

WATCHDOG

NJ nominee to regulate group homes said this about resident care

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The nominee set to oversee New Jersey's agency that regulates group homes told legislators that the state needs to be more focused on improving resident care and, when asked, said a recent NorthJersey.com article about a 21-year-old who died two days after moving into a group home "breaks my heart."

In a wide-ranging discussion on Feb. 19, members of the Senate Judiciary Committee raised concerns about New Jersey's system for investigating abuse, neglect and deaths of individuals with developmental and intellectual disabilities while questioning Dr. Stephen Cha, Gov. Mikie Sherrill's nominee to head the Department of Human Services.

Sen. Kristin Corrado, R-Passaic, quoted extensively from [NorthJersey.com's story](#) detailing the state's investigation into the death of 21-year-old Katie Moronski, who succumbed to a lethal mix of prescription medication. A New Jersey investigation concluded that there was neglect by the company but stopped short of saying the neglect caused her death.

Corrado read aloud from the article that it took four months for the Department of Human Services to open an investigation into Moronski's death, and that the state's final report and

letter listed no consequences or penalties for the group home or workers who were found to have violated state and company policy.

Story continues below photo gallery.

“Clearly, something went seriously wrong,” Corrado said.

“I read that same story you did, Senator Corrado, and it breaks my heart to read that,” Cha said. “Of course it does. It should, right?”

Cha said he could not discuss the case due to an ongoing lawsuit the Moronski family has filed against group home operator Broadstep and its parent company, the for-profit RHA Health Services.

But he said the state needs to take a new approach.

“We haven’t had a culture of improvement,” Cha said. “How do we think about taking those instances and learning from them? How do we take those mistakes and say, not just corrections, actions, fines — and yes, we should do that. I’m not shirking those responsibilities. But how do we learn from them? How do we understand? How do we make systems of care work better?”

To elaborate, he pulled from his past experience: Cha served as counselor to the secretary of U.S. Health and Human Services, worked at the Centers for Medicare & Medicaid Services, and practiced as a part-time primary care physician in a Washington, DC, homeless shelter.

He recounted how infections caused by catheter insertions were rampant in hospitals. People were dying of sepsis.

“We could have sat there and said, ‘Let’s find everybody who has a central line infection. Let’s go out and find every hospital and just keep on slapping their

hand.' Wouldn't have got us there," Cha said.

"It took a conversation to say, 'How is this working? How can we get better?' And someone developed a checklist: Here are the five things you need to do every time to prevent those central line infections. Drastically reduced, right? So that's quality improvement as opposed to accountability. We need both."

In past responses to NorthJersey.com about preventive steps, a Human Services spokesperson said group homes "are required to document actions taken and planned to prevent future occurrences" in response to state concerns found during investigations. But those "plans of correction" are not public.

The state has also denied records requests from NorthJersey.com for reports analyzing incident report data, such as trend reports on residents who have choked.

'Repeated oversight failures'

Like Corrado, Sen. Michael Testa, R-Atlantic, pointed to articles about flaws in the \$1.5 billion group home system when questioning Cha.

"A recent report by NorthJersey.com highlighted repeated oversight failures in the licensed group home environments. Where do you see the greatest gaps in the current monitoring and enforcement process?" Testa asked.

NorthJersey.com's series [Hidden at Home](#) revealed serious ongoing problems in the group home system, including a lack of basic care for residents and dozens of preventable deaths. Katie Moronski's death was first detailed in the 2025 series and elaborated on in subsequent stories.

Cha said bills passed late last year provide the department with more tools to take enforcement actions against group home providers and improve the quality of care — laws that his department is tasked with implementing. One law for the first

time allows the department to fine providers when vulnerable residents in their care are harmed.

However, the state must weigh whether a company has a history — or pattern — of violations among other factors when levying fines.

Another law creates a 13-member advisory committee to review certain deaths and cases of abuse, neglect and exploitation; the committee will have two years to complete the review.

But the committee does not change the system in which the majority of cases are investigated by group homes themselves, a practice Corrado called “questionable.” Hidden at Home found that just 2% of all reported incidents are investigated by the state.

A bill that would have required a nurse — or a certified medication aide working under the supervision of a nurse — to administer medication in group homes and supervised apartments never advanced in the Legislature last year. Corrado called for that change.

“We need to have some type of nursing or medical professional that is overseeing medication in every single one of these homes,” she said.

The Judiciary Committee unanimously advanced Cha’s confirmation to head the state’s largest agency, which is tasked with overseeing a wide range of programs serving 2.1 million residents, such as food stamps, Medicaid and mental health services, along with group homes.

Sherrill’s pick will continue in an acting role until the full Senate votes to confirm him.