resident and results in serious harm or injury or results in the resident's
arrest or detention;

This REQUIREMENT is not met as evidenced by:
Complaint #NJ179422

Based on interview, record review, document review, and facility policy review, the facility failed to immediately report an incident that resulted in NJ Exec Order for 1 (Resident #1) of 3 sampled residents reviewed for NJ Exec Order 2

Findings included:

A facility policy titled "Reportable Events" dated 09/01/2010, revealed "1. The Residence will notify DHSS [Department of Health and Senior Services] immediately by telephone at 1-800-792-9770 followed within 72 hours with written confirmation of the following: A. Interruption for three or more hours of basic physical plant services such as HVAC [heating, ventilation, and air conditioning], light, power, fire alarm and sprinkler system, all elevator service, water, food or staff shortage. B. Any major occurrence or incident of unusual nature, including but not limited to, all fires, disasters, elopements and all deaths resulting from accidents or incidents in the Residence or related to Residence services."

A "Resident Information Sheet" indicated the facility admitted Resident #1 on NJ Exec Order 26.4b1
According to the Resident Information Sheet, the resident had a medical history that included

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A 609	Continued From page 2 diagnoses of NJ Exec Order 26.4b1 . Resident #1's "Plan of Care" included a problem statement dated NJ Exec Order 26.4b1 that indicated the resident required the use of a NJ Exec Order 26.4b1 . Interventions directed NJ Exec Order 26.4 and facility staff to NJ Exec Order 26.4 the resident with a NJ Exec Order 26.4b1 . Resident #1's "NJ Exec Order 26.4 Aide Care Plan" dated NJ Exec Order 26.4b1 , revealed the plan directed staff to utilize a NJ Exec Order 26.4b1 with a minimum of NJ Exec all times. A facility "Incident/Accident Report" dated NJ Exec Order 26.4b1 revealed Resident #1's medical power of attorney (POA) provided video camara footage to the Executive Director (ED) and Director of Health Services that showed NJ Exec Order 26.4 #5 NJ Ex Order 26.4(b)(1) Resident #1 from a NJ Exec Order 26.4b1 NJ Ex Order 26 without utilizing a NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 . Per the report, on NJ Exec Order 26.4b1 Resident #1 NJ Exec Order 26.4b1 during a NJ Exec Order 26.4 with NJ Exec #5 and NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1 , NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 , and the NJ Exec Order 26.4b1 . The facility "Conclusion Statement - reportable event [Resident #1] NJ Exec Order " revealed, "Statements were collected from staff working with [NJ Exec #5] all stated that he did not ask them to assist with the [NJ Exec Order 26.4b1 of [Resident #1] and he NJ Exec Order 26.4b1 [him/her] from [his/her] NJ Ex Order NJ E the NJ Ex Or by himself." On 10/17/2025 at 11:10 AM, 1:05 PM, and 2:15 PM, the surveyor attempted a telephone interview with NJ Exec #5; however, there was no answer and a voicemail message was left with no return	A 609		

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A 609	Continued From page 3 telephone call. During an interview on 10/16/2025 at 10:15 AM, the ED stated NJ Exec #5 did not report the incident with Resident #1. The ED stated she was not aware there was an incident with the resident until NJ Exec Order 26.4b1, when Resident #1's medical POA showed her the video that revealed NJ Exec #5 NJ Exec Order 26.4b1 Resident #1 NJ Exec Order and the resident NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1.	A 609		
A 775	8:36-7.5(a) Resident Assessments and Care Plans (a) The facility or program shall arrange for health care services to be provided to residents as needed, in accordance with assessments and with the health service plan. The administrator shall develop a system to identify the residents receiving health care services. This REQUIREMENT is not met as evidenced by: Complaint #NJ179422 Based on interview, record review, document review, and facility policy review, the facility failed to follow the service plan for 1 (Resident #1) of 5 sampled residents. Specifically, Resident's #1's service/care plan revealed staff were required to utilize a NJ Exec Order 26.4b1 the resident. On NJ Exec Order 26.4b1) #5 NJ Exec Order 26.4b1 the resident NJ Exec Order 26.4b1 or assistance from other staff and the resident NJ Exec during the NJ Exec Order 26.4 and NJ Exec Order 26.4b1 to their NJ Exec and NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1	A 775		

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A 775	Continued From page 4 Findings included: A facility policy titled, "Fall Assessment," revised 01/01/2016, indicated, "The General Service Plan, Resident Care Plan and Resident Profile will also reflect care needs related to transfer and ambulation, and designate the resident as a potential fall risk placed on a fall management program." A "Resident Information Sheet" indicated the facility admitted Resident #1 on NJ Exec Order 26.4b1. According to the Resident Information Sheet, the resident had a medical history that included diagnoses of NJ Exec Order 26.4b1 . Resident #1's "Plan of Care" included a problem statement dated NJ Exec Order 26.4b1 that indicated the resident required the use of a NJ Exec Order 26.4b1 Interventions directed NJ Exec Order 26.4 and facility staff to NJ Exec Order 26.4 the resident with a NJ Exec Order 26.4b1. Resident #1's "NJ Exec Order 26.4 Aide Care Plan" dated NJ Exec Order 26.4b1, revealed the plan directed staff to utilize a NJ Exec Order 26.4b1 with a minimum of NJ Exec at all times. A facility "Incident/Accident Report" dated NJ Exec Order 26.4b1 revealed Resident #1's medical power of attorney (POA) provided video camara footage to the Executive Director (ED) and Director of Health Services (DHS) that showed NJ Exec #5 NJ Exec Order 26.4b1 Resident #1 from a NJ Exec Order 26.4 NJ Exec Or to bed without NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. Per the report, on NJ Exec Order 26.4b1 Resident #1 NJ Exe to the NJ Exec O during a NJ Exec Order 26.4 with NJ Exec #5 and NJ Exec Order 26.4b1, NJ Exec Order 26.4b1	A 775		

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A 775	Continued From page 5	A 775		

and NJ Exec Order 26.4b1, and the NJ Exec Order 26.4b1.

The facility "Conclusion Statement - reportable event [Resident #1] NJ Exec Order 26.4 revealed, "Statements were collected from staff working with [NJ Exec #5] all stated that he did not ask them to NJ Exec Order with the [NJ Exec Order 26.4b1 of [Resident #1] and he NJ Exec Order 26.4b1 [him/her] from [his/her] NJ Exec Order to the NJ Exec by himself."

On 10/17/2025 at 11:10 AM, 1:05 PM, and 2:15 PM, the surveyor attempted a telephone interview with NJ Exec Order 26.4b1 #5; however, there was no answer and a voicemail message was left with no return telephone call.

During an interview on 10/16/2025 at 2:27 PM, Certified Medical Assistant (CMA) #2 stated the NJ Exec Order 26.4 agency and facility care plans instructed staff how to NJ Exec Order 26.4 Resident #1. According to CMA #2, two staff were always required to NJ Exec Order 26.4 residents safely with a NJ Exec Order 26.4b1.

During an interview on 10/16/2025 at 3:13 PM, the DHS stated the facility had dedicated NJ Exec Order 26.4 staff that worked daily with residents who received NJ Exec Order 26.4 services. The DHS stated the NJ Exec Order 26.4 agency had a resident care plan, and the facility made sure they provided the NJ Exec Order 26.4 aides with a copy of the facility's care plan every time they were updated. The DHS stated prior to caring for residents, she talked to the NJ Exec Order 26.4 aide, went over their assignment, and ensured they were able to care for the resident. According to the DHS, NJ Exec #5 should have known how to NJ Ex Order 26.4(b Resident #1 because she was provided a copy of the resident's care plan.

During an interview on 10/16/2025 at 10:15 AM, the ED stated she was not aware there was an

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A 775	Continued From page 6 incident with the resident until NJ Exec Order 26.4b1, when Resident #1's medical POA showed her the video that revealed NJ Exec #5 NJ Exec Order 26.4b1 Resident #1 NJ Exec Order and the resident NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1.	A 775		
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: NJ189349 Based on observations, interviews, and facility policy review, the facility failed to discard expired food items and label and date items stored in the refrigerator and dry storage room. The facility further failed to ensure food service equipment was clean, plate covers were air dried, and the prep area of the kitchen was clean and orderly. These deficient practices had the potential to affect all 80 residents who currently resided in the facility. Findings included:	A 891		

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A 891	Continued From page 7 A facility policy titled, "Hand Hygiene," revised 03/10/2020, revealed, "II. Hand hygiene indications: e. Before preparing or serving all food types." During an observation of the kitchen on 12/02/2025 at 3:10 PM, the surveyor noted the spice shelf had a moderate amount of spilled seasonings on the shelf. During an observation of the walk-in cooler on 12/02/2025 at 3:15 PM, the following concerns were noted: - 12 individual serving bowls of lettuce and cucumber stored on a metal pan on a rack uncovered, with no date - 14 individual bowls of lettuce, tomato, and cucumber stored on a metal pan on a rack uncovered, with no date - One large pan of chopped romaine lettuce with no date - One opened bag of shredded cheese with no opened date - One bag of opened grated parmesan cheese with no opened date - One container of feta cheese with no date and not labeled - One container of black sliced olives with no date - One gallon (gal) of honey mustard with an expiration date of 09/24/2025 - One gal of Asian sesame dressing with an expiration date of 10/21/2025 - One gal of dill pickle chips with no opened date - One gal of mild banana peppers opened with no opened date - One 64 ounces (oz) jug of garlic parmesan wing sauce with no opened date - One opened, gal of country style mustard with no opened date	A 891		

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A 891	Continued From page 8 - One gal of salad dressing with no opened date - One 18 pound tub of apple cinnamon muffin mix with no opened date - One block of Swiss cheese opened with no opened date - One plastic bag of pork roll with no discard date - One 32 oz bottle of horseradish sauce with no opened date - Four 15.2 oz tubs of beef base with no opened date - One 48 oz container of whipped cream cheese spread with no opened date - One container of whole garlic cloves with no opened date - Two containers of light sour cream with no opened date During an observation on 12/02/2025 at 3:40 PM, the surveyor noted 39 plastic plate covers were stacked wet over the steam table. During an observation on 12/02/2025 at 4:18 PM, the surveyor noted the meat slicer had some food debris on the bottom blade. During an observation on 12/02/2025 at 4:20 PM, the shelves below the steam table had an accumulated amount of food debris. During an observation on 12/02/2025 at 4:25 PM, two trash cans had a moderate amount of black matter/markings on the outside of the containers. During an interview on 12/02/2025 at 5:20 PM, the Executive Director (ED) stated the facility did not have a policy specifically for discarding outdated food items, dating, and labeling food items. The ED further stated the facility did not have a specific policy for infection control and hand washing for the kitchen.	A 891		

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A 891	Continued From page 9 During an interview on 12/02/2025 at 5:39 PM, the Food Service Director stated it was his expectation that all opened food items be dated, food taken out of its original package be labeled and dated, expired food items to be discarded, all food items in the walk-in to be covered and dated, all opened food items in the dry storage room to be dated, plastic food covers be allowed to air dry, meat slicer to be cleaned and disinfected after each use, shelves and counters to be cleaned and disinfected after each meal service and at the end of the day, trash can to be power washed weekly and more often if needed, and the kitchen to be cleaned daily and deep cleaned weekly. During an interview on 12/02/2025 at 6:06 PM, the ED stated it was her expectation that opened food items should be dated and labeled, outdated food should be disposed, all food items should be covered and dated, the kitchen should be cleaned daily and wiped down after each meal service, and the meat slicer should be cleaned and disinfected after each use. The ED indicated that there had been no foodborne illnesses.	A 891		
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.	A1249		

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A1249	Continued From page 10	A1249		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure the building was maintained and kept free of hazards to the residents' health. This had the potential to affect all 80 residents who currently reside in the facility.

Findings included:

An undated facility cleaning schedule revealed the staff should daily "Clean and sanitize all surfaces: This includes counters, tables, and equipment" and "Clean and sanitize sinks and toilets." Per the cleaning schedule, on a weekly basis staff should "Deep clean and sanitize sinks: including legs and underneath. Clean and sanitize all surfaces: This includes under counters, tables, and equipment."

During a concurrent interview and observation of the main kitchen on 10/16/2025 at 11:10 AM with the Building Services Director and the Food Service Director (FSD), there was a significant accumulation of dirt, food scraps, and debris under the countertops, shelving, dishwashing area, and under the appliances on the main cook line. The FSD stated the staff member who usually cleaned the kitchen did not work on 10/15/2025 and the kitchen could use help. According to the FSD, he was responsible for ensuring the kitchen was clean.

