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
	02A016	A. BUILDING: ______ B. WING ______	11/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISTAL AT WOODCLIFF LAKE, THE	364 CHESTNUT RIDGE ROAD WOODCLIFF LAKE, NJ 07677

(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: CENSUS: 141 SAMPLE SIZE: 5 TYPE OF SURVEY: Standard Survey of 154 residential units 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		
A1041	8:36-14.3(a) Drills and Tests (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	A1041		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE   TITLE   (X6) DATE
12/26/25

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A1041	Continued From page 1 may participate in drills. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to request of the local fire department that at least one joint fire drill be conducted annually. Additionally, the facility failed to notify first aid and civil defense agencies of this drill and participated in a community-wide disaster drill. This deficient practice and was evidenced by the following: On 11/07/2025, in the presence of the Executive Director (ED) and Maintenance Director (MD), the surveyor reviewed documentation regarding emergency drills. The record review revealed that emergency drills were conducted on 04/5/2025 and 11/6/2025, but there was no evidence of a request of a joint drill or of participation in a community-wide disaster drill. During surveyor interview, the ED confirmed and acknowledged that they have not requested a joint drill or participated in a community-wide disaster drill.	A1041		
A1089	8:36-16.3(b) Ventilation (b) Means of ventilation shall be provided for every bathroom or water closet (toilet) compartment. Ventilation shall be provided either by a window with an openable area or by	A1089		

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A1089	Continued From page 2 mechanical ventilation. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to ensure that a means of ventilation was provided either by a window with an openable area or by mechanical ventilation for every bathroom or water closet. This deficient practice was evidenced by the following: On 11/06 and 11/07/25, in the presence of the Maintenance Director (MD), the surveyor observed that the ventilation in resident rooms: Rooms 338, 337, 353, 320, 220, 117, 24 and 2 was not functioning when tested by the MD. The surveyor interviewed the MD regarding the ventilation which the MD confirmed that the ventilation was not functioning when he tested it in the presence of the surveyor.	A1089		
A1097	8:36-16.6 Fire Suppression Systems All facilities shall be provided with a fire suppression system in accordance with the Uniform	A1097		

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A1097	Continued From page 3 Construction Code, N.J.A.C. 5:23. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that the kitchen hood suppression system was Inspected, Tested and Maintained (ITM) in accordance with N.J.A.C 5:23 and N.J.A.C 5:70; and that electrical fire pumps were ITM in accordance with NFPA 25 section 8.3 . This deficient practice was evidenced by the following: On 11/06/25, in the presence of the Maintenance Director (MD), the surveyor reviewed the kitchen suppression system documentation. The record review revealed that the kitchen suppression system's semi-annual reports conducted on 03/18/25 and 09/18/25 indicated, "System is Non-Compliant" on the Kitchen System Report. The system report also revealed, "Description of Deficiencies: (3) 3-gallon Ansul cylinders are due for NFPA test, (3) Ansul Hoses need to be replaced, (1) Ansul Regulator needs to be replaced, (1) Double Tank." Additionally, the surveyor reviewed the fire pump	A1097		

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A1097	Continued From page 4 documentation, in the presence of the MD which revealed that the facility did not conduct monthly fire pump test for at least 10 minutes. During surveyor interview, the MD confirmed that both reports indicated that the kitchen suppression system was non-compliant and stated that the repairs have not been made yet because they were waiting on an approval of the repair quote. The MD also confirmed that the fire pump testing was not conducted monthly. On 11/07/25 the MD provided the surveyor with the repair quote for the kitchen suppression system dated 11/6/25 which was approved after the surveyor inquiry on 11/06/25.	A1097		
A1169	8:36-16.15(a) Fire Extinguisher Specifications (a) Fire extinguishers shall comply with National Fire Protection Association (NFPA) 10, Standards For Portable Fire Extinguishers, 2002 edition, incorporated herein by reference, as amended and supplemented, available from: NFPA, One Batterymarch Park, Quincy, MA, 02169- 7471, http://www.nfpa.org, 1-800-344-3555. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to ensure that fire extinguishers were Inspected, Tested and Maintained (ITM) in accordance with NFPA 10. This deficient practice was evidenced by the	A1169		

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A1169	Continued From page 5 following: On 11/06/25 at 12:29 p.m., in the presence of the Maintenance Director (MD), the surveyor observed that the fire extinguisher in Elevator 1, machine room needed a recharge. During surveyor interview, the MD confirmed that the fire extinguishers gauge was showing that a recharge was needed. At 12:31 p.m., in the presence of the MD, the surveyor observed that the fire extinguisher in Elevator 2 machine room did not contain a monthly inspection tag. During surveyor interview, the MD confirmed that the inspection tag was missing on the fire extinguisher. On 11/07/25 at 10:42 a.m., and 11:11 a.m., in the presence of the MD, the surveyor observed that the fire extinguishers near resident rooms 122 and 20 needed a recharge. During surveyor interview, the MD confirmed that the fire extinguisher gauges showed that a recharge was needed.	A1169		
A1225	8:36-17.3(b)(8)(i-ii) Resident Environment (b) The following safety conditions shall be met: 8. An electrician licensed in accordance with N.J.A.C. 13:31 shall annually inspect and provide a written statement that the electrical circuits and wiring in the facility are satisfactory and in safe condition;	A1225		

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A1225	Continued From page 6 i. The written statement shall include the date of inspection, and shall indicate that circuits are not overloaded, that all wiring and permanent fixtures are in safe condition, and that all portable electrical appliances, including lamps, are Underwriters Laboratories (U.L.) approved; and ii. The written statement shall be available for review by the Department during survey. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to provide an annual written statement that the electrical circuits and wiring in the facility were satisfactory and in safe condition by a licensed electrician in accordance with N.J.A.C 13:31. This deficient practice was evidenced by the following: On 11/06/25 in the presence of the Maintenance Director (MD), the surveyor reviewed the annual electrical inspection documentation. The record review revealed that the electrical inspected was last completed on 12/18/2023, over 23 months ago. During surveyor interview, the MD confirmed that the last annual electrical inspection was completed over 23 months ago.	A1225		

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A1249	Continued From page 7	A1249		
A1249	8:36-17.7 Building and Grounds 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review ,it was determined that the facility failed to ensure that the building and grounds were kept free from fire hazards and other hazards to resident's health and safety by : 1) ensuring emergency generator Inspection, Testing and Maintenance (ITM) was in accordance with NFPA 110, 2) ensuring that exit signs were installed above doors through which the egress path leads and 3) ensuring that stairway enclosures were kept clear of any storage. This deficient practice was evidenced by the following: On 11/06/25 in the presence of the Maintenance Director (MD), the surveyor reviewed the emergency generator logs. The generator logs revealed that a 30-minute monthly load test was not conducted in August, September or October of 2025.	A1249		

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A1249	Continued From page 8	A1249		

During surveyor interview with the MD, the MD confirmed the above concern and stated that the facility only run the generator for 20 minutes without load.

On 11/07/25 at 10:49 a.m., the surveyor observed that the exit sign above the fire/smoke barrier doors near resident room 31 had broken off and was missing.

During surveyor interview, the MD confirmed that the exit sign was broken and missing.

At 11:01 a.m., in the presence of the MD, the surveyor observed a bed box spring, and a reclining chair were stored in the Stair 1 Level B exit stairway enclosure.

During surveyor interview with the MD regarding the bed box spring and reclining chair being stored in the exit stairway, the MD stated that he would have someone remove the items right away.

POC #3 received 1/6/26
Accepted

The Bristal at Woodcliff Lake

New Jersey Department of Health – Survey 11/07/2025

A 1041

Element 1

No specific resident identified.

Element 2

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

Element 3

On 12/22/25, a recurring annual reminder for the joint fire drill and community-wide disaster drill, each to occur during a set month each calendar year for consistency, has been added to the facility's Outlook calendar and annual In-Service Education Calendar for the Director of Maintenance (DOM) or designee to invite local fire and first aid and civil defense agencies to annual drills. On 11/13/25, the Executive Director (ED) re-educated the Director of Maintenance (DOM) regarding the fire and disaster drill process and requirement.

Element 4

In addition to the drill scheduled for 12/31/25, the ED or designee will ensure invitation for annual fire and disaster drills are submitted by DOM as set in Outlook and Education calendars. The corrective action will be monitored until 100% compliance has been achieved for two consecutive months, at which time the QAPI Committee will evaluate whether ongoing audits may be reduced or integrated into routine oversight.

Completion Date: 12/31/25

Accepted

A1089

Element 1

No residents identified to be adversely affected by this deficiency.

Element 2

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

Element 3

Immediately upon identification of this deficiency, the Director of Maintenance (DOM) inspected the community's rooftop ventilation units and replaced the industrial drive belts restoring ventilation to rooms 338, 337, 353, 320, 220, 117, 24 and 2 (12/15/25). Maintenance staff were reeducated by the Regional Director of Maintenance on the requirements of NJ regulation 8:36-16.3(b) Ventilation as it pertains to

functionality of bathroom ventilation systems 11/13/2025.

Director of Maintenance or designee will check bathroom ventilation room by room monthly during building inspections. Monthly task has been added to the community's electronic maintenance task tracking tool (TELS). DOM and Maintenance Assistants completed a full community inspection of all resident rooms, in addition to the aforementioned rooms, by 12/22/25.

Element 4

The Executive Director or designee will monitor compliance through the [NJ Exec Order 26] program weekly for the next two months. All audit results will be reviewed during the community's QAPI meetings and tracked for compliance for the next two QAPI meetings. (4/15/2026).

Completion Date: 12/22/25

accepted

A1097

Element 1

No residents identified to be adversely affected by this deficiency.

Element 2

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

Element 3

Immediately upon identification of the deficient practice, pertaining to the kitchen hood suppression system, the repair quote was approved (11/7/25) and tests of (3) 3-gallon Ansul cylinders and replacement of (3) Ansul Hoses and Ansul Regulator were completed 12/23/25.

The Regional Director of Maintenance (RDOM) provided maintenance staff with re-education on N.J.A.C. 5:23, N.J.A.C. 5:70 as it pertains to the kitchen hood suppression system, and NFPA 25 fire pump testing requirements, including monthly testing duration and documentation expectations on 11/13/25.

Element 4

The ED or designee will complete monthly audits of fire pump testing logs in TELS to confirm testing is completed for at least 10 minutes and properly documented for the next two months.

All audit results of the fire pump testing logs will be reviewed during the community's QAPI meetings and tracked for compliance for the next two QAPI meetings.

The DOM and ED or designee will review semi-annual kitchen hood suppression system inspections for 2026 to ensure system is compliant.

All audit results of the kitchen hood suppression system will be reviewed during the community's QAPI meetings and tracked for compliance for 2026.

Completion 12/23/25

A1169

Element 1

No residents identified to be adversely affected by this deficiency.

Element 2

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

Element 3

Immediately upon identification of the deficient practice, the DOM took action to ensure resident safety. All fire extinguishers identified as needing recharge (Elevator 1 machine room, Elevator 2 machine room and near resident rooms 122 and 20) were removed from service and replaced with fully charged and inspection-tagged extinguishers. A licensed fire protection vendor was contacted to inspect, recharge, and service all affected extinguishers in accordance with NFPA 10 standards on 12/24/25.

The Maintenance Director conducted a facility-wide audit of all fire extinguishers, including resident corridors, common areas, mechanical rooms, and ancillary spaces. This audit included verification of pressure gauges, inspection tags, inspection dates, and overall condition. Any extinguisher found to be non-compliant was immediately addressed (11/10/25).

On 11/18/25, fire protection vendor provided in-service to ED, DOM, Maintenance Assistants, Director of Wellness (DOW), Associate Director of Wellness (ADOW), Director of Housekeeping, Director of Reflections, Director of Dining Services, Director of Admin Services, Director of Community Relations, and Community Relations Coordinator on requirements of visual inspections of fire extinguishers in accordance with NFPA 10 standards.

The DOM or designee will continue to inspect all facility extinguishers monthly beyond pressure gauge checks to include inspection tags, inspection dates, and overall condition.

Element 4

The ED or designee will conduct 5 random monthly audits to verify extinguisher condition for the next two months. All audit results will be reviewed during the community's QAPI meetings and tracked for compliance for the next two QAPI meetings.

Completion Date: 12/24/25 accepted

A 1225

Element 1

No residents identified to be adversely affected by this deficiency.

Element 2

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

Element 3

Following the survey, the DOM contacted the licensed electrician on 11/10/25 and determined an annual inspection had taken place 12/2023 as shown to the surveyor and reflected in the DOH SOD. The electrician also provided the missing documentation indicating an annual inspection had taken place on 12/18/2024 and 10/16/2025. Documentation provided to the facility showing full compliance.

The DOM or designee will contact the vendor in January of every year to confirm scheduled date, annually, of that calendar year. This will be entered into our electronic maintenance task tracking tool (TELS); accessible to ED, Reg. Director of Maintenance, & Regional Vice President of Operations (RVPO). On 11/10/25, the Executive Director re-educated the DOM regarding the annual test requirement.

Element 4

The ED or designee will ensure the completion of the task in TELS by reviewing the weekly task report.

Completion Date: 11/10/25

accepted

A 1249

Element 1

No specific resident identified for items 1, 2, and 3.

Element 2

All residents in the community have the potential to be affected by these deficient practices for items 1, 2, and 3.

Element 3

1) The Director of Maintenance (DOM) and the Executive Director (ED) received retraining by the Regional Director of Maintenance on NFPA 110 requirements, documentation standards, and life safety compliance expectations, specifically a monthly 30-minute load test. 11/10/25

   The ED was educated on the importance of reviewing generator logs monthly. 11/10/25

2) Immediately upon identification of this deficiency, the DOM installed the missing exit sign (11/7/2025). The Director of Maintenance or designee will check exit signs monthly during building inspections. Monthly task has been added to the community's electronic maintenance task tracking tool NJ Exec Order 26.4 DOM completed a full community inspection of all exit signs, in addition to replacing the aforementioned exit sign, by 12/22/25.

3) Immediately upon identification of this deficiency, the DOM removed bed box spring and reclining chair from stairwell 1, level B (11/7/2025). The DOM, Maintenance Assistants, Director of Housekeeping, and Housekeeping Staff were provided an in-service by the ED on facility policy "Maintenance Standards" which includes inspections of the building interior ensuring means of egress are continuously maintained, free of all obstructions to full use in case of emergency (11/13/26). Full community inspection of all means of egress/stairwells was completed by DOM on 11/13/25.

Signage was placed in stairwell areas indicating storage is prohibited. (11/13/26)

Element 4

1) The ED will review and sign the generator log monthly to confirm that the 30-minute load test was completed and documented correctly for the next 3 months.

   Generator test compliance will be added as an agenda item in the facility's Quality Assurance Performance Improvement (QAPI) committee for the next 2 QAPI meetings. The ED ensures that these corrective actions and systemic changes will be implemented and monitored through these QAPI meetings to prevent recurrence of these deficiencies. If any deficiency is detected, monthly audits will resume until consistent compliance is re-established.

2) The Executive Director or designee will monitor compliance through the NJ Exec Orde program monthly for the next three months. All audit results will be reviewed during the community's QAPI meetings and tracked for compliance for the next two QAPI meetings.

3) The ED or designee will conduct weekly audits of all community stairways for the next two months to ensure compliance with obstruction-free stairway enclosures. All audit results will be reviewed during the community's QAPI meetings and tracked for compliance for the next two QAPI meetings.

Completion Date: 12/22/25

accepted

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER Y1	MULTIPLE CONSTRUCTION A. Building B. Wing Y2	DATE OF REVISIT Y3
02A016		1/9/2026

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISTAL AT WOODCLIFF LAKE, THE	364 CHESTNUT RIDGE ROAD WOODCLIFF LAKE, NJ 07677

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 A1041 Reg. # 8:36-14.3(a) LSC	Correction Completed 12/31/2025	ID Prefix A1089 Reg. # 8:36-16.3(b) LSC	Correction Completed 12/22/2025	ID Prefix A1097 Reg. # 8:36-16.6 LSC	Correction Completed 12/23/2025
ID Prefix A1169 Reg. # 8:36-16.15(a) LSC	Correction Completed 12/24/2025	ID Prefix A1225 Reg. # 8:36-17.3(b)(8)(i-ii) LSC	Correction Completed 11/10/2025	ID Prefix A1249 Reg. # 8:36-17.7 LSC	Correction Completed 12/22/2025
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	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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
11/7/2025	