STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	19A004	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHELSEA AT SPARTA, THE	513 LAFAYETTE ROAD SPARTA, NJ 07871

(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 with Complaint COMPLAINT #: NJ171756 CENSUS: 72 SAMPLE SIZE: 7 SURVEY DATE: 11/03/2025 - 11/05/2025 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, based on this Complaint Survey. 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 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/24/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 310	Continued From page 1	A 310		

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and facility policy review, the facility failed to ensure staff followed the policy and notified [redacted] when 1 (Resident #1) of 7 sampled residents were found to have a medical emergency.

Findings included:

A facility policy titled, "Medical Emergency," revised 03/01/2020, specified, "1. The following situations will be considered medical emergencies: Complaint of chest pain. Difficult breathing. Fall and apparent injury, pain or difficulty moving a limb. Any possible head injury. Bleeding. Change in level of consciousness, unresponsive, or sudden confusion, or change in mental status or behavior. Seizure (without history). Ingestion or contact with a poisonous substance. Stroke symptoms, [that is] sudden weakness or loss of movement of limbs, slurred speech or unresponsiveness. Mention of suicide. 2. For all conditions listed above, call 911 and then notify the RN [registered nurse]."

A "Resident Information Sheet" indicated the facility admitted Resident #1 on [redacted]. According to the Resident Information Sheet, the resident had a medical history that included a diagnosis of [redacted]

Resident #1's "Incident/Accident Report" dated [redacted], revealed a nurse found the resident [redacted] with [redacted] and [redacted]

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A 310	Continued From page 2 Resident #1's progress note electronically signed by Licensed Practical Nurse (LPN) #1 and dated NJ Exec Order 26.4b1 at 11:22 PM, revealed at 9:45 PM, Resident #1 was NJ Exec Order 26.4b1 [redacted] Per the progress note, an NJ Exec [redacted] was applied to the resident's NJ Exec Order 26.4b1 the resident's NJ Exec Order 2 was NJ Exec Order 26.4 and the Assistant Health Services Director (AHSD) and ambulance were called. During a telephone interview on 11/04/2025 at 1:01 PM, LPN #1 stated Resident #1 was NJ Exec Orde on the NJ Exec Order 26.4b1, with NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1 LPN #1 stated she thought the resident was NJ Exec Orde and called other staff to come assist. LPN #1 stated she called the on-call nurse then called the ambulance. During an interview on 11/05/2025 at 2:00 PM, the AHSD stated the process if a resident had a change in condition was to first assess the resident then call NJ Exec C The AHSD stated LPN #1 called for guidance on the night of the incident with Resident #1. The AHSD stated LPN #1 assessed the resident and thought the resident was NJ Exec Order 2 and reported the resident's vitals were NJ Exec Orde The AHSD stated she did not know why LPN #1 did not call NJ Exec first. During an interview on 11/04/2025 at 1:22 PM, the Health Services Director (HSD) stated she did not think LPN #1 realized the severity of the situation when she called the AHSD before calling NJ Exec C NJ Exec first. During an interview on 11/05/2025 at 11:04 AM, the Executive Director (ED) stated LPN #1 was reprimanded for not calling NJ Exec first.	A 310		

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	19A004	A. BUILDING: _____ B. WING _____	C 11/05/2025

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A 310	Continued From page 3 During a follow-up interview on 11/05/2025 at 4:17 PM, the HSD stated her expectation was for NJ Exec to be called first in an emergency before calling the on-call nurse. During a follow-up interview on 11/05/2025 at 4:19 PM, the ED stated she expected staff to call NJ Exec before calling the on-call nurse in an emergency.	A 310		
A1041	8:36-14.3(a) Emergency Services and Procedures (a) The facility shall conduct at least one drill of the emergency plans every month. The 12 drills shall be conducted on a rotating basis, to ensure that four drills occur during each working shift on an annual basis. The facility shall maintain documentation of all drills, including the date, hour, description of the drill, participating staff, and signature of the person in charge. In addition to drills for emergencies due to fire, the facility shall conduct at least one drill per year for emergencies due to a disaster other than fire, such as storm, flood, other natural disaster, bomb threat, or nuclear accident (a total of 12 drills). All staff shall participate in at least one drill annually, and selected residents may participate in drills. This REQUIREMENT is not met as evidenced by: Based on interview, document review, and facility policy review, the facility failed to ensure all employees completed at least one drill annually.	A1041		

