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
	02A020	A. BUILDING: ____ B. WING ____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTVIEW PARAMUS	**396 FOREST AVENUE PARAMUS, NJ 07652**

(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: Complaint Complaint #: NJ178326, NJ183057, NJ188860 Census: 74 Sample Size: 7 Survey Date: 10/2/25, 10/6/25 The facilty is not in substantial compliance with all of the standards in teh 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 389	8:36-4.1(a)(16) 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: 16. The right to be free from physical and mental abuse and/or neglect;	A 389		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE　　TITLE　　(X6) DATE 11/11/25

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A 389	Continued From page 1 This REQUIREMENT is not met as evidenced by: Complaint # NJ183057 Based on interview, record review and review of pertinent facility documents, it was determined that the facility failed to ensure residents were protected from NJ Ex Order 26.4(b)(1) when staff failed to immediately report to their supervisors NJ Ex Order 26.4(b)(1). Several hours after two complaints were made by Resident #1 and #2 against a Certified Home Health Aide (CHHA) #1, CHHA #1 was observed NJ Ex Order 26.4(b)(1) Resident #2. CHHA #1 continued working for three hours while continuing to be assigned to Residents #1 and #2. Both residents resided in the facility's NJ Ex Order 26.4(b)(1) unit. This deficient practice was identified as an imminent danger for 2 of 3 residents reviewed (Resident #1, #2) and was evidenced by the following: The surveyor reviewed a Facility Reportable Event (FRE) that was submitted to the New Jersey Department of Health (NJDOH) on NJ Ex Order 26.4 The FRE revealed that on NJ Ex Order 26.4 at 12:00 p.m., Resident #2 was observed during the lunch meal NJ Ex Order 26.4(b)(1) CHHA #1. CHHA #1 NJ Ex Ord Resident #2's NJ Ex Order 26.4(b)(1) while attempting to NJ Ex Order 26.4(b)(1) to the resident. Resident #2 NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) presumably NJ Ex Order 26.4(CHHA #1. The following day on 2/2/25 at 3:00 p.m. the memory care unit's Director notified the Executive Director (ED) of the NJ Ex Order 26 lunchtime incident between CHHA #1 and Resident #2. The ED suspended CHHA #1 pending the completion of the investigation (her last shift worked was NJ Ex Order 26.4	A 389		

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A 389	Continued From page 2 - 7 a.m. to 3 p.m.). The facility's investigation uncovered the following: Resident #1 and Resident #2 shared a NJ Exec Order 26.4b1) on the NJ Ex Order 26.4(b)(1) unit for residents diagnosed with NJ Ex Order 26.4(b)(1). CHHA #1 was assigned to both residents on NJ Ex Order 26.4 During morning care on NJ Ex Order 26, Resident #1 was NJ Ex Order 26.4(b)(1) and later stated they did not want CHHA #1 NJ Ex Order 26.4(b)(1)." During 2/1/25 morning medication administration, Resident #2 stated to Certified Medication Aide (CMA) #1 "NJ Ex Order 26.4(b)(1)." CMA #1 attempted to elicit more information from Resident #2, however, the resident did not elaborate. On 2/2/25, the nurse on duty performed NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b)(1) assessments on Residents #1 and #2 with NJ Ex Order 26.4(b)(1) findings. The physician and families were notified. On 2/5/25 the investigation was completed and CHHA #1 was found to NJ Ex Order 26.4(b)(1) to Resident #2. The surveyor interviewed the ED on 10/2/25 at 12:00 p.m. She stated Resident #1 told CMA #1 during the NJ Ex Order 26 morning medication administration they NJ Ex Order 26.4(b)(1) CHHA #1 NJ Ex Order 26.4(b)(1) to them. Resident #2 verbalized the same during medication administration that same day. The ED stated CMA #1 did not report the statements from Residents #1 and #2 until 24	A 389		

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A 389	Continued From page 3 hours later when she told the Director of the NJ Ex Order 26.4(b)(1) unit. At the time of the survey the NJ Ex Order 26.4(b)(1) Director was NJ Exec Order 26.4b1 at the facility. The surveyor interviewed the Health Services Director (HSD) on 10/2/25 at 12:30 p.m. who relayed similar information as noted by the ED that same day at 12:00 p.m. Neither the ED nor the HSD addressed the delay in reporting the lunch incident by the NJ Ex Order 26.4(b)(unit Director to the ED for more than 24 hours after the event. The surveyor interviewed CMA #1 on 10/6/25 at 10:40 a.m. CMA #1 stated Residents #1 and #2 told her on NJ Ex Order 26.4 they did not want CHHA #1 to NJ Ex Order 26.4(b)(1) them. CMA #1 told the surveyor she reported this to the Director of the NJ Ex Order 26.4(b)(unit on NJ Ex Order 26 after morning medication administration was completed. The facility provided documentation which showed actions taken to prevent recurrence which included: CHHA #1 was terminated, and was reported to the NJ Department of Health Clearinghouse, and all of the staff were reeducated on abuse, neglect, and proper reporting procedures. The surveyor reviewed the facility's policy and procedure titled, "Reporting Abuse, Neglect, or Financial Exploitation" effective 10/30/24 and scheduled for the next review on 10/30/25 which included the following: Procedure #3 indicated "If abuse, neglect, or financial exploitation is suspected, associates must immediately notify their supervisor, who must immediately notify the Executive Director."	A 389		

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A 607	8:36-5.15(a)(1) Notification Requirements (a) The resident's family, guardian, and/or designated responsible person or community agency shall be notified, when known, and with the resident's consent, immediately after the occurrence, in the event of the following: 1. The resident acquires an acute illness requiring medical care; This REQUIREMENT is not met as evidenced by: Complaint # NJ188860 Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to verify a resident's identity prior to transferring Resident #5 to the emergency room (ER), which resulted in the incorrect resident's (Resident #6's) medical documentation being sent to the ER and the incorrect family being informed of the ER transfer. This deficient practice was identified as an imminent danger and was evidenced by the following: The surveyor reviewed a Facility Reportable Event (FRE) that was submitted to the New Jersey Department of Health (NJDOH) on 9/27/25. The FRE revealed that on NJ Ex Order 26.4(at 10:50 PM, the Wellness nurse, Licensed Practical Nurse (LPN) #1, was alerted a resident (Resident	A 607		

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A 607	Continued From page 5 #5) NJ Ex Order 26.4(b)(1) n their apartment. The nurse arrived at the apartment, assessed the resident and determined that the resident was NJ Ex Order 26.4(b)(1) . The nurse called for an ambulance to transfer the resident to the hospital. The nurse notified the family of Resident #6 of the NJ Ex O and transfer to the hospital. The family arrived at the hospital to discover that Resident #6 was not at the hospital instead a different resident was at the hospital. The hospital called the community to verify the resident that was sent to the hospital. It was discovered at the time that Resident #5 was at the hospital. LPN #1 did not verify which resident had NJ Ex Order 26. and needed medical treatment. On 10/6/25 at 10:50 AM, the surveyor interviewed the Executive Director (ED), who stated that Resident #5 was transferred from the facility to the ER on NJ Ex Order 26.4(b), following NJ Ex Order 26.4 their room, and LPN #1 did not verify the identity of the resident and sent the wrong resident's, (Resident #6's), medical documentation to the ER. She also stated that LPN #1 documented the incident in Resident #6's medical record and contacted Resident #6's family regarding the ER transfer. The ED stated that Resident #5 was not interviewable and would not have been able to state what their name was upon transfer to the ER. The ED also stated that the family of Resident #6 went to the ER and told the ER staff that the resident was not their family member and that it was a different resident, Resident #5. The ED also provided the surveyor with a written investigation/summary of what occurred on NJ Ex Order 26.4(b, which confirmed the information that the ED told the surveyor. The surveyor reviewed the universal transfer form (UTF), which was sent to the ER during the	A 607		

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A 607	Continued From page 6 discharge of Resident #5 on NJ Ex Order 26.4(b)(1) The UTF indicated the incorrect resident's name, Resident #6, was transferred to the ER on NJ Ex Order 26.4(b) at 11:15 PM. The UTF indicated that the resident was to be sent to ER because of NJ Ex Order 26.4(b)(1) the resident's apartment and the resident had complained of NJ Ex Order 26.4(b)(1). The UTF was signed as completed by LPN #1, who's signature was at the bottom of the form. Included with the UTF, and sent to the ER, was also the incorrect resident's face sheet, which included Resident # 6's diagnoses, code status and medications. The surveyor reviewed Resident #6's medical records, which were included in the UTF and sent to the ER on NJ Ex Order 26.4(with Resident #5. Resident #6's NJ Ex Order 26.4(b)(1) was documented as NJ Ex Order 26 . Resident #6's diagnoses included, but were not limited to, NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). Resident #6's medication list included, NJ Ex Order 26.4(b (NJ Ex , NJ Ex Order 26.4((NJ Ex), NJ Ex Order 26.4(b)(1) (NJ), NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)), and NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)). A review of Resident #6's progress notes (PN), revealed documentation completed by LPN #1 on NJ Ex Order 26.4(at 11:20 PM, "At around 10:50 PM, resident was NJ Ex Order 26.4(b)(1) the [resident's] bed NJ Ex Order 26.4(b)(1) [resident's] NJ Ex Order 26.4(b)(1). Resident c/o NJ Ex Order 26.4(b)(1). Called NJ Exec and responder NJ Ex Ord [resident] NJ Ex Order 26.4(b)(1) then transferred to NJ Ex Order 26.4(b)(1) Sent out to [hospital name redacted] ER for further evaluation. HSD, MD and [resident's family] notified."	A 607		

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A 607	Continued From page 7 The surveyor reviewed Resident #5's medical records, which revealed that the NJ Ex Order 26.4(b)(1) was documented as NJ Ex Order 26.4(b)(1) The medical records revealed the following diagnoses for Resident #5, which included, but were not limited to, NJ Ex Order 26.4(b)(1), NJ Ex Order NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) A review of Resident #5's records revealed the following medications ordered: NJ Ex Order 26.4(b)(1) (NJ , NJ Ex Order 26.4 (NJ Ex), NJ Ex Order 26.4(b)(1) (NJ Ex), NJ Ex Order 26.4(b)(1) (NJ), NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)), and NJ Ex Order (NJ Ex). There were no PN's written on NJ Ex Order 26.4(regarding Resident #5's transfer to the ER. On 10/6/25 at 12:20 PM, the ED provided the surveyor with the LPN #1's written statement of what occurred on NJ Ex Order 26.4(b)(It revealed "Around 10:50 PM, a staff member informed me that a resident NJ Ex O I went downstairs to check on the resident and observed the resident NJ Ex Order 26.4(b)(1) I asked, NJ Ex Order 26.4(b)(1)? The resident said NJ . I went to the nursing office and did paperwork for the transfer. I called the resident's family and informed them about NJ Ex Order 26.4(I did the incident report and left the facility. About 15-30 minutes later, [staff member] called me and said that I had sent the wrong paperwork. I drove back [to the facility] and I faxed the ER the necessary paperwork, did another incident for [the resident] and left."	A 607		

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A 607	Continued From page 8	A 607		

The facility provided documentation which showed actions taken to prevent reccurence which included: On NJ Ex Order 26.4(the ED's written statement revealed LPN #1 was terminated, the facility reported the events to the proper authorities, and staff was re-educated on emergency response procedures to include verification of correct resident identification and correct paperwork by at least 2 staff members.

Also, per the ED and per record review, LPN #1 documented in Resident #6's PN on NJ Ex Order 26.4(at 12:22 AM "Disregard previous progress notes for NJ Ex Order 26.4(11:20 PM." LPN #1 also documented in Resident #5's PN on NJ Ex Order 26.4(b) at 12:22 AM which revealed "At around 10:50 PM, resident was NJ Ex Order 26.4(b)(1) the [resident's] bed NJ Ex Order 2 [resident's] NJ Ex Order 26.4(b)(1) Resident c/o NJ Ex Order 26.4(b)(1). NJ Ex Order 26.4(b)(1. Called NJ Exec and responder NJ Ex Ord [resident] NJ Ex Order 26.4(b)(1) then transferred to NJ Ex Order 26.4(b)(1) Sent out to [hospital name redacted] ER for further evaluation. HSD, MD and [resident's family] notified." Further PN's on NJ Ex Order 26.4(in Resident #5's medical record on NJ Ex Order 26.4(at 11:19 AM revealed "Spoke with [resident's family] to discuss [resident's NJ Ex Order 26.4(b)(1) that lead [resident] to being sent out to the hospital. [Family] expressed concern that [resident] was sent to the hospital with incorrect documentation."

No policy and procedures were provided and no other information was provided.

POC#2 received 11/21/25
Accepted 11/21/25

BRIGHTVIEW
SENIOR LIVING
PARAMUS

November 19, 2025

Re: Plan of Correction for Brightview Paramus, License # 02A020

Deficient Practice: A389, 8:36-4.1(a)(16) 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: 16. The right to be free from physical and mental abuse and/or neglect.

1. Resident #1 & Resident #2 no longer reside at the community.
2. All residents have the potential to be affected by the deficient practice.
3. Administrator re-educated all department directors as to proper abuse/neglect reporting procedures on February 18, 2025. All staff members receive automated Relias training on proper abuse/neglect reporting yearly in March.
4. Quarterly compliance of education training will be reviewed during Quarterly QAPI/Safety Committee.

Completion date: November 30, 2025 KF approved 11/21/25

Deficient Practice: A607, 8:36-5.15 (a)(1) Notification Requirements (a) The resident's family, guardian, and/or designated responsible person or community agency shall be notified, when known, and with the resident's consent, immediately after the occurrence, in the event of the following: 1. The resident acquires an acute illness requiring medical care.

1. LPN responsible for proper identification of residents was NJ Exec Order 26.4b1 from facility on NJ Ex Order 26.4(b)(1) and all staff members who have the potential to transfer residents from the community were re-educated by RN on 10/15/25, ensuring residents 1 &2 will not be affected by this deficient practice. Resident #1 and Resident #2 still reside at the community.
2. All residents have the potential to be affected by the deficient practice.
3. RN on 10/15/25 in serviced resident med techs and wellness nurses outlining our new process to ensure at least 2 staff members verify a resident's identity before being transported out of the community.
4. RN will review all transfer paperwork to ensure the 2 staff verification has taken place. Quarterly review to be reported out during QAPI/Safety Committee for compliance.

Completion date: November 30, 2025 KF approved 11/21/25

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
02A020		11/21/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTVIEW PARAMUS	396 FOREST AVENUE PARAMUS, NJ 07652

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 A0389 Reg. # 8:36-4.1(a)(16) LSC	Correction Completed 11/30/2025	ID Prefix A0607 Reg. # 8:36-5.15(a)(1) LSC	Correction Completed 11/30/2025	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
10/6/2025

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**