

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30A004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/17/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BRIGHTON GARDENS OF WEST ORANGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>220 PLEASANT VALLEY WAY</b> <b>WEST ORANGE, NJ 07052</b>
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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: Type of Survey: Complaint</p> <p>Complaint #: NJ00188575</p> <p>Census: 87</p> <p>Sample Size: 3</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 313	<p>8:36-3.4(a)(4) Administrator's Responsibilities</p> <p>(a) The administrator or designee shall be responsible for, but not limited to, the following:</p> <p>4. Ensuring the provision of staff orientation and staff education;</p> <p>This REQUIREMENT is not met as evidenced by: Complaint#: NJ00188575</p>	A 313		

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

TITLE

(X6) DATE

11/14/25

New Jersey Department of Health

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A 313	<p>Continued From page 1</p> <p>Based on interview and record review, it was determined that the Executive Director (ED) failed to provide staff education after a resident [redacted] the facility for 1 of 3 residents reviewed, Resident #3. This deficient practice was evidenced by the following:</p> <p>On 8/22/2025 at 9:25 a.m., the Department of Health (DOH) received a Facility Reportable Event (FRE) (A document used by health care facilities to report events) dated [redacted], regarding a resident [redacted] the facility on [redacted]. According to the FRE, on [redacted] at 2:00 p.m., the care manager, reported seeing Resident #3 [redacted]. Resident #3 was [redacted] the community around 2:25 p.m. Further review of the FRE indicated that Resident #3 was assessed by the nurse and sent to the hospital for evaluation due to [redacted].</p> <p>On 9/17/25 at 9:55 a.m., the surveyor reviewed the Electronic Medical Record (EMR) which revealed that Resident #3 had a move in date of [redacted] with diagnoses of [redacted] and [redacted].</p> <p>The surveyor received a Staff list with 87 staff names listed. The surveyor reviewed a [redacted] document titled, "Drill Attendance Record" for [redacted] Resident" for the 3rd shift with 5 names listed.</p> <p>At 12:28 p.m., the surveyor interviewed the ED and the Director of Nursing (DON), in the presence of the Regional Clinical Director (RCD) about if any education was provided to staff after the [redacted] incident for Resident #3, the ED stated that Resident #2 was not [redacted] prior to the time of the incident on [redacted].</p>	A 313		

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A 313	<p>Continued From page 2</p> <p>The DON stated that since the [redacted] resident drill was conducted monthly and Resident #3 was [redacted] in a timely manner, the DON confirmed that she had not conducted training with staff after the [redacted] incident.</p> <p>The surveyor reviewed the 8/7/25 facility policy titled, "Missing Resident" revealed "Policy Statement: It is the policy of every [facility] community to provide a safe resident environment to reduce the incident of missing resident and elopement events. and promote resident safety. ..."Procedure: a. The Executive Director (ED) is responsible for overseeing the Missing Resident Policy. 2. The ED/designee conducts training via the Missing resident drills ... 3. All communities use the Drill Attendance Sheet to capture team member participation..."</p>	A 313		
A 401	<p>8:36-4.1(a)(22) Resident Rights</p> <p>(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:</p> <p>22. The right to live in safe and clean conditions in a facility that does not admit more residents than it can safely accommodate while providing services and care;</p> <p>This REQUIREMENT is not met as evidenced</p>	A 401		

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A 401	<p>Continued From page 3</p> <p>by: Complaint#: NJ00188575</p> <p>Based on observation, interview and record review, it was determined that the facility failed to ensure a safe environment for a resident who <b>NJ Ex Order 26.4(b)(1)</b> the facility, for 1 of 3 residents reviewed, Resident #3. This deficient practice was evidenced by the following:</p> <p>On 8/22/2025 at 9:25 a.m., the Department of Health (DOH) received a Facility Reportable Event (FRE) (A document used by health care facilities to report events) dated <b>NJ Ex Order 26.4(b)(1)</b>, regarding a resident <b>NJ Ex Order 26.4(b)(1)</b> the facility on <b>NJ Ex Order 26.4(b)(1)</b>. According to the FRE, on <b>NJ Ex Order 26.4(b)(1)</b> at 2:00 p.m., the care manager, reported seeing Resident #3 <b>NJ Ex Order 26.4(b)(1)</b>. Resident #3 was <b>NJ Ex Order 26.4(b)(1)</b> the community around 2:25 p.m. Further review of FRE indicated that Resident #3 was assessed by the nurse and sent to the hospital for evaluation due to <b>NJ Ex Order 26.4(b)(1)</b>.</p> <p>On 9/17/25 at 9:45 a.m., during the entrance, the surveyor interviewed the Executive Director (ED) regarding Resident #3's <b>NJ Ex Order 26.4(b)(1)</b> the ED stated that Resident #3 was not at risk for <b>NJ Ex Order 26.4(b)(1)</b>. The ED stated that Resident #3 usually <b>NJ Ex Order 26.4(b)(1)</b>, and staff was aware that Resident #3 usually <b>NJ Ex Order 26.4(b)(1)</b> every day after lunch around 1:30 p.m. The ED stated that Resident #3 was not <b>NJ Ex Order 26.4(b)(1)</b> at the time of the <b>NJ Ex Order 26.4(b)(1)</b> admission assessment.</p> <p>At 9:55 a.m., the surveyor review of the Electronic Medical Record (EMR) revealed Resident #3 had a move in date of <b>NJ Ex Order 26.4(b)(1)</b> with diagnoses of <b>NJ Ex Order 26.4(b)(1)</b> and <b>NJ Ex Order 26.4(b)(1)</b>. The surveyor review of</p>	A 401		

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A 401	<p>Continued From page 4</p> <p>Resident #3's Progress Notes (PNs) revealed a PN dated [redacted] at 3:58 p.m., written by the Director of Nursing (DON), revealed that Resident #3 was [redacted] and [redacted] the facility by staff on [redacted] at 2:25 p.m. The PN further revealed that Resident #3 was transferred to the hospital for [redacted].</p> <p>At 12:28 p.m., the surveyor asked the ED, and DON in the presence of regional clinical director (RCD) if any education to staff was completed on [redacted] since the incident with Resident #3. The ED explained that the resident was not an [redacted] risk prior to the time of incident. The DON stated that because the [redacted] resident drill was conducted monthly, that was why Resident #3 was found in a timely [redacted]. The DON confirmed that she had not conducted training with staff after the [redacted] incident.</p> <p>At 2:13 p.m., the surveyor interviewed the Care Manager (CM) who saw Resident #3 along the road as she was on her way to work and inquired about the incident. The CM stated that she saw Resident #3 [redacted]. The CM explained that she was not the [redacted] and she could not stop to assist Resident #3. So, she arrived at the facility and notified the ED.</p> <p>During continued interview, the CM further explained that Resident #3 usually [redacted] and [redacted]. The surveyor asked the CM if she had completed any training on [redacted] since the incident with Resident #3, the CM confirmed that she was not educated on [redacted] after the incident.</p> <p>The facility failed to ensure that Resident #3, was safe in the community by failing to [redacted].</p>	A 401		

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A 401	<p>Continued From page 5</p> <p>Resident #3's <b>NJ Ex Order 26.4(b)(1)</b> until an incoming staff member notified the ED that Resident #3 was <b>NJ Ex Order 26.4(b)(1)</b> the facility.</p> <p>The surveyor reviewed the 8/7/25 facility policy titled, "Missing Resident" revealed "Policy Statement: It is the policy of the [facility] community to provide a safe resident environment to reduce the incidence of missing resident and elopement events. and promote resident safety...</p> <p>Definitions: Missing Resident: A resident is missing if team members do not know their whereabouts,...Elopement: when a resident who exhibits symptoms or behaviors associated with cognitive impairment leaves the community perimeter, including the building and the parking lot, unsupervised, unnoticed and out of line of sight..."</p>	A 401		
A1073	<p>8:36-15.6(b) Resident Records</p> <p>(b) All assessments and treatments by health care and service providers shall be entered according to the standards of professional practice. Documentation and/or notes from all health care and service providers shall be entered according to the standards of professional practice.</p> <p>This REQUIREMENT is not met as evidenced</p>	A1073		

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A1073	<p>Continued From page 6</p> <p>by: Complaint#: NJ00188575</p> <p>Based on interview and record review, the facility failed to provide documentation of a thorough investigation to include witness statements and staff education after a resident [redacted] the facility for 1 of 3 residents reviewed, Resident #3. This deficient practice was evidenced by the following:</p> <p>On [redacted] at 9:25 a.m., the Department of Health (DOH) received a Facility Reportable Event (FRE) (A document used by health care facilities to report events) dated [redacted] regarding a resident [redacted] the facility on [redacted]. According to the FRE, on [redacted] at 2:00 p.m., the care manager (CM), reported seeing Resident #3 [redacted] Resident #3 was [redacted] around 2:25 p.m. Further review of FRE indicated that Resident #3 was assessed by the nurse and sent to the hospital for evaluation due to [redacted]</p> <p>On 9/17/25 at 9:45 a.m., during the entrance, the surveyor interviewed the Executive Director (ED) regarding Resident #3's [redacted] the ED stated that Resident #3 was [redacted] for [redacted] or [redacted]. The ED stated that Resident #3 usually [redacted] through the [redacted] and staff was aware that Resident #3 usually [redacted] after lunch around 1:30 p.m. The ED stated that Resident #3 was not [redacted] at the time of the [redacted] admission assessment.</p> <p>At 12:28 p.m., the surveyor asked the ED if there were any statements from staff. The ED stated that as soon as staff told her that Resident #3</p>	A1073		

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A1073	<p>Continued From page 7</p> <p>was NJ Ex Order 26.4(b)(1), she immediately went into NJ Ex Order 26.4(b)(1) the resident. During continued interview, the surveyor asked the ED and DON if any NJ Ex Order 26.4(b)(1) training was completed after the incident. The DON stated that since the NJ Ex Order 26.4(b)(1) drill was conducted monthly and Resident #3 was found in a timely manner, the DON confirmed that she had not conducted training with staff after the NJ Ex Order 26.4(b)(1) incident.</p> <p>At 2:13 p.m., during an interview with the CM, the surveyor asked the CM if she had completed any training on NJ Ex Order 26.4(b)(1) drill since the incident. The CM stated that she had not completed any training since the NJ Ex Order 26.4(b)(1) incident with Resident #3.</p> <p>The surveyor reviewed the 4/24/25 facility policy titled, "Incident and Event Reporting Policy" revealed "Policy Statement: It is the policy of the community to ensure that [facility] team members...document incidents to...improve safety for residents, team members...and reduce the risk of harm...12. The ED/designee will investigate each incident/event to determine the circumstances of the incident/event and institute appropriate measures to prevent similar future situations..."</p> <p>The surveyor reviewed the 8/7/25 facility policy titled, "Missing Resident" revealed "Policy Statement: It is the policy of the [facility] community to provide a safe resident environment to reduce the incidence of missing resident and elopement events, and promote resident safety. Definitions: Missing Resident: A resident is missing if team members do not know their whereabouts,... Procedure: ...2. The ED/designee conducts training via the Missing</p>	A1073		
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A1073	Continued From page 8 resident drills...9. The ED/designee oversees the investigation of the missing resident event..."	A1073		

**STATE FORM: REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 30A004	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 12/2/2025
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NAME OF FACILITY BRIGHTON GARDENS OF WEST ORANGE	STREET ADDRESS, CITY, STATE, ZIP CODE 220 PLEASANT VALLEY WAY WEST ORANGE, NJ 07052
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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 A0313	Correction	ID Prefix A0401	Correction	ID Prefix A1073	Correction
Reg. # 8:36-3.4(a)(4)	Completed	Reg. # 8:36-4.1(a)(22)	Completed	Reg. # 8:36-15.6(b)	Completed
LSC	11/24/2025	LSC	11/24/2025	LSC	11/24/2025
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 9/17/2025		<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		