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A1041	Continued From page 4 This had the potential to affect all 72 residents who currently resided in the facility. Findings included: A facility policy titled, "Emergency Drills," revised 03/01/2010, revealed "All staff will participate in at least one drill annually and selected residents may also participate." During an interview on 11/05/2025 at 2:31 PM, CHHA/CMA #2 stated he worked one to two Saturdays every month. Per CHHA/CMA #2 he did not participate in any fire drills in 2024. A facility document indicated CHHA/CMA #2 was hired on 06/09/2022. During an interview on 11/05/2025 at 2:47 PM, the Business Office Manager (BOM) stated CHHA/CMA #2 only worked in the facility one to two times a month on a Saturday during the 3:00 PM to 11:00 PM shift. According to the BOM, she wound contact CHHA/CMA #2 and inform him that in order to work in the facility, he had to participate in a fire frill. During an interview on 11/05/2025 at 2:54 PM, the Health Services Director stated she expected everyone to follow the fire drill policy. During an interview on 11/05/2025 at 3:01 PM, the Executive Director stated he expected all staff to attend at least one fire drill annually.	A1041		
A1035	8:36-14.2(b) Emergency Plans and Procedures (b) The emergency plans, including a written evacuation diagram specific to the unit that includes	A1035		

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A1035	Continued From page 5 evacuation procedure, location of fire exits, alarm boxes, and fire extinguishers, and all emergency procedures shall be conspicuously posted throughout the facility. All employees shall be trained in procedures to be followed in the event of a fire and instructed in the use of fire-fighting equipment and resident evacuation as part of their initial orientation and at least annually thereafter. All residents shall be instructed in emergency evacuation procedures. This REQUIREMENT is not met as evidenced by: Based on documentation review and interviews on 10/28/2025 and 10/29/2025, in the presence of the Executive Director (ED) and Building Services Director (BSD), it was determined that the facility failed to ensure that the Emergency Preparedness Plan (EPP) was reviewed and updated at least every two years, in accordance with Appendix Z, Emergency Preparedness for all Provider and Supplier Types. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review on 10/29/2025 of the EPP revealed: 1. No signature page indicating review of the EPP program for the year 2025 or any previous years. 2. No updated Transfer Agreements between other facilities. In and interview with the Executive Director (ED) at 12:30 PM on 10/29/2025, the ED confirmed the	A1035		

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A1035	Continued From page 6 EPP, including all Transfer Agreements and had not been updated or forwarded to other agencies in accordance with State and municipal laws. The facility's Executive Director and Building Services Director were informed of the deficient practice during the Life Safety Code exit conference at 1:00 PM. N.J.A.C. 8:36-14.2(a) N.J.A.C. 5:70 NFPA 101	A1035		
A1097	8:36-16.6 Fire Suppression Systems All facilities shall be provided with a fire suppression system in accordance with the Uniform Construction Code, N.J.A.C. 5:23. This REQUIREMENT is not met as evidenced by: Based on observations and interview on 10/28/2025 in the presence of the Building Services Director (BSD), it was determined that the facility failed to install sprinklers as required by CMS regulation § 483.90(a) physical	A1097		

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A1097	Continued From page 7	A1097		

environment and in accordance with NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and NFPA 13, 2012 Edition, Section 8.15.3.2.1. The deficient practice had the potential to affect all residents and was evidenced for 2 of 2 stairways by the following:

1). An observation on 10/28/2025 at 11:15 AM, revealed that stairwell #1 was not provided with any sprinkler coverage at the most accessible exit/egress by the door leading to the public way.

a). In an interview at the time, the BSD confirmed the observation.

2). An observation at 12:00 PM revealed that stairwell #2 was not provided with any sprinkler coverage at the most accessible exit/egress by the door leading to the public way.

a). In an interview at the time, the BSD confirmed the observation.

Observations on 10/28/2025 from 10:00 AM to 12:30 PM revealed:

1) Missing escutcheon in the Low Voltage Closet on floor 3.

2) Missing escutcheon resident room 200 closet.

3) Missing escutcheon Theater by fireplace.

4) Stairway 1, landing one, unsealed penetration in concrete flooring where sprinkler riser comes through floor.

5) On Cottage hallway, storage room had briefs stacked 8 inches from the ceiling. Minimum

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A1097	Continued From page 8 of 18"clearance from the bottom of the sprinkler head must be maintained. 6) Second floor Linen Room near Lafyette Lounge had 3 three drawer storage bins stored on the top shelf of shelving unit leaving less then 1 inch clearance from the ceiling. The first unit was blocking the only sprinkler in the room preventing activation in the event of a fire. The Executive Director and Building Services Director were informed of the deficient practice at the Life Safety Code exit conference on 10/29/2025 at 1:00 PM. N.J.A.C. 8:39-31.1(c), 31.2 (e) NFPA 13	A1097		
A1179	8:36-17.1(a) Provision of Services (a) The facility shall provide and maintain a sanitary and safe environment for residents. This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 10/28/25 in the presence of the Building Services Director (BSD) it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with NFPA 101: 2012 Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice had the potential to affect all residents and was evidenced by the following:	A1179		

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A1179	Continued From page 9 Observations from 10:00 AM to 12:30 PM in the presence of the BSD revealed room doors did not operate properly as follows: - Observed Basement Maintenance Office - Door was held open with a chock. When attempting to close door it would not positively latch without lifting up on handle. When forced into latched position there was a 1/2" gap on the top right side when looking at it from the hall which would allow the passage of smoke. - Observed Basement Staff Lounge - Door was held open with a chock. When released, door would not positively latch. - Observed Residential Hallway Smoke doors by Country Cottage had a 3/4" gap at meeting point from top to bottom when closed. - Observed 2nd Floor Laundry Room door held open by a chock. - Observed the 2nd floor elevator fire door P1 being held open by the carpeting when released from magnet. - Observed 2 of 2 fire labels on the buck systems for the 2nd floor elevators painted over. An observation at 11:50 AM revealed the 1st floor Low Voltage Room, approximately 6 foot by 7.5 feet, with no ceiling, exposing all three floors above. All electrical equipment within the room was covered in plastic sheeting preventing the equipment from "breathing" properly and building up heat. The lack of a ceiling would allow smoke and fire	A1179		

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A1179	Continued From page 10 to bypass the single sprinkler within the room and had the potential to affect all residents. In an interview at the time the BSD confirmed the above findings. The facility's Executive Director and Building Services Director were informed of the deficient practices at the Life Safety Code exit conference on 10/29/25 at 1:00 PM. NJAC 8:39-31.1(c), 31.2(e) N.J.A.C. 8:36-17.3(b) N.J.A.C. 5:70	A1179		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
19A004		12/31/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CHELSEA AT SPARTA, THE	513 LAFAYETTE ROAD SPARTA, NJ 07871

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0310 Reg. # 8:36-3.4(a)(1) LSC	Correction Completed 11/06/2025	ID Prefix A1041 Reg. # 8:36-14.3(a) LSC	Correction Completed 11/12/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	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	
11/5/2025	☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
19A004 (Y1)	A. Building B. Wing (Y2)	12/31/2025 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CHELSEA AT SPARTA, THE	513 LAFAYETTE ROAD SPARTA, NJ 07871

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A1035 Reg. # 8:36-14.2(b) LSC	Correction Completed 12/22/2025	ID Prefix A1097 Reg. # 8:36-16.6 LSC	Correction Completed 12/19/2025	ID Prefix A1179 Reg. # 8:36-17.1(a) LSC	Correction Completed 12/16/2025
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	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	
11/5/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO