

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 16A023	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/24/2025
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NAME OF PROVIDER OR SUPPLIER BRISTAL AT WAYNE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1440 HAMBURG TURNPIKE WAYNE, NJ 07470
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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
A 000	<p>Initial Comments</p> <p>Initial Comments: CENSUS: 136 SAMPLE SIZE: 5</p> <p>TYPE OF SURVEY: Standard Survey and Life Safety Code survey of 152 residential units</p> <p>The facility is not in substantial compliance with all the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs.</p> <p>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> <p>A Life Safety Code Survey was conducted by the State Agency on 10/24/2025. The facility was not in substantial compliance with New Jersey Administrative Code, Chapter 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs.</p>	A 000		
A 749	<p>8:36-7.3(a) Resident Assessments and Care Plans</p> <p>(a) The resident general service plan shall be reviewed and, if necessary, revised semi-annually, and more frequently as needed based upon the resident's response to the care provided and any changes in the resident's physical or cognitive status.</p>	A 749		

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

TITLE

(X6) DATE

12/16/25

New Jersey Department of Health

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A 749	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>2. A "Move In Record" indicated the facility admitted Resident #4 on NJ ex order 26.4b1. According to the Move In Record, the resident had a NJ ex order 26.4b1</p> <p>Resident #4's "Service Plan Report" indicated the most recent service plan review was completed on NJ Exec Order 26.4b1</p> <p>During an interview on 10/24/2025 at 4:57 PM, the DOW stated the completion of general service plans had backed up over a one-month period. The DOW stated that she realized they needed a plan in place to correct the problem. She stated that it was her expectation that the service plans be updated every six months. The DOW stated that the service plans reflected resident care needs. She stated that the service plans could also be updated as needed or with a change in condition. The DOW stated that from that point on, she and the Assistant Director of Nursing would be responsible for completing the service plans.</p> <p>During an interview on 10/24/2025 at 4:43 PM, the Executive Director (ED) stated that the RNs were responsible for updating the service plans. The ED further stated that the workload had increased with hospital stays, rehabilitation, and new admissions. The ED stated that the service plans were due every six months and more often if there was a change in condition. The ED stated that it was her expectation that the service plans</p>	A 749		

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A 749	<p>Continued From page 2</p> <p>be completed every six months. The ED stated that the facility discovered the service plans were behind, and they put a performance improvement plan in place effective 08/01/2025 with an expected completion date of 12/31/2025.</p> <p>Based on facility policy review, record review, and interview, the facility failed to ensure general service plans were reviewed by a registered nurse (RN) every six months for 2 (Resident #1 and Resident #4) of 5 residents reviewed for service plan requirements.</p> <p>Findings included:</p> <p>1. A facility policy titled, "Medical Evaluation, RN Assessments, General and Health Service Plan," revised 06/07/2022, revealed, "General Service Plan (GSP)" included, "b. GSPs will be reviewed by the RN (with documentation of review) and, if needed, revised: i. semi-annually."</p> <p>A "Move In Record" indicated the facility admitted Resident #1 on NJ ex order 26.4b1. According to the Move In Record, the resident had a medical history that included diagnoses of NJ ex order 26.4b1 [REDACTED]</p> <p>Resident #1's "Service Plan Report" indicated the most recent review was completed on NJ Exec Order 26.4b1</p> <p>During an interview on 10/24/2025 at 4:05 PM, the Regional Director of Healthcare (RDOH) stated that the Director of Wellness (DOW) and their assistant were responsible for monitoring the service plans. The RDOH stated she expected the service plans to be completed every six months.</p>	A 749		
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A 749	Continued From page 3 During an interview on 10/24/2025 at 4:57 PM, the DOW stated the completion of general service plans had backed up over a one-month period. The DOW stated that she realized they needed a plan in place to correct the problem. The DOW stated the expectation was for the service plans to be reviewed every six months to reflect the residents' care needs. She stated that the service plans could also be updated as needed or with a change in condition. The DOW stated Resident #1's service plan was two months behind, and it was completed that day NJ ex order 26.4b1 .	A 749		
A1249	8:36-17.7 Housekeeping-Sanitation-Safety-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 facility policy review, facility document review, and interview, the facility failed to exercise their emergency generator monthly under load for at least 30 minutes according to National Fire	A1249		

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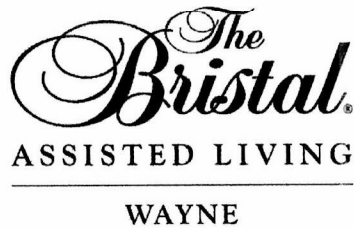
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A1249	<p>Continued From page 4</p> <p>Protection Association (NFPA) 110, Standard for Emergency and Standby Power Systems, for 8 of 12 months reviewed. The deficiency had the potential to affect all the residents in the facility.</p> <p>Findings included:</p> <p>An undated policy titled, "Maintenance Standards" indicated, "Maintenance of the physical plant is the primary focus of the Maintenance Department in order to provide a safe, homelike atmosphere for our residents and a safe place for our staff members to work." The policy revealed, "Life Safety Standards" included, "Emergency Generator (where applicable) operable, regularly serviced and tested in accordance with local codes or NFPA with run log available for review (exception of generator is [sic] on automatic timer)."</p> <p>A facility document titled, "Logbook Report," generated on 10/24/2025 for the prior 12 months, revealed "Logbook Documentation" revealed monthly generator load tests were performed for less than 30 minutes on 10/29/2024 (five minutes) and 01/26/2025 (five minutes). There was also no documented evidence of a monthly generator load test for 11/2024, 12/2024, 02/2025, 03/2025, 04/2025, or 06/2025.</p> <p>During an interview on 10/24/2025 at 1:25 PM, the Director of Maintenance (DOM) stated that he was aware of the requirement to exercise the generator monthly under load for a least 30 minutes. He acknowledged that the generator was not exercised under load for 30 minutes during 10/2024, 11/2024, 12/2024, 01/2025, 02/2025, 03/2025, 04/2025, 04/2025, or 06/2025. The DOM stated he expected the generator to be exercised monthly under load for at least 30</p>	A1249		

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A1249	Continued From page 5 minutes. During an interview on 10/24/2025 at 1:40 PM, the Executive Administrator (ED) stated the previous DOM and now the current DOM were responsible for ensuring the generator was exercised monthly under load for at least 30 minutes. She stated that she was not aware that the monthly load tests were not completed because she did not review the generator inspection documentation. The ED stated that she expected the generator to be exercised monthly under load for at least 30 minutes.	A1249		



The Bristol at Wayne

New Jersey Department of Health – Survey 10/24/2025

A 749

Element 1

Resident #1: The overdue general service plan review was completed on [redacted] by the Director of Wellness (DOW), ensuring that all current physical, cognitive, and care needs were accurately reflected.

Resident #4: The overdue general service plan review was completed on [redacted] by the DOW, ensuring that all current physical, cognitive, and care needs were accurately reflected.

Both residents' service plans were reviewed and revised as needed based on current condition, ensuring compliance with the semi-annual requirement and any additional updates required by change in condition.

Element 2

All residents in the community have the potential to be affected by untimely service plan review and completion.

A facility-wide audit of all residents' General Service Plans (GSPs) was initiated on 8/1/2025 to be completed by 12/31/25 to identify any overdue semi-annual service plan reviews.

Any residents found to have plans approaching or past the six-month due date were immediately scheduled for RN review and revision to ensure full compliance.

Element 3

Nursing staff (DOW, ADOW) received re-education on regulatory requirement for semi-annual RN reviews and updating plans with change of condition as per regulation 8:36-7.3(a) Resident Assessments and Care Plans. 12/15/2025

The Executive Director (ED), DOW, and Assistant Director of Wellness (ADOW) jointly review workload assignments weekly to ensure staffing and time allocation for service plan completion.

The electronic medical record dashboard will be reviewed daily during community morning meeting to identify any residents due for a 6-month assessment and appropriately scheduled to ensure compliance.

Element 4

The ED or designee will review the service plan dashboard in the electronic medical record monthly to verify that due dates are being met and that no backlogs are developing.

The ED ensures that these corrective actions and systemic changes will be implemented and monitored through the facility's Quality Assurance Performance Improvement (QAPI) program to prevent recurrence of these deficiencies. QAPI committee will assess compliance trends, determine if further action is needed, and make recommendations.

Completion Date: 12/31/25

A 1249

Element 1

No specific resident identified.

Element 2

All residents in the community have the potential to be affected by improper and inconsistent testing of the generator.

Element 3

The Director of Maintenance (DOM) and the ED received retraining by the Regional Director of Maintenance on NFPA 110 requirements, documentation standards, and life safety compliance expectations. 10/27/25

The ED was educated on the importance of reviewing generator logs monthly. 10/27/25

Element 4

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.

Completion Date: 03/09/2026

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 16A023	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 12/23/2025
Y1	Y2	Y3
NAME OF FACILITY BRISTAL AT WAYNE, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1440 HAMBURG TURNPIKE WAYNE, NJ 07470

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 A0749	Correction	ID Prefix A1249	Correction	ID Prefix	Correction
Reg. # 8:36-7.3(a)	Completed	Reg. # 8:36-17.7	Completed	Reg. #	Completed
LSC	12/31/2025	LSC	03/09/2026	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <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 10/24/2025		<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		