STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	sipfep	A. BUILDING: _____ B. WING _____	C 02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ECHELON LAKE	207 LAUREL ROAD VOORHEES, NJ 08043

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A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint Complaint #: NJ 00189855, NJ 00189856, NJ 00189502 Date of Survey: 2/12/2026 and 2/13/2026 CENSUS: 105 SAMPLE SIZE: 4 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.	A 000		
A 310	8:36-3.4(a)(1) Administrator's Responsibilities (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 04/10/26

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A 310	Continued From page 1	A 310		

This REQUIREMENT is not met as evidenced by:
Complaint #: NJ 00189855, NJ 00189856

Based on interview and record review, it was determined that the Administrator failed to implement the facility policy titled, "Resident Call Systems and Door Alarm Response," and failed to include in the policy a time frame for responding to pendant calls for 1 of 4 residents, Resident #3. This deficient practice was evidenced by the following:

On 2/13/26 at 10:34 a.m., the surveyor reviewed Resident #3's Medical Record (MR), which revealed that Resident #3 was admitted to the facility in NJ Ex Order 26.4(b)(1) with a diagnosis of NJ Ex Order [redacted].

Surveyor review of a Progress Note (PN), written by a Licensed Practical Nurse (LPN) #1, dated NJ Ex Order 26 at 3:55 a.m., revealed, "Resident dial NJ Ex Or from room. Resident states NJ Ex Order 26.4(b)(1)!' when asked what was the matter ..."

At 11:45 a.m., the surveyor interviewed a Certified Home Health Aide (CHHA) #1 regarding the pendant call response system, and the time frame staff should respond to a pendant call. The CHHA stated that she was not sure what the time frame was to answer pendant calls. The CHHA

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A 310	Continued From page 2	A 310		

explained that she tried to answer the pendant calls within 10 minutes.

The surveyor interviewed LPN #1 at 1:44 p.m., via telephone, regarding her documentation on [NJ Ex Order 26] when Resident #3 called [NJ Ex Or] and stated that he/she [NJ Ex Order 26.4(b)(1)]. LPN #1 stated that Resident #3 used his/her pendant throughout the night and did not complain of not feeling well. LPN #1 explained that she was not aware of Resident #3 not feeling well until the paramedics arrived at the facility.

At 9:52 a.m., the surveyor interviewed the Health and Wellness Director (HWD) regarding Resident #3 calling [NJ Ex Or] on [NJ Ex Order 26] and the pendant call response system. The HWD stated that Resident #3 called [NJ Ex Or] because the resident [NJ Ex Order 26.4(b)(1)] [redacted]. The surveyor then asked the HWD the expected pendant call response time frame. The HWD explained that there was no set time to answer a pendant call. Further, the HWD stated that she would expect staff to answer pendant calls between 7 to 10 minutes.

At 10:20 a.m., the surveyor interviewed the ED regarding the pendant call response system and the time frame staff should respond to a pendant call. The ED stated that there was no set time frame in which to answer the pendants in the policy. The surveyor then requested the pendant call log. The ED later informed the surveyor that there were issues with pulling the pendant call log and that the log would not be available for the surveyor to review.

At 1:00 p.m., the surveyor interviewed Resident #4, who was Resident #3's roommate, and inquired about Resident #3's [NJ Ex Or] call on [NJ Ex Order 26.4(] Resident #4 stated that Resident #3 pressed the

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A 310	Continued From page 3 button on the pendant several times with no response from staff. Resident #4 stated that he/she called [NJ Ex Or] after waiting an hour and a half for staff to answer the pendant call alert. Resident #4 explained that he/she decided to call [NJ Ex Or] because Resident #3, "[NJ Ex Order 26.4(b)(1)]" and Resident #3 stated that he/she felt like he/she was [NJ Ex Order 26.4(b)] [redacted] The surveyor reviewed the facility policy, titled, "Resident Call Systems and Door Alarm Response,"with a last revised date of 12/25, which revealed, "...B. Responding to resident call system alerts ... a. When an associate receives a resident call system alert, he or she would respond within a timely manner. B. If the associate is unable to respond in a timely manner, he or she should request assistance from another associate ..."	A 310		
A 401	8:36-4.1(a)(22) Resident Rights (a) Each assisted living provider shall post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: 22. The right to live in safe and clean conditions in a facility that does not admit more residents than it can safely accommodate while providing services and care;	A 401		

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A 401	Continued From page 4 This REQUIREMENT is not met as evidenced by: Complaint # NJ 00189502 Based on interview and record review, it was determined that the facility failed to ensure interventions were initiated to ensure a safe environment while providing care and services to residents for 2 of 4 residents, Residents #1 and Resident #2. This deficient practice is evidenced by the following: On [redacted], the Department of Health (DOH) received a Facility Reportable Event (FRE), (a document used by facilities to report incidents to the DOH), The FRE revealed that on [redacted] at 5:10 p.m., Resident #1 was [redacted] in his/her room [redacted] Resident #1 informed the [redacted] that he/she was [redacted] an unidentified individual. On 2/12/26 at 10:34 a.m., the surveyor reviewed Resident #1's MR which revealed that Resident #1 was admitted to the facility in [redacted] with a diagnosis of [redacted] Further review of a progress note (PN) dated [redacted] at 5:10 p.m., written by Licensed Practical Nurse (LPN) #1 revealed that Resident #1 was [redacted] in room [redacted] LPN #1 called and when [redacted] arrived, Resident #1 reported a NJ Ex Order 26.4(b)(1) ." The PN documents that there were no residents or staff that fits the description given by Resident #1. On 2/12/26 at 10:05 a.m., the surveyor interviewed a Certified Home Health Aide (CHHA) #4 and inquired about the incident on [redacted] when Resident #1 and Resident #2 had a	A 401		

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A 401	Continued From page 5	A 401		

NJ Ex Order 26.4(b)(1). CHHA #4 stated that she was made aware of the incident by another staff member who instructed her (CHHA #4) to keep Resident #1 away from Resident #2.

At 10:34 a.m., the surveyor reviewed Resident #1's MR which revealed that Resident #1 was admitted to the facility in NJ Ex Order 26.4(b)(1), with a diagnosis of NJ Ex Order 26.4(b)(1)

The surveyor reviewed Resident #1's Progress Note (PN), written by a Licensed Practical Nurse (LPN) #2, dated NJ Ex Order 26.4(b) at 10:35 a.m., which revealed, "Resident observed NJ Ex Order 26.4(b)(1) on [his/her] NJ Ex Order 26 in the hallway. NJ Ex Order 26.4(b)(1) noted on [his/her] NJ Ex Orde ... When this nurse asked what happened [he/she] stated that [he/she] was trying to NJ Ex Order 26.4 the [medication technician] on shift ...staff stated that it took [three] employees to NJ Ex Order 26.4(b) [Resident #1] from [his/her] NJ Ex Orde ..."

At 10:45 a.m., the surveyor reviewed Resident #2's Medical Record (MR) which revealed that Resident #2 was admitted to the facility in NJ Ex Order 26.4(b)(1) with a diagnosis of NJ Ex Order 26.4(b)(1) However, there was no documentation of the NJ Ex Order 26.4(b) incident in Resident #2's MR.

At 11:17 a.m., the surveyor interviewed the Director of Health and Wellness (HWD) and inquired about Resident #1 and Resident #2, NJ Ex Order 26.4(b)(1) that occurred on NJ Ex Order 26.4(b). The HWD stated that Resident #1 thought Resident #2 was NJ Ex Order 26.4(b)(1) the medication technician so Resident #1 became NJ Ex Order 26.4(b)(1) towards Resident #2. The surveyor then asked the HWD what intervention(s) was put in place to ensure the safety of Resident #1 and Resident #2 after

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A 401	Continued From page 6 the above incident. The HWD stated that interventions were not necessary because Resident #1 went to the [redacted] and remained in [redacted] until [redacted] and Resident #2 was later transferred to the [redacted] on [redacted] for unrelated issue. The HWD explained that the only intervention in place was the verbal instructions provided to staff to ensure Resident #1 [redacted] from Resident #2. The surveyor reviewed the facility policy dated 5/21 and titled, "Abuse, Neglect [and] Exploitation Policy", which revealed under Response to Incident, " ... c. Resident on Resident Contact. If an incident involves resident on resident contact ... Residents exhibiting aggressive behavior should be considered for continued appropriateness and interventions should be developed to address their behaviors. The resident assessment and service plan should be updated as appropriate ..."	A 401		
A 537	8:36-5.7(a)(1) Policy and Procedure Manual (a) A policy and procedure manual(s) for the organization and operation of the facility or program shall be developed, implemented, and reviewed at least annually. Each review of the manual(s) shall be documented, and the manual(s) shall be available in the facility or program to representatives of the Department at all times. The manual(s) shall include at least the following: 1. An organizational chart delineating the lines of	A 537		

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A 537	Continued From page 7 authority, responsibility, and accountability for the administration and resident care services of the facility or program; This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to review its policies and procedures in accordance with N.J.A.C. 8:36-5.7, which required that all policies be reviewed at least annually, and that such review be documented. This deficient practice was evidenced by the following: On 2/12/26, during the entrance conference, the surveyor requested the facility's policy and procedure (PP) manual from the Executive Director (ED) for review. The ED stated that all PPs were electronic and would provide the surveyor with a printed copy of the index from the electronic PP. The surveyor reviewed the facility policy titled, "Universal Transfer Form Policy" provided by the ED, which was revised on 11/22. There was no documented evidence that this policy was reviewed or updated at least annually. The surveyor reviewed the facility policy titled, "Abuse, Neglect [and] Exploitation Policy" provided by the ED, which was revised on 5/21. There was no documented evidence that this policy was reviewed or updated at least annually.	A 537		

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A 537	Continued From page 8 On 2/13/26 at 2:00 p.m., the surveyor interviewed the ED and inquired about the annual review of the facility PP. The ED stated that the corporate office updated all PPs and explained that some policies may not have been updated annually.	A 537		
A 753	8:36-7.3(c) General and Health Service Plans (c) Documentation in the resident's record shall indicate review and any necessary revision of the resident service plan and/or health service plan. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00189502 Based on interview and record review, it was determined that the facility failed to update residents' Service Plan (SP) with intervention(s) to address NJ Ex Order 26.4(b)(1) [redacted] for 2 of 4 residents, Resident #1 and Resident #2. This deficient practice was evidenced by the following: On 2/12/26 at 10:34 a.m., the surveyor reviewed Resident #1's MR which revealed that Resident #1 was admitted to the facility in NJ Ex Order 26.4(b)(1) with a diagnosis of NJ Ex Order 26.4(b)(1) At 10:45 a.m., the surveyor reviewed Resident #2's medical record (MR) which revealed that	A 753		

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A 753	Continued From page 9 Resident #2 was admitted to the facility in NJ Ex Order 26.4(b)(1) with a diagnosis of NJ Ex Order 26.4(b)(1) Review of a PN, written by a LPN #2, dated NJ Ex Order 26.4(at 10:35 a.m., revealed "Resident observed NJ Ex Order 26.4(b)(1) on [his/her] NJ Ex Order 26.(in the hallway. NJ Ex Order 26.4(b)(1) noted on [his/her] NJ Ex Ord ... When this nurse asked what happened [he/she] stated that [he/she] was trying to NJ Ex Order 26.4(the [medication] tech on shift ...staff stated that it took [three] employees to NJ Ex Order 26.4([Resident #1] NJ Ex Orde [his/her] peer ..." [Resident #2] At 2:19 p.m., the surveyor interviewed the Health and Wellness Director (HWD) and inquired if there were any intervention(s) put in place regarding the NJ Ex Order 26.4(b)(1) documented on NJ Ex Order 26.4(. The HWD stated that staff were verbally instructed to monitor Resident #1 following the incident on NJ Ex Order 26.4(b)(and NJ Ex Order 26.4(b)(. During interview, the HWD stated that regarding the incident on NJ Ex Order 26.4(b, she verbally instructed staff to keep Resident #1 NJ Ex Order 26.4(b)(1) Resident #2. However, there was no documented evidence in the SP to address the NJ Ex Order 26.4(b)(1) that occurred on NJ Ex Order 26.4(b) The surveyor reviewed the facility policy titled, "Service Plan Process policy", dated 9/25, which indicated, " Individual resident service plans are developed through the evaluation process or other identified systems and provide information about the resident needs to the care associate ... Policy Detail... The service plan should be reviewed and revised as necessary ..."	A 753		

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A1073	Continued From page 10	A1073		
A1073	8:36-15.6(b) Resident Records (b) All assessments and treatments by health care and service providers shall be entered according to the standards of professional practice. Documentation and/or notes from all health care and service providers shall be entered according to the standards of professional practice. This REQUIREMENT is not met as evidenced by: Complaint#: NJ 00189502 Based on interview and record review, it was determined that the facility failed to document in the medical record (MR) a NJ Ex Order 26.4(b)(1) [redacted] for 1 of 3 residents, Resident #2. This deficient practice was evidenced by the following: On NJ Ex Order 26.4(b)(, the Department of Health (DOH) received a Facility Reportable Event (FRE), (a document used by facilities to report incidents to the DOH), The FRE revealed that on NJ Ex Order 26.4(b)(at 5:10 p.m., Resident #1 was NJ Ex Order 2 in his/her room NJ Ex Order 26.4(b)(1) Resident #1 informed the NJ Ex Order 26.4(b)(1) that he/she was NJ Ex Order 26.4(b)(1) an unidentified individual.	A1073		

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A1073	Continued From page 11 On 2/12/26 at 10:45 a.m., the surveyor reviewed Resident #2's Medical Record (MR) which revealed that Resident #2 was admitted to the facility in NJ Ex Order 26.4(b)(1), with a diagnosis of NJ Ex Order 26.4(b)(1) At 10:34 a.m., the surveyor reviewed Resident #1's MR which indicated that Resident #1 was admitted to the facility in NJ Ex Order 26.4(b)(1) with a diagnosis of NJ Ex Order 26.4(b)(1). Further review of the progress note (PN), written by a Licensed Practical Nurse (LPN) #2, dated NJ Ex Order 26.4(b) at 10:35 a.m., revealed "Resident observed NJ Ex Order 26.4(b)(1) [redacted] on [his/her] NJ Ex Order 26. in the hallway. NJ Ex Order [redacted] noted on [his/her] face ... When this nurse asked what happened [he/she] stated that [he/she] was trying NJ Ex Order 26.4(b)(1) the [medication] tech on shift ... staff stated that it took [three] employees to NJ Ex Order 26.4([Resident #1] NJ Ex Orde [Resident #2] ..." However, surveyor further review of Resident #2's MR did not reveal documentation of the NJ Ex Order 26.4(b) [redacted] on NJ Ex Order 26.4(between Resident #1 and Resident #2. At 1:14 p.m., the surveyor interviewed LPN #2 via telephone and inquired about the NJ Ex Order 26.4(b)(1) [redacted] that occurred on NJ Ex Order 26.4([redacted] at 10:35 a.m. LPN #2 stated that Resident #1 hit Resident #2, and that Resident #2 appeared to be NJ Ex Order 26.4(b)(1) following the NJ Ex Order 26.4(b) [redacted]. LPN #2 further confirmed that she documented the incident in Resident #1's MR only and that she did not document the incident in Resident #2's MR. LPN #2 stated that she did not document the incident in Resident #2's MR because Resident #1 was NJ Ex Order 26.4(b)(1). LPN #2	A1073		

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A1073	Continued From page 12 explained that she also notified Resident #2's physician and family but she did not document the notification in Resident #2's MR. At 2:19 p.m., the surveyor interviewed the Health and Wellness Director (HWD) and inquired about the missing documentation in Resident #2's MR regarding the NJ Ex Order 26.4(b)(1) [redacted] that occurred on NJ Ex Order 26.4(b) [redacted] The HWD confirmed that the incident and notifications should have been documented in Resident #2's MR as well. The surveyor reviewed the facility's policy, titled, "Change of Condition," dated 4/25, which revealed, "... 5. Update the Resident Record and Service Plan as needed ..." .	A1073		
A1399	8:36-21.1(b)(3) Quality Improvement Program (b) Quality improvement activities shall include, but not be limited to, the following: 3. Establishment of objective criteria for evaluation of the resident care provided by each service area;	A1399		

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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
A1399	Continued From page 13 This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00189855, NJ 00189856 Based on interview and record review it was determined that the facility failed to collect and analyze available data in order to determine the timeliness of pendant response times through the facility's quality improvement program for 1 of 3 residents, Resident #3. This deficient practice was evidenced by the following: On 2/13/26 at 10:34 a.m., the surveyor reviewed Resident #3's Medical Record (MR) which indicated that Resident #3 was admitted to the facility in NJ Ex Order 26.4(b)(1), with a diagnosis of NJ Ex Order [redacted] Surveyor review of a Progress Note (PN), written by a Licensed Practical Nurse (LPN) #1, dated NJ Ex Order 26 at 3:55 a.m., revealed Resident #3 called NJ Ex Or him/herself because he/she NJ Ex Order 26.4(b)(1) ." At 10:20 a.m., the surveyor requested the pendent call log from the Executive Director (ED) At 12:10 p.m., the ED informed the surveyor that there were issues with retrieving the pendant call log and it would not be available for the surveyor to review. At 1:00 p.m., the surveyor interviewed Resident #4 and inquired about Resident #3's NJ Ex Or call on NJ Ex Order 26.4 Resident #4 stated that Resident #3 pressed the pendant call button several times with no response from staff. Resident #4 stated that he/she waited an hour and a half for a staff member to answer the pendant alert before	A1399		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	sipfep	A. BUILDING: _____ B. WING _____	C 02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ECHELON LAKE	207 LAUREL ROAD VOORHEES, NJ 08043

(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
A1399	Continued From page 14 Resident #4 called [redacted] The facility did not provide the surveyor with a printed copy of the call log of the residents' pendant calls. Additionally, there was no documented evidence that pendant call log information was evaluated as part of the facility's quality improvement program in order to evaluate the effectiveness and implementation of the pendant call system. The surveyor reviewed the policy titled, "Resident Call Systems and Door Alarm Response," with a last revised date of 12/25, which revealed, " ...data will be maintained for no longer than 30 days ... data may be utilized as part of performance improvement and tracking and trending for customers satisfaction ..."	A1399		
H 000	Initials Comments TYPE OF SURVEY: Complaint Complaint #: NJ 00189855, NJ 00189856 and NJ 00189502 Date of Survey: 2/12/2026 and 2/13/2026 CENSUS: 105 SAMPLE SIZE: 4 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.	H 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	sipfep	A. BUILDING: _____ B. WING _____	C 02/13/2026

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H 000	Continued From page 15 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.	H 000		
H3480	8:43E-10.11(c)(3) Other Rprtng Rqrmnts Unrltd to Pt Sfty Act (c) Examples of reportable events in the nature of physical plant and operational interruptions, include, but are not limited to, the following: 3. Fires, disasters, or accidents that result in injury or death of patients, residents or employees, or in evacuation of patients or residents from all or part of the facility; This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00189502 Based on interview and record review, it was determined that the facility failed to notify the Department of Health (DOH) of [redacted] incident immediately by telephone, followed by a written confirmation within 72 hours, for 2 of 4 Residents reviewed, Resident #1 and Resident #2. This deficient practice was evidenced by the following:	H3480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	sipfep	A. BUILDING: _____ B. WING _____	C 02/13/2026

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H3480	Continued From page 16 On NJ Ex Order 26.4(b)(1), the Department of Health (DOH) received a Facility Reportable Event (FRE) (a document used by facilities to report incidents to the DOH). The FRE revealed that on NJ Ex Order 26.4(b)(1) at 5:10 p.m., Resident # 1 was NJ Ex Order 26.4(b)(1) in his/her room NJ Ex Order 26.4(b)(1) Resident #1 informed the paramedics that he/she was punched by an unidentified individual. 1. On 2/12/26 at 10:34 a.m., the surveyor reviewed Resident #1's MR which revealed that Resident #1 was admitted to the facility in NJ Ex Order 26.4(b)(1), with a diagnosis of NJ Ex Order 26.4(b)(1) Review of a PN, written by a Licensed Practical Nurse (LPN) #4, dated NJ Ex Order 26.4(b)(1) at 6:03 p.m., revealed "Resident was asked to come out for diner by a staff then resident stated that NJ Ex Order 26.4(b)(1) ' staff asked who? Resident reply' NJ Ex Order 26.4(b)(1) Review of a PN in Resident #1's MR, written by a LPN #2 dated NJ Ex Order 26.4(b)(1) at 10:35 a.m., which revealed, "Resident observed NJ Ex Order 26.4(b)(1) on [his/her] NJ Ex Order 26.4(b)(1) in the hallway. NJ Ex Order 26.4(b)(1) noted on [his/her] NJ Ex Order 26.4(b)(1) ... When this nurse asked what happened [he/she] stated that [he/she] was trying NJ Ex Order 26.4(b)(1) the [medication] tech on shift ...staff stated that it took [three] employees to NJ Ex Order 26.4(b)(1) [Resident #1] from [his/her] NJ Ex Order 26.4(b)(1) ..." [Resident #2] 2. At 10:45 a.m., the surveyor reviewed Resident #2's medical record (MR) which revealed that Resident #2 was admitted to the facility in NJ Ex Order 26.4(b)(1) with a diagnosis of NJ Ex Order 26.4(b)(1). On 2/13/2026 at 1:44 p.m., the surveyor interviewed the Executive Director (ED) and	H3480		

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	sipfep	A. BUILDING: _____ B. WING _____	C 02/13/2026

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BROOKDALE ECHELON LAKE	207 LAUREL ROAD VOORHEES, NJ 08043

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H3480	Continued From page 17 inquired if the DOH was notified of the incidents that occurred on NJ Ex Order 26.4(b)(1) and [redacted] The ED confirmed that the incidents on [redacted] and [redacted] should have been reported to the DOH. However, the ED stated that she was not sure if the incidents were reported to the DOH and could not provide the surveyor documented evidence that the DOH was notified of the above incidents. The surveyor reviewed the policy titled, "REPORTABLE EVENTS GRID," with a last revised date of 5/25, which indicated, "...6. Suspected resident abuse (by ...other residents ...)" under "TIME FRAME TO NOTIFY ASAP no later than 24 hours."	H3480		
H5770	8:43E-13.4(c) Mandatory use of Universal Transfer Form (c) A licensed healthcare facility or program shall send a completed, paper copy of the Universal Transfer Form with a patient when a patient is transferred. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00189855, NJ 00189856 Based on interview and record review, it was determined that the facility failed to maintain a copy of the Universal Transfer Form (UTF) (a	H5770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	sipfep	A. BUILDING: _____ B. WING _____	C 02/13/2026

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H5770	Continued From page 18	H5770		

form used to communicate pertinent patient care information at the time of a transfer between health care facilities/programs), when a resident was transferred to the NJ Ex Order 26.4(b)(1) for evaluation for 1 of 4 residents, Resident #1. This deficient practice was evidenced by the following:

On 2/12/26 at 10:34 a.m., the surveyor reviewed Resident #1's MR which revealed that Resident #1 was admitted to the facility in NJ Ex Order 26.4(b)(1), with a diagnosis of NJ Ex Order 26.4(b)(1)

Review of Resident #1's Progress Note (PN) revealed a PN, dated NJ Ex Order 26.4(b)(1), written by a Licensed Practical Nurse (LPN) #3, which indicated that Resdient #1 was transferred to the NJ Ex Order 26.4(b) due to a NJ Ex Order 26.4(b)(1) " and a NJ Ex Order 26.4(b)(1).

The surveyor did not observe a completed UTF in the MR for the NJ Ex Order 26.4(b)(1) transfer to the NJ Ex Order 26.4(b) on NJ Ex Order 26.4(b)(1) for evaluation following NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1).

At 1:05 p.m., the surveyor interviewed the Health and Wellness Director (HWD) and inquired about UTFs. The HWD stated that a UTF should be sent with residents to the NJ Ex Order 26.4(b)(The surveyor then requested a copy of the UTF for Resdient #1's transfer to the NJ Ex Order 26.4(b) on NJ Ex Order 26.4(b)(1. The HWD stated that she was not able to locate the UTF for Resident #1's transfer to the NJ Ex Order 26.4(b) on NJ Ex Order 26.4(b)(1. The HWD could not provide the surveyor a copy of the UTF for Resident #1 transfer to the NJ Ex Order 26.4(b) on NJ Ex Order 26.4(b)(1)

The surveyor reviewed the policy, titled, "Universal Transfer Form Policy," with a last revised date of 11/22, which revealed, "...1. The New Jersey Universal Transfer Form (UTF) is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	sipfep	A. BUILDING: _____ B. WING _____	C 02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ECHELON LAKE	**207 LAUREL ROAD VOORHEES, NJ 08043**

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H5770	Continued From page 19 completed in paper form by the Executive Director (ED), Nurse, or designee at the time of the Resident's transfer to another licensed [Department of Health and Senior Service] healthcare facility or program. A copy of the complotted [UTF] is retained in the resident's record in the community..."	H5770		

Received 4/23/26 POC#2
Acceptable POC letter
Sent 5/1/26.

