

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25240	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2021
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NAME OF PROVIDER OR SUPPLIER CHELSEA AT CLIFTON, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 682 VALLEY ROAD CLIFTON, NJ 07013
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(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: Initial Inspection of New Construction of 91 Residential Units in a three (3) story building, which included a Memory Care Unit, all common areas, activity areas, dining rooms, offices, and mechanical rooms on the lower level, 1st, 2nd, and 3rd floors. This inspection is for 100 Licensed Assisted Living Beds.</p> <p>Census: 0</p> <p>The facility is 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.</p>	A 000		

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

TITLE

(X6) DATE