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A1269	Continued From page 11	A1269		
A1269	8:36-17.8(g) Housekeeping-Sanitation-Safety-Maintenance (g) If the facility provides a laundry service on site in lieu of using a commercial laundry service, it shall provide a receiving, holding, and sorting area with hand-washing facilities. The walls, floors, and ceilings of the area shall be clean and in good repair. The flow of ventilating air shall be from clean to soiled areas, and ventilation shall be adequate to prevent heat and odor build-up. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure hand-washing facilities were available in the laundry receiving, holding, and sorting area. This deficient practice had the potential to affect all 80 residents who currently reside in the facility. Findings included: During a concurrent interview and observation of the main laundry room on 10/16/2025 at 11:40 AM, there was not a hand-washing sink in the facility's main laundry room. The Building Services Director stated there had never been a handwashing sink in the main laundry room.	A1269		

POC#2 received 2/5/26
Accepted 2/5/26

Chelsea Shrewsbury

Deficiency A609: General Requirements (a) Notification to a resident's family immediately following an incident with a resident resulting in serious harm or injury

PLAN OF CORRECTION

1. **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice**

On 9/3/24 Executive Director (ED) and Resident Care Director (RCD) reported the incident occurring with resident #1 and NJ Exec Order 26.4b1 to the Department of Health and Ombudsman immediately after being notified by the resident's power of attorney (POA) on NJ Exec Order 26.4b1 The Executive Director viewed the video footage of the incident dated NJ Exec Order 26.4b1 which was provided by the power of attorney on NJ Exec Order 26.4b1

Records show that resident #1 was discharged in NJ Exec Order 26.4b1 for a NJ Exec Order 26.4b1 of care.

2. **How will the facility identify other residents having the potential to be affected by the same deficient practice.**

All residents have the potential to be affected by this deficient practice.

3. **What measures will be put in place or systemic changes made to ensure that the deficient practice will not occur.**

2/3/26 – ED held a call with NJ Exec Order 26.4b1 company representative. Copies of in-service education conducted by NJ Exec Order 26.4b1 were provided. Inservice was done on 9/4/2024 on neglect and reporting topic.

Verbal confirmation that agency NJ Exec Order 26.4b1 #5 was removed from servicing at the commnity post incident discovery.

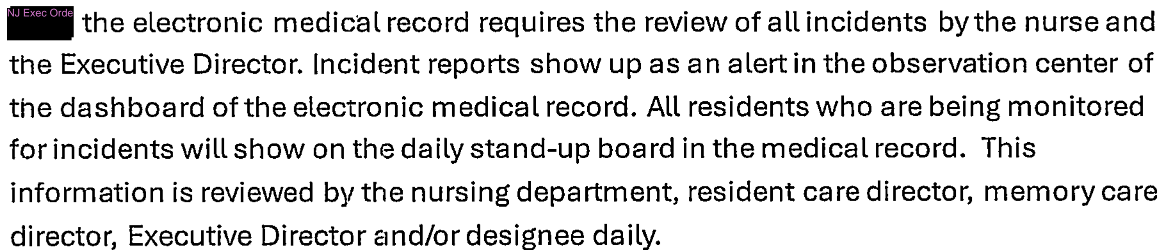
ED and/or designee will review all incident reports in the electronic medical record and report required incidents by phone and in writing within 72 hours. Timeframes for reporting incidents of a more immediate nature will be followed as well.

2/2/26 and 2/3/26– Inservice education was provided to the staff by Regional Vice President of Engagement for the company, regarding reporting requirements. Reviewed

the information provided from the State of New Jersey, Department of Health, dated 4/21/2025 – subject: reportable events.

1/20/26 – Re-hire orientation and education was provided for all staff who are now employees of the community as of 1/15/26. This training was conducted by various members of the company corporate team. Education included, Abuse, neglect, resident rights.

4. **How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put in place to monitor the continued effectiveness of the systemic changes.**



NJ Exec Orde the electronic medical record requires the review of all incidents by the nurse and the Executive Director. Incident reports show up as an alert in the observation center of the dashboard of the electronic medical record. All residents who are being monitored for incidents will show on the daily stand-up board in the medical record. This information is reviewed by the nursing department, resident care director, memory care director, Executive Director and/or designee daily.

The resident care director and/or designee will notify or call the Executive Director if not at the community, the day an incident occurs that meet reporting requirements, and the Executive Director and/or designee will make the reporting to the Department of Health as required.

Mandatory postings with the Ombudsman's number and the Department of Health are located in the resident mailroom area, along with resident rights.

During the monthly safety meeting, incidents will be reviewed with the safety committee, led by the Executive Director, Maintenance Director and/or designee.

In addition to the community level monitoring, the regional vice president does a monthly review for compliance of incident completion.

Completion Date:__2/4/26__________

approved 2/5/26

Chelsea Shrewsbury

Deficiency A0775: Resident Assessments and Care plans- Facility shall arrange for health care service plans to be provided to residents as needed, in accordance with assessments and with health service plans

PLAN OF CORRECTION

1. **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice**

Agency NJ Exec Order 26.4b1 #5 failed to follow Resident #1 health service plan. Resident #1 was assessed by the Registered Nurse on NJ Exec Order 26.4b1 Family and Nurse Practitioner were notified of the incident on NJ Exec Order 26.4b1. Agency NJ Exec Order 26.4b1 #5 was reported to his agency for deficient practice and placed on the NJ Exec Order 26.4b1 community as of NJ Exec Order 26 when the Executive Director became aware of the incident.

Resident #1 was discharged in NJ Exec Order 26.4b1 to a NJ Exec Order 26.4b1.

2. **How will the facility identify other residents having the potential to be affected by the same deficient practice.**

Residents with a health service plan that are on NJ Exec Order 26.4b1 and on a NJ Exec Order 26.4b1 have the potential to be affected by this deficient practice. The NJ Exec Order 26.4b1 #5 will not return to the community.

3. **What measures will be put in place or systemic changes made to ensure that the deficient practice will not occur.**

During the communities weekly care coordination meetings, led by the resident care director, memory care director, executive director or designee, NJ Exec Order 26.4b1 will be educated on the location of the health service plan and the execution of the health service plan. The first meeting will be held the week of 2/9/26.

The community has a standing weekly care coordination meeting with ancillary service providers, including NJ Exec Order 26.4b1 led by the resident care director, memory care director, Executive Director or designee. The topic of education will be discussed to ensure education is provided to NJ Exec Order 26.4b1 and agency hospice aides on the location and execution of the health service plan will be a standard for review each week. This standard is in the process of being initiated and will be completed by 2/13/26.

Documentation of training, as confirmed by the NJ Exec Order 26.4b1 company during the meetings, will be noted in our internal minutes.

The resident care director and/or memory care director and/or designee is responsible to provide the NJ Exec Order 26.4b1 company with information on health service plans and their location.

January 12th through January 19, 2026, all nursing staff received training on nursing protocol and duties, including health service plans. Training was done by corporate nursing specialists and the regional VP of Nursing.

A new company policy and competency checklist was implemented and education for all clinical staff were provided on mechanical lifts/ policy in January 2026. The community uses a rehabilitation provider to assist with training of new employees upon hire and as needed. This is managed by the resident care director, memory care director and/or designee.

4. **How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put in place to monitor the continued effectiveness of the systemic changes.**

Executive director, resident care director, memory care director or designee, if not in attendance at the meeting, will review the weekly care coordination notes to ensure health service plans are in place. Weekly, or sooner, if necessary, due to a change in condition, the resident care director will inform hospice of any changes to the health service plan. During the weekly care coordination meeting, the topic of education will be reviewed to ensure compliance.

As an additional step and as part of the plan to audit all current residents, a full re-assessment of all residents will be done by 2/28/26, and health service plans will be initiated, adjusted, or eliminated as needed upon re-assessment. If any residents have changes to their current health service plan the resident care director and/or memory care director will communicate that to hospice at the time of the change.

Completion Date:_____2/28/26__________ approved 2/5/26

Chelsea Shrewsbury

Deficiency A891: Dining Services

The facility and personnel should comply with the provisions of N.J.A.C 8:24, retail food establishment and food and beverage vending machines of the NJ Sanitary code.

Plan of Correction

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.

The food service director was and is responsible for ensuring that cleaning was and is done for the kitchen area and that food was and is discarded if not labeled, dated, or has expired. Per the former Executive Director, on 12/2/25 the spice rack was cleaned. The items that were not labeled and dated were discarded. Items that expired were discarded. Plate covers were rewashed and air dried. The meat slicer was cleaned and disinfected. The trash cans were cleaned.

2. How will the facility identify other residents having the potential to be affected by the same deficient practice.

All residents have the potential to be affected

3. What measures will be put in place or systematic changes made to ensure the deficient practice will not occur.

Inservice training was provided on 2/3/26 by the regional vice president of dining service to the dining staff (cooks). The dining director was included in this training. Training included, health inspection reports, cleaning schedules, labeling and dating of food, dining department annual staff training, standard operating procedures – record keeping and documentation, storage of food, chemicals and supplies, storeroom sanitation, temperature control, and receiving food. The food service director and/or cook designee is responsible for checking all storage areas for expired items. Training on food labeling and dating system – branded standard was completed on 2/3/26 by the regional vice president of food service. Training included, how staff should fill food safety labels out, (food item, prep/open date, discard date, initials). Required, logo visible, clear handwriting, both dates filled out, staff initials. No label – discard immediately. Other training included, refrigerator and storage organization, walk in

cooler food storage chart, refrigerator storage chart, food safety, hold time quick guide – posted in every kitchen. New labels were obtained.

4. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, ie what program will be put in place to monitor the continued effectiveness of the systematic change.

The food service supervisor will be responsible for having daily checks of all items labeled, dates current, first in first out rotation followed and expired food. The Food service director is responsible to keep a copy of the food safety program accessible for use in the kitchen and maintain a file of support documentation (such as employee training). One time per month, there will be a visual inspection of the kitchen using an audit tool for food safety and sanitation. This will be part of the monthly safety meeting led by the Executive Director, Maintenance Director, and/or designee. Quarterly, during the infection control meeting, the Executive Director will ensure food safety and sanitation checklist is reviewed. A new dietician was contacted with as of 2/1/26. The regional vice president of resident care met with the dietician prior to contracting with her (Jan 2026) to review Arbor standards and expectations.

Completion Date: ____2/3/26________________________________

approved 2/5/26

Chelsea Shrewsbury

Deficiency A1249: Housekeeping-Sanitation-Safety-Maintenance- maintaining the building and keeping free of hazards to the residents' health

PLAN OF CORRECTION

1. **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice**

The food service director was responsible for the cleaning. On 10/16/25 dirt, food scraps, and debris were cleaned from under the countertops, shelving, dishwashing area, and under the appliances on the main cook line.

2. **How will the facility identify other residents having the potential to be affected by the same deficient practice.**

All residents have the potential to be affected by this deficient practice.

3. **What measures will be put in place or systemic changes made to ensure that the deficient practice will not occur.**

Inservice training was conducted on 2/3/26 by the regional vice president of dining. The food service director was included in the training.

The food service director and/or designee will review all cleaning task sheets weekly and review findings of the dining staff. Audit tool will be completed monthly and reviewed by the Executive director and/or designee.

4. **How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put in place to monitor the continued effectiveness of the systemic changes.**

The Executive Director, Food Service Director, and/or designee will report findings of the audit tool monthly at the safety meeting and quarterly at the Continuous Quality Improvement meeting.

Completion Date:___2/4/26____________ approved 2/5/26

Chelsea Shrewsbury

Deficiency A1269: Housekeeping-Sanitation-Safety-Maintenance: if facility provides a laundry service onsite, it shall provide receiving, holding, and sorting area with handwashing facilities

PLAN OF CORRECTION

1. **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice**

   On 10/16/25 signs posted above sink in facility laundry room designated as a handwashing sink. Soap, paper towels and set trashcan located next to sink.

   On 2/3/26, the regional vice president of engagement and the executive director confirmed that the notice was posted above the sink and that there were paper towels, soap and a trash can.

2. **How will the facility identify other residents having the potential to be affected by the same deficient practice.**

   All residents have the potential to be affected by this deficient practice.

3. **What measures will be put in place or systemic changes made to ensure that the deficient practice will not occur.**

   In servicing was done on the handwashing sink in the laundry area in the basement on 2/2/26 and 2/3/26 for the staff by the regional vice president of engagement. Training included location and function. The maintenance director will train new hires during new hire orientation and as needed.

4. **How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put in place to monitor the continued effectiveness of the systemic changes.**

   The maintenance director and/or designee will provide education to new employees during the building walk through in orientation. Monthly this area will be inspected for sign placement and reviewed in the monthly safety meeting, led by the maintenance director, Executive director and/or designee.

Completion Date:_____2/3/26_________ approved 2/5/26

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
13A019 (Y1)	A. Building B. Wing (Y2)	2/5/2026 (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 A0609 Reg. # 8:36-5.15(a)(2) LSC	Correction Completed 02/04/2026	ID Prefix A0775 Reg. # 8:36-7.5(a) LSC	Correction Completed 02/28/2026	ID Prefix A0891 Reg. # 8:36-10.5(a) LSC	Correction Completed 02/03/2026
ID Prefix A1249 Reg. # 8:36-17.7 LSC	Correction Completed 02/04/2026	ID Prefix A1269 Reg. # 8:36-17.8(g) LSC	Correction Completed 02/03/2026	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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 12/2/2025	☐ 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 (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
13A019		2/5/2026

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 A0891 Reg. # 8:36-10.5(a) LSC	Correction Completed 02/03/2026	ID Prefix A1249 Reg. # 8:36-17.7 LSC	Correction Completed 02/04/2026	ID Prefix A1269 Reg. # 8:36-17.8(g) LSC	Correction Completed 02/03/2026
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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	
12/2/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO