

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 02A029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/16/2025
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NAME OF PROVIDER OR SUPPLIER BRISTAL AT ENGLEWOOD, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 412 SOUTH VAN BRUNT STREET ENGLEWOOD, NJ 07631
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A 000	<p>Initial Comments</p> <p>Initial Comments: Type of Survey: Standard with Complaints</p> <p>Complaint #: NJ00187685, NJ00180363, NJ00173104, NJ00179007, NJ00188486, NJ00170385</p> <p>Census: 225</p> <p>Sample Size: 8</p> <p>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.</p>	A 000		
A 310	<p>8:36-3.4(a)(1) Administrator's Responsibilities</p> <p>(a) The administrator or designee shall be responsible for, but not limited to, the following:</p> <p>1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;</p>	A 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

11/25/25

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A 310	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00170385</p> <p>Based on observation, interview, and record review, it was determined that the Administrator failed to develop a dietary policy which specified a timeframe for meal services, implement and enforce the "Standard for Meal Service" policy; and failed to implement the policy for disposal of medications, for 2 of 2 Unsampled Residents. This deficient practice was evidenced by the following:</p> <p>1. On 10/14/25 at 12:12 p.m., the surveyor reviewed the Resident Council Minutes (RCM) from January of 2025 to September of 2025, which were provided by the Executive Director (ED). Surveyor review of the RCM dated 7/22/25, revealed that a resident reported to staff that there were complaints regarding wait times for meal services which were up to one hour.</p> <p>On 10/15/25 at 11:30 a.m., the surveyor interviewed Resident #1 and inquired about the wait times for meal services. Resident #1 stated that wait times for meals were sometimes up to one and half (1-1/2) hours after being seated for a meal.</p> <p>At 12:01 p.m., the surveyor interviewed Unsampled Resident #1 and inquired about the wait times for meal services. Unsampled</p>	A 310		

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A 310	<p>Continued From page 2</p> <p>Resident #1 stated that he/she has waited up to one hour for a meal. Additionally, the unsampled resident stated that lunch and dinner services had longer wait times than breakfast service.</p> <p>At 12:08 p.m., the surveyor interviewed Unsampled Resident #2 and inquired about the wait times for meal services. Unsampled Resident #2 stated that he/she usually waited about one hour for meal service. The unsampled resident stated that dinner service had the longest wait times.</p> <p>On 10/16/25 at 8:58 a.m., the surveyor interviewed the Food Service Director (FSD) and inquired about the meal service wait times for residents. The FSD stated that prior to the facility hiring a second cook, the wait times for meals were about 25 minutes and now the wait times were between 15 and 20 minutes.</p> <p>During continued interview, the surveyor inquired about the facility's "Standard for Meal Service" policy and inquired about the standard for meal service wait times. The FSD stated that the goal was for meals to be served within 15 to 20 minutes. Additionally, the FSD acknowledged that the policy did not specify a timeframe for what is considered a "timely manner" for meal services.</p> <p>At 10:03 a.m., the surveyor interviewed a server and inquired about the meal service wait times for residents. The server stated that meal services sometimes took up to 30 to 35 minutes. Additionally, the server stated that prior to the additional cook being hired, meal service times were closer to 45 minutes.</p> <p>The surveyor reviewed a facility policy, "Standard for Meal Service," dated 11/26/24, which</p>	A 310		

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A 310	<p>Continued From page 3</p> <p>revealed, " ... To ensure appropriately and garnished meals are delivered to our Residents in a timely manner ..."</p> <p>2. On 10/15/25 at 12:06 p.m., the surveyor observed three (3) ceramic mugs, two (2) ceramic saucers, and one (1) drinking glass that were set on the dining room tables, prior to meal service, and had stains and particles on them.</p> <p>At 11:30 a.m., the surveyor interviewed Resident #1 and inquired about the dishwares and Resident #1 stated that the glasses and plates were dirty.</p> <p>On 10/16/25 at 10:09 a.m., the surveyor observed one (1) ceramic saucers with stains on it in the dining room, prior to meal service.</p> <p>On 10/16/25 at 8:58 a.m., the surveyor interviewed the FSD and inquired about the dishwares with dirty stains. The FSD stated that staff members were responsible for inspecting the cleanliness of the dishware. The FSD stated that the dining staff members were also instructed to show the FSD any dishes that were not clean, and the dishes would then be re-washed. The FSD explained that she noticed some of the drinking glasses were cloudy after they were washed and she contacted the dishwasher company to service the dishwasher.</p> <p>At 10:03 a.m., the surveyor interviewed a server and inquired about the dirty dishwares. The server stated that if there were any dirty dishes, she would remove them. Additionally, the server stated that residents have reported dirty cups to her and she took them away from the residents.</p> <p>The surveyor reviewed a facility policy, "Standard</p>	A 310		

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A 310	<p>Continued From page 4</p> <p>for Meal Service," dated 11/26/24, which revealed, " ... Properly plate meals ensuring every plate is neat, clean and has appropriate garnish and condiments ..."</p> <p>3. On 10/15/25 at 11:00 a.m., during medication cart inspection on the 3rd floor with a Certified Medication Aide (CMA), the surveyor observed medications in the refrigerator:</p> <p>The surveyor observed medication labeled for Unsamped Resident #1, which revealed an order for NJ Ex Order 26. 4B1 [REDACTED]. The order indicated that Unsamped Resident #1, should receive an NJ Ex Order 26. 4B1 [REDACTED] one dose. The surveyor observed that the medication label had an expiration date of 12/22/24.</p> <p>On 10/16/25 at 10:53 p.m., the surveyor inspected the medication refrigerator in the wellness center on the 2nd floor with a License Practical Nurse (LPN) and observed:</p> <p>4. The surveyor observed medication labeled for Unsamped Resident #2, which revealed an order for NJ Ex Order 26. 4B1 [REDACTED]. The order indicated that Unsamped Resident #2 should receive NJ Ex Order 26. 4B1 [REDACTED] before meals per NJ Ex Order 26.4(b)(1); NJ Ex Order 26. 4B1 [REDACTED]. The surveyor observed that the medication label had an expiration date of 9/18/25.</p> <p>During interview with the LPN regarding the expired medications still in the refrigerator, the LPN stated that she was not aware that the medications expired.</p>	A 310		

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A 310	Continued From page 5 The surveyor reviewed the facility policy and procedure dated August 2013, titled "Disposal of Medications and Related Equipment ... "The Director of Wellness will assure: 2. Discontinued and expired medications for Residents receiving assistance with medication administration are removed from the medication cart and/or central storage areas and disposed of according to state and federal requirements ..."	A 310		
A 517	8:36-5.6(b)(1-7) Staffing Requirements (b) The facility or program shall develop and implement a staff orientation and a staff education plan, including plans for each service and designation of person(s) responsible for training. All personnel shall receive orientation at the time of employment and at least annual in-service education regarding, at a minimum, the following: 1. The provision of services and assistance in accordance with the concepts of assisted living and including care of residents with physical impairment; 2. Emergency plans and procedures; 3. The infection prevention and control program; 4. Resident rights; 5. Abuse and neglect; 6. Pain management; and	A 517		

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A 517	<p>Continued From page 6</p> <p>7. The care of residents with Alzheimer's and related dementia conditions and in accordance with N.J.A.C. 8:36-19.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to provide general staff orientation upon hire for 4 of 11 employees reviewed. This deficient practice was evidenced by the following:</p> <p>On 10/15/25 at 8:58 a.m., the surveyor reviewed employee records, which were provided by the Executive Director (ED) and observed that some of the employees did not receive a general orientation upon their dates of hire (DOH). The findings were as follows:</p> <p>1. The Registered Nurse (RN), an Assessment nurse with the DOH of [redacted], received her general orientation on 6/25/25, [redacted] [redacted] after her DOH.</p>	A 517		
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A 517	<p>Continued From page 7</p> <p>2. A Lifestyle Coordinator with the DOH of [redacted] received his general orientation on 6/25/25, over [redacted] [redacted] after his DOH.</p> <p>3. A Licensed Practical Nurse (LPN), a Shift Supervisor with the DOH of [redacted] received her general orientation on 6/25/25, [redacted] [redacted] after her DOH.</p> <p>4. A Resident Services Aide with the DOH of [redacted], received her general orientation on 6/25/25, [redacted] [redacted] after her DOH.</p> <p>On 10/16/25 at 9:04 a.m., the surveyor interviewed the ED and inquired about the general orientation that was provided to new employees. The ED stated that the Director of Administrative Services (DAS) usually provided a monthly general orientation to new hires. The ED stated that the DAS no longer worked for the facility and there was an internal transfer for a new DAS at the facility. The ED explained that the general orientations were not provided monthly during the transition period of the new DAS.</p> <p>During continued surveyor interview, the ED stated that the general orientation was not always provided to the employees immediately upon their DOH; however, they always received job-specific orientations upon their DOH.</p> <p>The surveyor reviewed a facility policy, "Employee Initial Training, Orientation & Annual In-Service," dated 4/08, which revealed, " ... The BOM is responsible for provision of General New Employee Orientation ..."</p>	A 517		

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A 709	Continued From page 8	A 709		
A 709	<p>8:36-7.2(d)(1-18) Health Care Assmnt. and Health Service Plan</p> <p>(d) Each health care assessment by the registered professional nurse shall include, at a minimum, evaluation of the following:</p> <ol style="list-style-type: none"> 1. Need for assistance with "activities of daily living"; 2. Cognitive patterns; 3. Communication/hearing patterns; 4. Vision patterns; 5. Physical functioning and structural problems; 6. Continence; 7. Psychosocial well-being; 8. Mood and behavior problems; 9. Activity pursuit patterns; 10. Disease diagnoses; 11. Health conditions and preventive health measures, including, but not limited to, pain, falls, and lifestyle; 12. Oral/nutritional status; 13. Oral/dental status; 14. Skin conditions; 15. Medication use; 	A 709		

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A 709	<p>Continued From page 9</p> <p>16. Special treatment and procedures;</p> <p>17. Restraint use; and</p> <p>18. Outside service utilization.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00188486</p> <p>Based on interview and record review, it was determined that the Registered Nurse (RN) failed to consistently obtain monthly ^{NJ Ex Order 26.4(c)} and/or perform the proper evaluation coordination of care after <u>NJ Ex Order 26. 4B1</u> of 8 residents reviewed, Residents #2, #3, and #4. This deficient practice was evidenced by the following:</p> <p>On 10/15/24 at 10:44 a.m., the surveyor reviewed Resident #2's medical record (MR), which revealed that the resident was admitted to the facility in ^{NJ Ex Order 26.4(b)(1)}, with diagnoses of ^{NJ Ex Order 26.4(b)(1)} and ^{NJ Ex Order 26.4(c)}. The surveyor reviewed Resident #2's Monthly ^{NJ Ex Order 26.4} Report dated from <u>NJ Ex Order 26.4(b)(1)</u>. The surveyor observed that Resident #2 ^{NJ Ex Order 26.4(b)(1)} <u>NJ Ex Order 26. 4B1</u> in ^{NJ Ex Order 26.4(b)(1)} and <u>NJ Ex Order 26. 4B1</u> in ^{NJ Ex Order 26.4(b)(1)}. The surveyor did not observe a ^{NJ Ex Order 26.4(b)(1)} recorded for <u>NJ Ex Order 26.4(b)(1)</u>. The surveyor observed that Resident #2 <u>NJ Ex Order 26. 4B1</u> between <u>NJ Ex Order 26.4(b)(1)</u>.</p> <p>Continued surveyor review of Resident #2's MR</p>	A 709		
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A 709	<p>Continued From page 10</p> <p>revealed that there was no documentation which reflected that the RN was notified of Resident #2's NJ Ex Order 26.4B1 or that the resident's physician was notified of the NJ Ex Order 26.4B1 between NJ Ex Order 26.4(b)(1).</p> <p>At 10:57 a.m., the surveyor reviewed Resident #3's closed MR, which revealed that the resident 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 observed that Resident #3 was NJ Ex Order 26.4B1. Surveyor review of Resident #3's Monthly NJ Ex Order 26.4 Report dated from NJ Ex Order 26.4(b)(1), revealed that there were no NJ Ex Order 26.4(i) documented for the resident.</p> <p>At 11:17 a.m., the surveyor reviewed Resident #4's MR, which revealed that the resident was admitted to the facility in NJ Ex Order 26.4(b)(1) with a diagnosis of NJ Ex Order 26.4(b)(1). Surveyor review of Resident #4's Monthly NJ Ex Order 26.4 Report dated from NJ Ex Order 26.4(b)(1), revealed that Resident #4 NJ Ex Order 26.4B1 in NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4B1 in NJ Ex Order 26.4(b)(1) a difference of NJ Ex Order 26.4 within NJ Ex Order 26.4(b)(1). The surveyor did not observe documented NJ Ex Order 26.4(i) for Resident #4 for NJ Ex Order 26.4(b)(1).</p> <p>Continued surveyor review of Resident #4's MR revealed there was no documentation which reflected that the RN or the resident's physician was notified of Resident #4's NJ Ex Order 26.4B1 between NJ Ex Order 26.4(b)(1).</p> <p>Additionally, the surveyor reviewed Resident #4's RN assessment dated NJ Ex Order 26.4(i), which documented that the resident was NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b) and NJ Ex Order 26.4. Surveyor review of Resident #4's NJ Ex Order 26.4 dated NJ Ex Order 26.4(b)(1), revealed that Resident #4 had documented interventions which</p>	A 709		
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A 709	<p>Continued From page 11</p> <p>included, " ... NJ Ex Order 26. 4B1 [REDACTED] ..."</p> <p>On 10/16/25 at 10:13 a.m., the surveyor interviewed a Medication Aide (MA) and inquired about changes in resident [REDACTED]. The MA stated that she would notify the RN of the [REDACTED] change and take the [REDACTED] again to double-check.</p> <p>At 10:16 a.m. and 1:33 p.m., the surveyor interviewed the Director of Wellness (DOW) and inquired about resident [REDACTED]. The DOW stated that resident [REDACTED] were taken every month. The DOW stated that if there were any concerns or discrepancies with the [REDACTED] the staff members were responsible to notify the nurses, who would then notify the [REDACTED].</p> <p>During continued surveyor interview, the DOW stated that she became aware of Resident #2's NJ Ex Order 26. 4B1 after the surveyor requested a copy of his/her Monthly [REDACTED] Report or [REDACTED]. Additionally, the DOW stated that she was unaware of Resident #4's NJ Ex Order 26. 4B1 [REDACTED] from February and March of 2025. The surveyor inquired about how frequently the [REDACTED] reviewed the residents [REDACTED] and the DOW stated that he reviewed a sample of residents monthly.</p> <p>The surveyor reviewed a facility policy titled, "Weights," dated 5/18/21, which revealed, " ... All Residents are weighed, at a minimum, once per month. Appropriate and indicated notifications, care planning, needed follow-up for Residents' demonstrating nutritional and/or weight gain/loss issues ... Documentation of weights into the Weight Log ... Notification of Resident's</p>	A 709		

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A 709	Continued From page 12 physician using the Weight Notification Form ..."	A 709		
A 891	8:36-10.5(a) Dining Services (a) The facility and personnel shall comply with the provisions of N.J.A.C. 8:24, Retail Food Establishments and Food and Beverage Vending Machines Chapter XII of the New Jersey Sanitary Code. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to store, label food, and maintain kitchen equipment in accordance with the provisions of Chapter 24, N.J.A.C. 8:24. "Sanitation in Retail Food Establishments and Food and Beverage Vending Machines," which placed the highly susceptible population of participants at risk for foodborne illnesses. This deficient practice was evidenced by the following: On 10/14/25 at 10:13 a.m., the Food Service Director (FSD) escorted the surveyor on a tour of the kitchen.	A 891		

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A 891	<p>Continued From page 13</p> <p>At 10:15 a.m., the surveyor observed three (3) opened boxes of NJ Ex Order 26.4(b)(1) Wine, which did not have the dates that they were opened documented on the packaging. The surveyor inquired about the labeling for the opened boxes of wine, and the FSD stated that the boxes of wine should have been dated with the dates that they were opened on and their expiration dates.</p> <p>At 10:28 a.m., the surveyor observed that the mixer was not in use and did not have a cover on it. The surveyor inquired about the cover for the mixer and the FSD stated that there was no cover for the mixer.</p> <p>At 10:29 a.m., the surveyor observed one scoop that was inside the container of all-purpose flour, one scoop that was inside the container of panko breadcrumbs, and one metal bowl and one scoop that was inside the container of brown rice. The surveyor inquired about the scoops and bowl that were in the three (3) containers and the FSD stated that the scoops were not normally kept in the containers.</p> <p>On 10/16/25 at 10:07 a.m., the surveyor returned to the kitchen and observed scoops inside the all-purpose flour and brown rice containers.</p> <p>On 10/14/25 at 10:30 a.m., during the continued kitchen tour with the FSD, the surveyor observed an opened bag of dried cranberries which was unlabeled, undated, and was not sealed. The surveyor inquired about the protocol for opened food and the FSD stated that the dried cranberries should have been re-wrapped and dated after opening.</p> <p>At 10:35 a.m., the surveyor toured the walk-in</p>	A 891		

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A 891	<p>Continued From page 14</p> <p>freezer and observed two (2) metal trays which had a total of six (6) pies that were uncovered, unlabeled, and undated in the walk-in freezer. Additionally, the surveyor observed four (4) baguettes which were stored between trays of uncooked meat and a package of tortillas that were opened and tortillas sticking out of the packaging. The surveyor inquired about the storage of food in the walk-in freezer and the FSD stated that all food should be covered, and the bread should not be in between or below the trays of meat.</p> <p>The surveyor reviewed a facility policy titled, "Receiving and Storage," dated 11/21/24, which revealed, " ... All items must be dated ... Raw and thawing meats must be stored below cooked and prepared items ... All opened items must be stored in airtight containers and bags; items should be labeled, dated with open and use by date, and always sealed ... All foods taken out of original container must be properly secured and covered ..."</p>	A 891		
A 901	<p>8:36-10.5(c)(4) Dining Services</p> <p>(c) Meals shall be planned, prepared, and served in accordance with, but not limited to, the following:</p> <p>4. Current menus with portion sizes and any changes in menus shall be posted in the food preparation area. Menus shall be posted in a conspicuous place in residents' area, and/or a copy of the menu shall be provided to each resident. Any changes or substitutes in menus shall be posted or provided in writing to each resident. Menus, with</p>	A 901		

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A 901	<p>Continued From page 15</p> <p>changes or substitutes, shall be kept on file in the facility for at least 30 days;</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain menus with portion sizes posted in the food preparation area for all residents who reside at the facility. This deficient practice was evidenced by the following:</p> <p>On 10/14/25 at 10:40 a.m., during the kitchen tour with the Food Service Director (FSD), the surveyor observed that there was no menu with the serving sizes posted near the food preparation area in the kitchen. The surveyor inquired about the menu with the serving sized and the FSD confirmed that there was no menu with the serving sizes posted in the food preparation area of the kitchen.</p> <p>The surveyor reviewed a facility policy titled, "Posting and Maintaining Cycle Menus and Diet Extensions," dated 6/24/25, which revealed, " ... Current dietitian approved cycle menus will be clearly posted in the food preparation area in the kitchen ... Menus will reflect portion sizes ... the Director of Food Service (DFS) is responsible for editing and posting cycle menus in the kitchen ..."</p>	A 901		

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A 999 A 999	<p>Continued From page 16</p> <p>8:36-11.7(e) Storage and Control of Medications</p> <p>(e) Discontinued or expired medications shall be destroyed within 30 days in the facility, or, if unopened and properly labeled, returned to the pharmacy for credit, if allowable, and in conformance with N.J.A.C. 13:39 and other State and Federal laws, codes, and regulations.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the Director of Wellness (DW) failed to ensure that discontinued and expired medications for residents receiving medication assistance, were removed from medication carts and/or central storage areas and disposed for 2 of 2 Unsampled Residents. This deficiency practice was evidenced by:</p> <p>On 10/15/25 at 11:00 a.m., during medication cart inspection on the 3rd floor with a Certified Medication Aide (CMA), the surveyor observed medications in the refrigerator.</p> <p>The surveyor observed medication labeled for Unsampled Resident #1, which revealed an order for NJ Ex Order 26. 4B1 [REDACTED]. The order indicated that Unsampled Resident #1, should receive an NJ Ex Order 26. 4B1 [REDACTED] one dose. The surveyor observed that the medication label had an expiration date of 12/22/24.</p> <p>The surveyor interviewed the CMA and inquired</p>	A 999 A 999		

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A 999	<p>Continued From page 17</p> <p>about the expired medication in the medication refrigerator. The CMA stated that she was not aware that the medication had expired. The CMA explained that the NJ Ex Order 26. 4B1 was administered only by a nurse. The surveyor asked the CMA how often medication refrigerator was inspected and the CMA replied that medication cart inspections were done every week by the licensed staff.</p> <p>On 10/16/25 at 10:53 p.m., the surveyor inspected the medication refrigerator in the wellness center on the 2nd floor with the License Practical Nurse (LPN), and observed that medication labeled for unsampled, Resident #2, revealed an order for NJ Ex Order 26. 4B1 [REDACTED]. The order indicated that Unsampled Resident #2, should receive NJ Ex Order 26. 4B1 [REDACTED] before meals per NJ Ex Order 26.4(b)(1) NJ Ex Order 26. 4B1 [REDACTED]. The surveyor observed that the medication label had an expiration date of 9/18/25.</p> <p>At 11:00 a.m., the surveyor interviewed the LPN and inquired about the expired medication in the medication refrigerator. The LPN stated that she was not aware that the medication had expired. The surveyor asked the LPN how often medication refrigerators were inspected and the LPN replied that CMAs and Nurses monitored the refrigerators and medication carts.</p> <p>The surveyor reviewed facility policy and procedure dated August 2013, titled "Disposal of Medications and Related Equipment ... "The Director of Wellness will assure: 2. Discontinued and expired medications for Residents receiving assistance with medication administration are</p>	A 999		

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A 999	Continued From page 18 removed from the medication cart and/or central storage areas and disposed of according to state and federal requirements ..."	A 999		
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 may participate in drills. This REQUIREMENT is not met as evidenced by: Based on a record review and interviews on 10/15/2025 and 10/16/2025 in the presence of the Director of Maintenance (DM), 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 participate in a community-wide	A1041		

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A1041	<p>Continued From page 19</p> <p>disaster drill. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>A record review of emergency preparedness drills indicate that the last community-wide disaster drill was conducted on 04/08/2024, over 18 months ago.</p> <p>In an interview at the time, the DM confirmed the record review and stated that they have not requested a joint drill or participated in a community-wide disaster drill since 04/08/2024.</p> <p>The facility's Executive Director and DM were informed of the deficient practices at the exit conference on 10/16/2025 at 1:30 PM.</p>	A1041		
A1095	<p>8:36-16.5(b) Automatic Fire Detection System</p> <p>(b) All fire detection systems shall be installed in accordance with the Uniform Construction Code, N.J.A.C. 5:23, N.J.A.C. 5:70 and the National Fire Alarm Code, National Fire Protection Association (NFPA) 72, 1999 Edition, incorporated herein by reference, as amended and supplemented.</p> <p>National Fire Protection Association publications are available from: NFPA, One Batterymarch Park, Quincy, MA, 02269-9101..</p> <p>This REQUIREMENT is not met as evidenced</p>	A1095		

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A1095	<p>Continued From page 20</p> <p>by: Based on record review and interviews on 10/15/2025 and 10/16/2025 in the presence of the Director of Maintenance (DM), it was determined that the facility failed to meet the requirements of N.J.A.C. 5:23 and 5:70 by not ensuring that the Fire Alarm System (FAS) was Inspected, Tested and Maintained (ITM) semi annually (every 6 months) in accordance with NFPA 72. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>A record review on 10/15/2025 revealed that ITM of the FAS was conducted on 01/31/2025 and 09/26/25, a few days shy of 8 months between inspections.</p> <p>In an interview at the time, the DM confirmed the record review.</p> <p>The facility's Executive Director and DM were informed of the deficient practice at the exit conference on 10/16/2025 at 1:30 PM.</p>	A1095		
A1097	<p>8:36-16.6 Fire Suppression Systems</p> <p>All facilities shall be provided with a fire suppression system in accordance with the Uniform Construction Code, N.J.A.C. 5:23.</p>	A1097		

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A1097	<p>Continued From page 21</p> <p>This REQUIREMENT is not met as evidenced by: Based on a record review and interviews on 10/15/2025 and 10/16/2025 in the presence of the Director of Maintenance (DM), it was determined that the facility failed to meet the requirements of N.J.A.C. 5:23 by not ensuring that the sprinkler system was Inspected, Tested and Maintained (ITM) quarterly (every 3 months) in accordance with NFPA 25. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>A record review on 10/15/2025 revealed that the wet and dry sprinkler systems were inspected on 04/24/2025 and 9/25/2025, 5 months between inspections.</p> <p>In an interview at the time, the DM confirmed the record review.</p> <p>The facility's Executive Director and DM were informed of the deficient practices at the exit conference on 10/16/2025 at 1:30 PM.</p>	A1097		
A1225	<p>8:36-17.3(b)(8)(i-ii) Resident Environment</p> <p>(b) The following safety conditions shall be met:</p> <p>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;</p>	A1225		

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A1225	<p>Continued From page 22</p> <p>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</p> <p>ii. The written statement shall be available for review by the Department during survey.</p> <p>This REQUIREMENT is not met as evidenced by: Based on a record review and interviews on 10/15/2025 and 10/16/2025 in the presence of the Director of Maintenance (DM), 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 had the potential to affect all residents and was evidenced by the following:</p> <p>A record review revealed that the last annual electrical inspection was conducted on 02/12/2024, over 20 months ago.</p> <p>In an interview at the time the DM confirmed the record review and stated that the annual inspection has not been conducted yet because they stopped using their old vendor and are still working on scheduling with a new one.</p>	A1225		

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A1225	Continued From page 23 The facility's Executive Director and DM were informed of the deficient practices at the exit conference on 10/16/2025 at 1:30 PM.	A1225		
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 observations and interviews on 10/15/2025 and 10/16/2025 in the presence of the Director of Maintenance (DM) it was determined that the facility failed to ensure that the building was kept free from fire hazards and other hazards to resident's health and safety by 1) Ensuring that all exit stairway enclosure doors self-closed and positive latched and 2.) Ensuring that penetrations through smoke/fire barriers were protected by a system or materials capable of restricting the transfer of fire/smoke. These deficient practices had the potential to affect all residents and was evidenced by the following:	A1249		

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A1249	Continued From page 24 An observation on 10/16/2025 at 10:56 AM revealed that the door to "Stair 5" on the fifth floor did not positive latch when tested. The handle lever on the inside of the door did not retract to release the latch which prevented the door from positive latching. In an interview at the time, the DM confirmed the observation and stated that they would have it repaired it as soon as possible. The facility's Executive Director and DM were informed of the deficient practices at the exit conference on 10/16/2025 at 1:30 PM.	A1249		
A1261	8:36-17.8(c) Laundry Services (c) All soiled laundry from resident rooms and other service areas shall be stored, transported, collected, and delivered in a covered laundry bag or cart. Laundry carts shall be in good repair, kept clean, and identified for use with either clean or soiled laundry. 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 all soiled laundry from resident rooms were collected and delivered in a covered laundry bag or cart for 1 of 8 residents reviewed, Resident #8. This deficient practice was evidenced by:	A1261		

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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
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A1261	<p>Continued From page 25</p> <p>On 10/14/25 at 11:19 a.m., during medication observation on the 4th floor with a Certified Medication Aide (CMA), the surveyor observed NJ Ex Order 26. 4B1 on the floor with NJ Ex Order 26.4(b) NJ Ex Order 26. 4B1 upon entering Resident #8's room. The surveyor interviewed the CMA about the NJ Ex Order 26. 4B1 NJ Ex Order 26. 4B1 and NJ Ex Order 26. 4B1 on the floor in the resident's room. The CMA confirmed the NJ Ex Order 26. 4B1 and stated that the NJ Ex Order 26. 4B1 were left on the floor after staff had provided morning care. Additionally, the CMA stated that the laundry should have been taken to the laundry room.</p> <p>The surveyor reviewed a facility policy titled, "Dirty Linen & Laundry" dated 12/15/16, which revealed, " ... Soiled linen must be placed into a clear plastic bags and filled no more than 2/3 full and securely tied at the neck; ... Used laundry is to be placed by the resident and/or staff into each resident's personal laundry bag to be collected by the laundry attendant ... All used /dirty linen and laundry is to be stored in a secure area until it is thoroughly cleaned. All collected laundry is to be cleaned same day or if collected after business hours laundered as soon as possible ..."</p>	A1261		
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The Bristol at Englewood

New Jersey Department of Health – Survey 10/16/2025

Complaint # NJ 00187685, NJ 00180363, NJ 00173104, NJ 00179007, NJ 00188486, NJ 00170385

A 310 (1)

Element 1

- a. Resident # 1 – Executive Director (ED) or designee will meet with this resident weekly to solicit feedback on their experience in the dining room as it pertains to wait times for the next 30 days.
- b. Resident # 2 – ED or designee will meet with this resident weekly to solicit feedback on their experience in the dining room as it pertains to wait times for the next 30 days.

On ^{NJ Ex Order 26, 481} a full time cook was hired. On 9/10/25 this full time cook assignment was adjusted to ensure adequate coverage during breakfast, lunch, and dinner. Part time cook position is posted for hire and expected to be filled by ^{NJ Ex Order 26}.

Element 2

All residents in the community have the potential to be affected by meal wait times.

ED or designee attended Resident Council meeting as requested by residents on 7/22/25 and monthly thereafter. ED or designee attendance to Food Council meetings started on 11/25/25 to solicit feedback on wait times and determine if other residents are affected by the deficient practice.

Element 3

Food Service Director (FSD) and Director of Dining Services (DDS) or designee will ensure meal tickets per table are delivered to grill/cold station first to address any specialty orders, allowing for main entrees to be processed at the plating station without additional delay.

A third seating will be introduced across all 3 meals.(1/2/26)

All dietary staff were re-educated on the Standard for Food Service policy by the FSD 10/22/25, including expectations for timely service and steps to escalate delays. Appetizer within 8-12 minutes of scheduled meal/seating time and entree within 25-35 minutes of scheduled meal/seating start time.

Effective immediately, meal service staffing assignments were adjusted to ensure adequate coverage during breakfast, lunch, and dinner.

Element 4

The FSD or designee will conduct meal-service time audits at least 5 times per week for 4 weeks, then 3 times per week for 1 additional month, rotating mealtimes (breakfast, lunch, dinner).

Wait-time data will be documented, trended, and reviewed at QA/QI meeting.

The ED ensures that these corrective actions and systemic changes will be implemented and monitored



through the facility's Quality Assurance Program to prevent recurrence of these deficiencies.

Completion Date: 1/31/26

A 310 (2)

Element 1

Resident # 1 – ED or designee will meet with this resident weekly to solicit feedback on their experience in the dining room as it pertains to table settings and cleanliness for the next 30 days. FSD or designee will inspect this resident's table setting 1 meal per day, 5 times per week for the next 4 weeks, then 1 meal per day, 3 times per week for 1 additional month, rotating mealtimes (breakfast, lunch, dinner).

Element 2

All residents in the community have the potential to be affected by improper table setting and clean/stained dishware.

Commencing 7/22/25, ED or designee will meet with the resident council representatives on a monthly basis, and attend monthly Food Council meetings monthly to solicit feedback on table setting cleanliness and determine if other residents are affected by the deficient practice.

Element 3

All dietary staff were re-educated on the Standard for Meal Service policy by the FSD 10/22/25, including expectations for neat and clean table settings and steps to escalate issues with settings that do not meet the standard.

Element 4

DDS or designee will inspect table settings, rotating meals (breakfast, lunch, dinner) at least 5 times per week for 4 weeks, then 3 times per week for 1 additional month.

The ED ensures that these corrective actions and systemic changes will be implemented and monitored through the facility's Quality Assurance Program to prevent recurrence of these deficiencies.

Completion Date: 1/31/26

A 310 (3) (4)

Element 1

Upon identification of the expired **NJ Ex Order 26. 4B1** for Unsamped Resident #1 and the expired **NJ Ex Order 26. 4B1** for Unsamped Resident #2, both medications were immediately removed from the medication refrigerators on 10/15/25 and 10/16/25 respectively. The medications were destroyed in accordance with N.J.A.C. 13:39, pharmacy requirements, and facility policy. The Director of Wellness (DOW) reviewed both residents' Medication Administration Records (MARs) and confirmed that no expired medication had been administered and **NJ Ex Order 26.4(b)(1)** resident outcomes resulted from this deficient practice. A full inspection of the 2nd and 3rd floor medication storage areas was completed to ensure no additional expired or discontinued medications were present.



Element 2

All residents receiving medication administration/assistance have the potential to be affected by medication expiration dates.

A facility-wide audit of all medication carts, central storage areas, and medication refrigerators was completed 10/17/25. The audit included review of all expiration dates, discontinued medications, and labeling accuracy for all residents receiving medication assistance.

Element 3

The "Disposal of Medications and Related Equipment" policy was reviewed to clarify staff responsibility for removing discontinued and expired medications and ensuring destruction within 30 days, in compliance with N.J.A.C. 13:39. 10/17/25

Certified Medication Aides (CMA's), prior to medication pass and before providing assistance with medication, will inspect expiration dates and any orders to discontinue medications. Licensed Practical Nurses (LPNs) or designee will perform bi-weekly inspections of medication carts and medication refrigerators, to ensure medication expiration dates have not passed and discontinued medications have been removed from aforementioned areas.

The Director of Wellness or designee will complete monthly audits of all medication storage areas and document findings.

The DOW or designee will review the Discontinued Medication report weekly to ensure identification and removal of medications once discontinued by the prescriber.

Element 4

The ED or designee will ensure the Director of Wellness completes monthly audits of all medication storage areas and document findings. Audit results will be reviewed during the facility's QAPI meetings and by the Pharmacy Consultant during quarterly reviews.

Any identified non-compliance will result in immediate corrective action, including retraining of staff and increased monitoring.

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: 1/31/26

A 517

Element 1

All employees identified during the survey employee # 1, employee # 2, employee # 3, employee # 4 have received the full General Orientation curriculum as stated in SOD.

Their orientation documentation has been completed, placed in their electronic personnel files, and reviewed by the Executive Director to ensure accuracy and compliance.



Element 2

All residents in the community have the potential to be affected by employees not completing orientation within 30 days of hire.

On 11/3/2025, a full audit of all current employee files (100%) was completed by the ED and Director of Administrative Services (DAS) to verify the presence of required General Orientation documentation for all active employees.

No additional employees were identified as missing general orientation requirements at the time of the audit.

Element 3

The following systemic changes have been implemented:

Orientation Process: Responsibility for providing and documenting General Orientation is managed by the Director of Administrative Services, as outlined in facility policy, ensuring clarity and continuity. DAS or designee will send an email to all new hires, that includes the ED and the new hires direct report, notifying them of the scheduled date of New Hire Orientation.

Orientation Scheduling Protocol: General Orientation will occur within the first 30 days of hire for all new employees. A backup facilitator, ED or designee, has been designated to ensure orientation is conducted even during staff transitions or absences.

Element 4

In addition to the full audit of employee files conducted on 11/3/25, the ED or designee will complete monthly audits of all new-hire electronic files for three (3) months to verify that General Orientation was completed within the required timeframe and that documentation is present.

The results of these audits will be reviewed in the Quality Assurance and Performance Improvement (QAPI) meeting. Any deviations will result in immediate retraining and corrective action.

Completion Date: 2/28/25

A 709

Element 1

- a. Resident # 2 – The recorded ^{NJ Ex Order 26.4(b)} [redacted] was entered in error and struck from the medical record by DOW (Director of Wellness), RN.
- b. Resident # 3 – Resident no longer resides at facility.
- c. Resident # 4 – ^{NJ Ex Order 26.4B1} [redacted] documented for October 2025 and notifications made to responsible party, PCP, dietician, and hospice provider. Going forward, any ^{NJ Ex Order 26.4(b)(1)} [redacted] ^{NJ Ex Order 26.4(b)(1)} will be reported to the aforementioned parties, and updated care-plan interventions to be entered as needed by RN/DOW.



Element 2

All residents in the community have the potential to be affected by breakdown in monthly weight process.

On 11/19/25, the DOW completed a 100% audit of all residents' Monthly Weights for the current month to identify:

- Missing monthly weights
- Significant weight changes (5% in 30 days, 10% in 180 days)
- Lack of documentation of RN/physician notification as it relates to weight.
- Incomplete follow-up or care-plan updates as it relates to weight.

Any resident identified with missing weights or unaddressed weight changes was:

- Re-weighed immediately.
- Reported to the physician and dietitian if there was a significant weight change.
- Notify Resident's responsible party.
- Provided updated care-plan interventions as needed related to weight.

The audit findings were summarized and reviewed with the ED and DOW for system-level corrections.

Element 3

On 11/21/25, the "Weights" policy was reviewed and nursing staff, medication aides, and caregivers re-educated emphasizing:

- Monthly weights must be completed and documented each month.
- Any resident refused weight must be documented and explained.
- Any weight change meeting facility thresholds must be reported to the RN/DOW.
- DOW or designee will review weights prior to end of month.

Element 4

In addition to the audit completed on 11/19/25, the DOW or designee will conduct a monthly audit of 100% of resident weights to confirm:

- All weights were obtained
- All significant losses/gains were reported
- Notifications to physicians and dietitians were documented
- Care plans were updated as needed

Weight-trend data and audit results will be reviewed at the QAPI meeting. Corrective actions or retraining will be implemented for any downward trends in compliance.

The ED or designee will conduct random chart audits monthly for (2) months, 10 resident records each month, to verify full policy implementation.

Completion Date: 1/31/26



A 891

Element 1

No specific resident identified.

Element 2

All residents in the community have the potential to be affected by food storage practices.

On 10/18/25, audit of all dry storage, refrigerators, freezers, and food-prep equipment was conducted by the FSD.

The audit included checks for:

Proper food labeling (opened dates and use-by dates)
Sealing and covering of all opened food items
Correct storage hierarchy (raw foods below ready-to-eat foods)
Absence of utensils or bowls in bulk storage containers
Proper covering/clean storage of equipment
Any items found out of compliance were immediately corrected.

The audit confirmed that all food areas were restored to compliance on 11/11/25.

Element 3

Re-training of all dietary staff:

1. On 11/11/25, mandatory in-service training on the Receiving and Storage policy and N.J.A.C. 8:24 requirements for labeling, dating, sealing, and food-storage hierarchy was completed.
2. Training included examples of acceptable labeling and practices for dry goods, refrigerated items, and frozen products.

Only approved utensils are permitted for bulk food handling; on 11/18/25, new sanitary scoop holders were installed outside all bulk bins. On 11/17/25, a new mixer cover was received and will be used whenever the mixer is not in use.

Element 4

The Food Service Director or designee will conduct a weekly comprehensive audit of all kitchen storage areas and equipment, documenting findings and following up immediately on any discrepancies.

Results of the weekly audits will be presented to the facility's Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will:

- Review trends
- Ensure corrective actions are sustained.
- Recommend additional interventions if compliance falls below 100%



This monitoring process, overseen by ED or designee, will remain in place for at least two (2) months, or longer if identified as necessary by QAPI.

Completion Date: 1/31/26

A 901

Element 1

No specific resident identified.

Element 2

All residents in the community have the potential to be affected by food portion sizes.

On 10/17/25, upon identification of the deficient practice, the Food Service Director (FSD) immediately obtained the current dietitian-approved cycle menu with clearly indicated portion sizes and posted it in the food preparation area. On 10/17/25, the FSD reviewed the menu with kitchen staff to ensure that all staff are aware of appropriate portion sizes for all meals served and the location of the posted menu with portion sizes.

Element 3

The FSD will maintain a designated "Menu Posting Station" in the food preparation area where the most current cycle menu and portion sizes must be displayed at all times. All dietary staff have been re-trained on the facility's "Posting and Maintaining Cycle Menus and Diet Extensions" policy, including the requirement to follow posted portion sizes.

Element 4

The FSD or designee will conduct weekly audits for (2) months to verify that the current menu with portion sizes is posted in the food preparation area.

Completion Date: 12/17/25

A 999

Element 1

Upon identification of the expired **NJ Ex Order 26. 4B1** for Unsamped Resident #1 and the expired **NJ Ex Order 26. 4B** for Unsamped Resident #2, both medications were immediately removed from the medication refrigerators on 10/15/25 and 10/16/25 respectively. The medications were destroyed in accordance with N.J.A.C. 13:39, pharmacy requirements, and facility policy. The Director of Wellness reviewed both residents' MARs and confirmed that no expired medication had been administered and **NJ Ex Order 26.4(b)(1)** resident outcomes resulted from this deficient practice. A full inspection of the 2nd and 3rd floor medication storage areas was completed to ensure no additional expired or discontinued medications were present.



Element 2

All residents receiving medication administration/assistance have the potential to be affected by medication expiration dates.

On 10/17/25, all medication carts, central storage areas, and medication refrigerators were audited to ensure no expired/discontinued medication were present and medications labeled accurately. The audit included review of all expiration dates, discontinued medications, and labeling accuracy for all residents receiving medication assistance.

Element 3

The "Disposal of Medications and Related Equipment" policy was reviewed to clarify staff responsibility for removing discontinued and expired medications and ensuring destruction within 30 days, in compliance with N.J.A.C. 13:39. 10/17/25

CMAs, prior to medication pass and before providing assistance with medication, will inspect expiration dates and any orders to discontinue medications. LPNs or designee will perform bi-weekly inspections of medication carts and medication refrigerators, to ensure medication expiration dates have not passed and discontinued medications have been removed from aforementioned areas.

The Director of Wellness or designee will complete monthly audits of all medication storage areas and document findings.

The DOW or designee will review the Discontinued Medication report weekly to ensure identification and removal of medications once discontinued by the prescriber.

Element 4

In addition to the initial audit completed on 10/17/25, the ED or designee will ensure the Director of Wellness completes monthly audits of all medication storage areas and document findings. Audit results will be reviewed during the facility's QAPI meetings and by the Pharmacy Consultant during quarterly reviews.

Any identified non-compliance will result in immediate corrective action, including retraining of staff and increased monitoring.

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: 12/17/25

A 1041

Element 1

No specific resident identified.

Element 2

Failure to conduct mandatory drills can affect all residents during an emergency.



Element 3

On 11/13/25, 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 re-educated the DOM regarding the fire and disaster drill process and requirement.

Element 4

In addition to the drill scheduled for 12/2/25, 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: 12/2/25

A 1095

Element 1

No specific resident identified.

Element 2

Failure to conduct tests on the required cadence can affect all residents.

Element 3

The DOM or designee will contact the Contracted company in January of every year to confirm scheduled dates within the months of January & July 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 11/20/25, the Executive Director re-educated the DOM regarding the automatic fire detection system inspection process and requirement.

Element 4

The ED or designee will ensure the completion of the task in TELS by reviewing the weekly task report. 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: 2/28/26

A 1097

Element 1

No specific resident identified.



Element 2

Failure to conduct tests on the required cadence can affect all residents

Element 3

The DOM or designee will contact the Contracted company in January of every year to confirm scheduled dates, every three months, of that calendar year. This will be entered into our electronic maintenance task tracking tool (TELS); accessible to ED, Reg. Director of Maintenance, & RVPO. On 11/20/25, the Executive Director re-educated the DOM regarding the fire suppression systems inspection process and requirement.

Element 4

The ED or designee will ensure the completion of the task in TELS by reviewing the weekly task report. The effectiveness of the corrective action will be audited during the community's next two QAPI meetings.

Completion Date: 4/30/26

A 1225

Element 1

No specific resident identified.

Element 2

Failure to conduct annual test can affect all residents.

Element 3

The DOM identified a new vendor. Scheduled site visit occurred on 11/7/2025. 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, & RVPO. On 11/13/25, 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: 11/7/25

A 1249

Element 1

No specific resident identified. The door to Stair 5 on the 5th floor was repaired 10/17/25 and now positively latches. The fire/smoke barrier penetration in the affected area was sealed 10/17/25, restoring the integrity of the barrier.



Element 2

Positively latched stairway enclosure doors & unprotected smoke/fire barriers can affect all residents.

Element 3

The preventative maintenance schedule has been updated to require monthly testing of all stairwell enclosure doors. Which will include self-closing, latch-functioning, and door integrity. All exit stairway enclosure doors were checked to ensure self-closure and positive latching on 11/20/25 by the DOM. On 11/13/25, the Executive Director re-educated the DOM regarding the requirements for all exit stairway enclosure doors.

Element 4

On 11/20/25, a full building fire barrier integrity check was completed to ensure all penetration areas were identified and meet the standards of the buildings and grounds maintenance. All areas in compliance.

The ED or designee will ensure the completion of the task in TELS by reviewing the weekly task report. All audit results will be reviewed at the next QAPI meeting. Any failures or correction actions will result in an immediate re-training.

Completion Date: 11/20/25

A 1261

Element 1

ED or Designee will check Resident # 8 apartment, two times per week for 30 days, to ensure the proper procedure for NJ Ex Order 26, 4B1 laundry is being followed.

Element 2

All residents in the community receiving housekeeping services have the potential to be affected by breakdown in soiled linen/laundry processes.

ED or designee will choose 5 different occupied apartments, per week, for 30 days, to spot check and ensure the proper procedure for soiled linen/laundry is being followed.

Element 3

Wellness, Reflections, & Housekeeping team members, were re-educated on the dirty linen & laundry policy by the DOW & Housekeeping Director on 11/30/25, including expectations for securing soiled items, demonstrating securing in clear plastic bag and location of placing secured bag.

Element 4

On 11/24/25, an audit of soiled linen/laundry process was completed. Three deficient areas were identified by the audit and were corrected. The Housekeeping Director or designee will conduct in-person audits of resident apartments on a weekly basis.

ED ensures that these corrective actions and systemic changes will be implemented and monitored through the facility's Quality Assurance Program to prevent recurrence of these deficiencies.

Completion Date: 12/17/25

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 02A029	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 12/17/2025
Y1	Y2	Y3
NAME OF FACILITY BRISTAL AT ENGLEWOOD, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 412 SOUTH VAN BRUNT STREET ENGLEWOOD, NJ 07631

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 A0517	Correction	ID Prefix A0709	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-5.6(b)(1-7)	Completed	Reg. # 8:36-7.2(d)(1-18)	Completed
LSC	12/17/2025	LSC	12/17/2025	LSC	12/17/2025
ID Prefix A0891	Correction	ID Prefix A0901	Correction	ID Prefix A0999	Correction
Reg. # 8:36-10.5(a)	Completed	Reg. # 8:36-10.5(c)(4)	Completed	Reg. # 8:36-11.7(e)	Completed
LSC	12/17/2025	LSC	12/17/2025	LSC	12/17/2025
ID Prefix A1041	Correction	ID Prefix A1095	Correction	ID Prefix A1097	Correction
Reg. # 8:36-14.3(a)	Completed	Reg. # 8:36-16.5(b)	Completed	Reg. # 8:36-16.6	Completed
LSC	12/17/2025	LSC	12/17/2025	LSC	12/17/2025
ID Prefix A1225	Correction	ID Prefix A1249	Correction	ID Prefix A1261	Correction
Reg. # 8:36-17.3(b)(8)(i-ii)	Completed	Reg. # 8:36-17.7	Completed	Reg. # 8:36-17.8(c)	Completed
LSC	12/17/2025	LSC	12/17/2025	LSC	12/17/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 10/16/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		