BROOKDALE
SENIOR LIVING SOLUTIONS

Brookdale Echelon Lake
207 Laurel Rd, Voorhees Township,
NJ 08043

Survey Date- 2/13/2026

NJ Ex Order 26.4(b) Accepted 5/1/26

A310 Administration Responsibilities

- **HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?**
  Resident #3 NJ Ex Order 26.4(b)(1) by this deficient practice. HWD and designated nurse reviewed call system log (computer system), and Shift to Shift report to verify the accuracy of resident calls vs associate response vs resident care needs.

- **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFIEICIENT PRACTICE?**
  All residents have the potential to be affected by this deficient practice.

- **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?**
  HWD or designee will review pendant/ call bell report daily. In-serviced care associates on 4/10/2026 regarding the following Brookdale Policies: 1. Pendant Response 2. Resident Change of Condition 3. Shift to Shift Report.

- **HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?**
  Executive Director or designee to monitor pendant review compliance weekly x 1 month, then 1x monthly and as needed. Pendant review started on 4/10/2026.
  Executive Director or designee to monitor compliance of the above required in-services 1x weekly for 1 month, and as needed thereafter. In-services completed on 4/10/2026.

COMPLETION DATE: 4/10/2026.

NJ Ex Order 26.4(b) Accepted 5/1/26

A401- 8:36-3.4 Resident Rights

- **HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?**
  Resident #1 and Resident #2 NJ Ex Order 26.4(b)(1) by this deficient practice. RN reviewed and updated resident #2 Personal Service Plans, care assignments, and Health Service Plans on 4/6/2026. Care conference with POA, care associates, conducted on 3/2/2026.

- **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFIEICIENT PRACTICE?**
  All residents have the potential to be affected by this deficient practice.

- **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?**
  On 4/1/2026 nurses and care associates completed a documented in-service on "Abuse and Neglect", "Managing Aggressive Behavior', "Response to an Aggressive Behavior", "Reportable Event". Review on update of residents Health Service Plans completed by Health and Wellness Director.

- **HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?**
  The Executive Director, Health and Wellness Director or designee to verify compliance adherence monthly for 3 months, and as needed thereafter.

COMPLETION DATE: 4/1/2026

NJ Ex Order 26.4(b)

Accepted 5/1/26

A537 8:36-5.7 (a) Policy and Procedure Manual

- **HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?**
  No residents were found to be affected by the deficient practice.

- **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFIEICIENT PRACTICE?**
  All residents have the potential to be affected by the deficient practice. The documentation and reporting policies has been reviewed.

- **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?**
  On 4/9/2026 the updated Brookdale NJ policy and procedure were presented and reviewed to all managers. On 4/9/2026 Brookdale policy and procedure printed and placed in a binder and made accessible to associates. On 4/9/2026 Brookdale policy and procedure signed by all managers.

- **HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?**
  The ED will ensure completion and compliance monthly for 1 month, then as needed thereafter.

COMPLETION DATE: 4/9/2026

NJ Ex Order 26.4(b)(1)

Accepted 5/1/26

A753 3:66-7.3 Health Service Plans

- **HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?**
  Resident #1 and resident #2 Personal Service Plans, current RN health assessment, MD notes, list of meds, And health service plans were all reviewed and updated on NJ Ex Order 26.4(b)(1) Updated Personal Service Plans and and Health Service Plans were presented to the POA, MD, Executive Director, and Health Wellness Director on NJ Ex Order 26.4(b)(1)

- **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFIEICIENT PRACTICE?**
  All residents have the potential to be affected by the deficient practice.

- **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?**
  On 4/1/2026 Health and Wellness Director, RNs and LPNs were in-serviced by the district support RNs on NJ state regulations and Brookdale policy on "Health Service Plans", "Personal Service Plans" and "Importance of clinical documentation". In addition, HSPs and PSPs for resident #1 and resident #2 were updated by the HWD.

- **HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?**

[redacted] Accepted 5/1/26

A 1399 Quality Improvement Plan/ Pendant Response Log

- **HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?**
  Resident #3 was found [redacted] by the deficient practice. Health and Wellness Director and Executive Director reviewed and updated resident #3 Personal Service Plan, Care Profile, and associate assignment plans (specific for resident #3). Completed on 4/1/2026.

- **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFIEICIENT PRACTICE?**
  All residents have the potential to be affected by the deficient practice.

- **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?**
  On 04/01/2026 Executive Director or designee in-serviced associates on "Call Bell Response policy",
  and "Daily compliance of Call Bell Log review".

- **HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?**
  Executive Director to monitor compliance 1x weekly and as needed thereafter.

COMPLETION DATE: 04/01/2026.

Executive Director or designee to ensure Health Service Plans, Personal Service Plans, and clinical documentation compliance 1x monthly, and as needed thereafter.

COMPLETION DATE: 4/1/2026

[redacted] Accepted 5/1/26.

A 1073 8:36-15:6 Resident Records

- **HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?**
  On 2/13/2026 resident #2 PCC/ e-MAR/ progress notes/ and nursing evaluation records were reviewed and audited for documentation compliance.

- **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFIEICIENT PRACTICE?**
  All residents have the potential to be affected by the deficient practice.

- **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?**
  On 4/1/2026 RNs, LPNs, and CMAs completed a documented in-service on Brookdale policy and procedure on "Resident Records", "Clinical Documentation", "PCC/ e-MAR compliance".

- **HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?**
  Executive Director to verify compliance adherence monthly for 3 months, and as needed thereafter.

COMPLETION DATE: 4/1/2026

A 1399 Quality Improvement Plan/ Pendant Response Log

- **HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?**
  No residents found to [redacted] the deficient practice.

- **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFIEICIENT PRACTICE?**
  All residents have the potential to be affected by the deficient practice.

- **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?**
  On 4/1/2026 Executive Director or designee in-serviced associates on "Call Bell Response policy", and "Daily compliance of Call Bell Log review".

- **HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?**
  Executive Director to monitor compliance 1x weekly for one month and as needed thereafter.

COMPLETION DATE: 4/1/2026.

H 3480 Reportable Events

[redacted] Accepted 5/1/26

- **HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?**
  Resident #1 and Resident #2 [redacted] this deficient practice.

- **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFIEICIENT PRACTICE?**
  All residents have the potential to be affected by the deficient practice.

- **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?**
  On 4/1/2026 Executive Director in-serviced managers, RNs, and LPNs on " Brookdale Reportable Events policy and procedure", and "NJ DOH Facility Reporting Events".

- **HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?**
  Executive Director to verify compliance adherence 1 weekly for 2 weeks, and as needed thereafter.

COMPLETION DATE: 4/1/2026

NJ Ex Order 26.4(b)(1) Accepted 5/1/26

H 5570 Universal Transfer Form

- **HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?**
  Resident #1 was NJ Ex Order 26.4(b)(1) this deficient practice.

- **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFIEICIENT PRACTICE?**
  All residents have the potential to be affected by the deficient practice.

- **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?**
  On 4/1/2026 Health and Wellness Director provided a documented in-service to CMAs, LPNs, and RNs on "Universal Transfer form compliance (Brookdale policy and procedure)".

- **HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?**
  Executive Director to verify compliance adherence 1x monthly for 3 months, and as needed thereafter.

COMPLETION DATE: 4/1/2026

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
sipfep Y1	A. Building B. Wing Y2	5/1/2026 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ECHELON LAKE	207 LAUREL ROAD VOORHEES, NJ 08043

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 A0310	Correction	ID Prefix A0401	Correction	ID Prefix A0537	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(22)	Completed	Reg. # 8:36-5.7(a)(1)	Completed
LSC	04/10/2026	LSC	04/01/2026	LSC	04/09/2026
ID Prefix A0753	Correction	ID Prefix A1073	Correction	ID Prefix A1399	Correction
Reg. # 8:36-7.3(c)	Completed	Reg. # 8:36-15.6(b)	Completed	Reg. # 8:36-21.1(b)(3)	Completed
LSC	04/01/2026	LSC	04/01/2026	LSC	04/01/2026
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 ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 2/13/2026

☐ 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
sipfep Y1	A. Building B. Wing Y2	5/1/2026 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ECHELON LAKE	207 LAUREL ROAD VOORHEES, NJ 08043

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 H3480	Correction	ID Prefix H5770	Correction	ID Prefix	Correction
Reg. # 8:43E-10.11(c)(3)	Completed	Reg. # 8:43E-13.4(c)	Completed	Reg. #	Completed
LSC	04/01/2026	LSC	04/01/2026	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 ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/13/2026	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO