

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315268	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/25/2025
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NAME OF PROVIDER OR SUPPLIER BROOKHAVEN HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 120 PARK END PLACE , EAST ORANGE, New Jersey, 07018
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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) COMPLETION DATE
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F0000	<p>INITIAL COMMENTS</p> <p>Complaint #: NJ 373825,373836, 373827, 373828</p> <p>Survey Date: 08/25/2025</p> <p>Census: 122</p> <p>Sample: 24 +3</p> <p>The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.</p>	F0000		09/30/2025
F0689 SS = D	<p>Free of Accident Hazards/Supervision/Devices</p> <p>CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents.</p> <p>The facility must ensure that -</p> <p>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, record review, and review of other facility documents, it was determined that the facility failed to provide appropriate and NJ Exec Order 26.4b1 to a resident to prevent an avoidable accident specifically by leaving an unattended cup of medication tablets in a resident's room. The deficient practice was identified for 1 of 2 (Resident 60) Residents review for Accidents.</p> <p>The deficient practice was evidenced by the following:</p>	F0689	<p>1. The Nurse immediately removed and properly disposed the medications in a medication cup from the resident's room.</p> <p>The Unit Manager immediately assessed the resident and monitored for adverse effects. NJ Exec Order 26.4b1 were observed or reported.</p> <p>The Unit Manager immediately notified the resident's physician and informed them of the incident. There was NJ Exec Order 26.4b1 observed or documented on resident #60.</p> <p>Nurses involved in the identified poor practice were counselled and re-educated on medication administration.</p> <p>The Unit Managers immediately conducted the rounds to all rooms and</p> <p>other resident's areas to ensure that there were no unattended medications</p> <p>left in resident rooms, none were found.</p>	09/30/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0689 SS = D	<p>Continued from page 1</p> <p>A review of Resident # 60's annual Minimum Data Set (an assessment tool) located in the Electronic Medical Record dated [REDACTED] (EMR) revealed that he/she had a Brief Interview of Mental Status score of ^{NJ} 15 indicating that Resident # 60 was ^{NJ Exec Order 26.4b1} [REDACTED]. A review of Resident # 60's EMR revealed under Diagnoses, that he/she had a diagnoses of but not limited to ^{NJ Exec Order 26.4b1} [REDACTED]. On 08/19/2025 at 9:30 AM during the initial tour, the surveyor observed Resident # 60 in their room. At that time, the surveyor observed four tablets in a cup on the resident's bedside table. At that time, the surveyor spoke to the ^{US FOIA (b)(6)} [REDACTED]. The ^{US FOIA (b)(6)} [REDACTED] stated the nurse should not have left the medications at the resident's bedside. On 08/22/2025 at 10:48 AM during an interview with the surveyor, the ^{US FOIA (b)(6)} [REDACTED] replied, "No, Sir." when asked should medications ever be left at the bedside unattended. The DON further replied, "Because somebody can take it or it might be missed." after the surveyor asked why medications should not be left at the bedside. A review of the facility-provided policy titled, "Administering Medications" reviewed and updated in 7/2025 revealed that, "21. For residents not in their rooms or otherwise unavailable to receive medication on the pass, the MAR [Medication Administration Record] may be "flagged." After completing the medication pass, the nurse will return to the missed resident to administer the medication.</p> <p>N.J.A.C. 8:29.2(d)</p>	F0689	<p>Continued from page 1</p> <p>All nurses were immediately in-serviced related to med pass and incident/accident related to unsupervised medication.</p> <p>2. All residents have a potential to be affected by this deficient practice.</p> <p>3. The Facility Educator and/or designee will re-educate all licensed nursing staff on federal regulation F689 related to incident and accident and unsupervised medication administration.</p> <p>The Facility Educator and/or designee will in-service all licensed nursing staff on "No unattended medication policy" and will be reinforced with immediate disciplinary action follow-up for non-compliance.</p> <p>The Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or Unit Manager started the medication pass competency.</p> <p>The Pharmacy Consultant will start the medication administration competency of two nurses monthly.</p> <p>4. DON/designee will audit 3x/ week x 4 weeks; then weekly x 4; then monthly X 3 to ensure medications are not left unattended.</p> <p>Outcomes of the audit will be presented monthly to the Quality Assurance Performance Improvement Committee.</p>	
F0697 SS = D	<p>Pain Management</p> <p>CFR(s): 483.25(k)</p> <p>§483.25(k) Pain Management.</p> <p>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p>	F0697	<p>The DON immediately reviewed the medication administration schedule for [REDACTED] and immediately reconciled.</p> <p>The Unit Manager immediately assessed the resident for any adverse effect ^{NJ Ex Order 26.4b1} [REDACTED] noted.</p> <p>The Unit Manager immediately notified the physician of the late administration, and she did not receive any new orders.</p>	09/30/2025

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	<p>Continued from page 2</p> <p>Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that [redacted] management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences, specifically by not administering medication for [redacted] within the required timeframes. The deficient practice was identified for 1 of 3 residents (Resident # 8) reviewed for significant medication errors.</p> <p>The deficient practice was evidenced by the following:</p> <p>A review of Resident # 8's Significant Change Minimum Data Set (MDS; an assessment tool) dated [redacted] revealed that he/she had a Brief Interview for Mental Status score of [redacted]/15 indicating [redacted]. The MDS also revealed that Resident # 8 was prescribed medication for [redacted] management. A review of Resident # 8's Physician's Orders located in the Electronic Medical Record (EMR) revealed an order for [redacted].</p> <p>[redacted]. A review of Resident # 8's Care Plan located in the EMR revealed a focus risk for [redacted] related to medical condition/diagnosis initiated on [redacted]. The Care Plan focus had an intervention to, "Administer medication as ordered". On 08/19/2025 at 10:34 AM during the initial tour of the facility, the surveyor observed Resident # 8 in bed. At that time, Resident # 8 informed the surveyor that he/she has [redacted]. He/She stated that the [redacted] caused [redacted]. He/She decided that they felt the [redacted] management was not adequate. A review of the Medication Audit Report located in the EMR revealed the following administration times for the [redacted] capsule to be given at 09:00 AM. On [redacted] was given at 10:53 [redacted], [redacted] was given at 10:38 AM On [redacted] was given at 10:37 [redacted], [redacted] was given at 12:30 PM On [redacted], [redacted] was given at 11:52 AM A review of the Medication Audit Report located in the EMR revealed the following administration times for the [redacted] capsule to be given at 09:00 PM. On [redacted] was given at 10:23 [redacted], [redacted] was given at 10:50 PM On [redacted] was given at 10:44 PM On 08/22/2025 at 10:33 AM during an interview with the surveyor, the [redacted] (US FOIA (b)(6)) said medications can be given an hour before and an hour after the scheduled medication time. After reviewing the [redacted] administration times, the [redacted] confirmed that the administration times are considered late. She said the nurse had to call the doctor and check for adverse</p>		<p>Continued from page 2</p> <p>The Facility Educator immediately conducted a re-education for all license nurses on medication administration to real time signing of the medication.</p> <p>2. All residents have a potential to be affected by this deficient practice</p> <p>3. The facility educator and/or designee re-educated all license nursing staff on federal guidelines F697 related to medication administration.</p> <p>The facility educator and/or designee initiated a medication pass competency with all the nurses.</p> <p>The Pharmacy Consultant will complete a separate Medication Administration competency of 2 nurses per month.</p> <p>4. The DON/designee will review and audit Electronic Medication Administration Records for timeliness and accuracy of medication administration of 3 residents weekly x 4 weeks; then 5 residents monthly for 3 months utilizing a medication audit tool.</p> <p>The DON and/or designee will submit the audit report to the Quality Assurance Performance Improvement Committee.</p>	

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F0697 SS = D	Continued from page 3 effects. A review of the facility-provided "Administering Medications" policy updated 7/2025 revealed, "4. Medications are administered in accordance with prescriber orders, including any required time frame." The policy further revealed that, "7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified..." N.J.A.C. 8:39-29.2(d)	F0697		
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an	F0756	1. Resident # 14 The Director of Nursing immediately checked the physician's order of NJ Exec Order 26.4b1 and order updated to check placement every shift. There was no identified missing dose of NJ Exec Order 26.4 The Director of Nursing immediately notified the physician of the missed follow-through of pharmacy recommendation. NJ Ex Order 26.4b1 outcomes noted. The Director of Nursing reviewed all residents with transdermal patch ordered and no other resident identified with the same problem. The Regional Clinical Supervisor established a new template for NJ Exec Order 26.4b1 that will include checking placement every shift with documentation in the EMAR. 2. All residents have a potential to be affected by this deficient practice 3. The facility educator and/or designee will in-service all the nurses on federal regulation F 756 related to drug regimen review completed by the Pharmacy Consultant. The Regional Clinical Supervisor established a new batch order template for all the transdermal medication ordered that will include checking placement every shift with documentation in the EMAR. 4. The Unit Manager and/or designee will audit 5 residents with transdermal order weekly x 4, then monthly for 3 months. The DON and/or designee will submit the audit report to the Quality Assurance Performance Improvement Committee.	09/30/2025

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F0756 SS = D	<p>Continued from page 4 irregularity that requires urgent action to protect the resident.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations, interview, and review of facility documentation it was determined that the facility failed to follow US FOIA (b)(6) recommendations for a resident wearing a weekly medication patch. This deficient practice was identified in 1 of 5 residents reviewed for medications (Resident #14) and was evidenced by the following:</p> <p>On 08/19/2025 at 10:13 AM, during the initial tour of the facility the surveyor observed Resident #14 in the day room sitting in a wheelchair during activities. The surveyor reviewed Resident #14 medical record.</p> <p>A review of the Admission Record revealed Resident #14 was admitted to the facility with medical diagnoses which included but were not limited to NJ Exec Order 26.4b1 [REDACTED] [REDACTED] [REDACTED]).</p> <p>The surveyor reviewed the quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Ord. The resident had a Brief Interview of Mental Status (BIMS) of NJ meaning the resident had NJ Exec Order 26.4b1 [REDACTED] .</p> <p>A review of the Physician Order Summary (POS) revealed the resident was prescribed the following medication:</p> <p>NJ Exec Order 26.4b1 [REDACTED] weekly, every Saturday for NJ Exec Order 26.4b1 [REDACTED] of administration and remove per schedule. The medication start date was NJ Exec Order [REDACTED] .</p> <p>A review of the residents Individualized Comprehensive Care Plan (ICCP) showed a focus of NJ Exec Order 26.4b1 [REDACTED] Goals were that the resident would remain free of complications of NJ Exec Order 26.4b1 [REDACTED] Interventions included but were not limited to administering medications as ordered. Observe for side effects such as NJ Exec Order 26.4b1 [REDACTED] [REDACTED] .</p> <p>On 8/21/25 at 10:15 AM, the surveyor reviewed the resident's monthly medication reviews that were completed by the Pharmacy Consultant (PC). Review of the NJ Exec Order 26.4b1 [REDACTED] review, the PC recommended to check NJ Exec Order 26.4b1 [REDACTED] placement every shift and document accordingly.</p> <p>The surveyor reviewed the NJ Exec Order 26.4b1 [REDACTED]</p>	F0756		

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F0756 SS = D	Continued from page 5 NJ Exec Order 26.4b1 Medication Administration Report and the Treatment Administration Reports and could not locate documentation of NJ Exec Order 26.4b1 Placement. On 8/25/25 at 10:11 AM, the surveyor interviewed the US FOIA (b)(6) regarding placement documentation of NJ Exec Order 26.4b1. The US FOIA told the surveyor it was important to check patch placement to ensure it was on the resident to keep the residents NJ Exec Order 26.4b1. The US FOIA stated that the nurse failed to do that. On 8/25/25 at 12:00 PM, the surveyor reviewed the policy titled, "Pharmacy Services-Role of the Consulting Pharmacist", the policy was dated 10/2024. Number five of the policy revealed that the consultant pharmacist will provide specific activities related to medication regimen review including a documented review of the medication regimen of each resident monthly and providing the facility with written reports and recommendations related to all aspects of medication and pharmaceutical services review. NJAC 8:39-29.3	F0756		
F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure all medications were administered without error of 5% or more. This deficient practice was observed during a medication administration observation on 8/21/2025. The surveyors observed 5 nurses administer medication to 9 residents a with a total of 33 opportunities, and 7 errors were observed which calculated a medication administration error rate of 21.21% during medication administration observation. This deficient practice was identified for 1of 9 residents (Resident #111) that were administered medications by 1 of 5 nurses on the NJ Ex Order 26.4b1	F0759	1. Resident #111 The Unit manager immediately assessed the resident, and NJ Exec Order 26.4b1 identified. The Unit Manager immediately notified the attending physician of the missed NJ Exec Ord dose. The US FOIA (b)(6) immediately counselled related to staffing schedule confusion. 2. All residents have the potential to be affected by this deficient practice. 3. The facility educator and/or designee re-educated all license nursing staff on federal guidelines F759 related to medication administration and the importance timeliness in med pass. The facility educator and/or designee initiated the medication pass competency with all the nurses.	09/30/2025

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F0759 SS = D	<p>Continued from page 6 nursing unit.</p> <p>The deficient practice was evidenced by the following:</p> <p>On 8/21/2025 at 10:02 AM during medication administration observations, the surveyor observed US FOIA (b)(6) dispensing and preparing to administer medication to Resident #111. During the process, the US FC first tested Resident #111's NJ Exec Ord. The resulting NJ Exec Order 26.4b1 was NJ Exec Order 26.4. US FC, the US FC the drew up NJ Exec Ord. US FC The US FC was about to draw up another 10 units of NJ Exec Order 26.4b1 per resident's order when the surveyor asked to see the order in the computer. Both NJ Exec Ord orders were ordered to be given at 7:30 AM before meals. The US FC decided then to hold the NJ Exec Ord until she talked to the doctor because the resident had already eaten breakfast.</p> <p>The US FC then proceeded to prepare the rest of Resident # 111's medications as followed:</p> <ol style="list-style-type: none"> NJ Exec Order 26.4b1 NJ Exec Ord) due at 8:00 AM, and to be given with NJ Exec Ord was administered at 10:18 AM NJ Exec Order 26.4b1 NJ Exec Ord due at 9:00 AM was administered at 10:18 AM NJ Exec Order 26.4b1 NJ Exec Ord) due at 9:00 AM was administered at 10:19 AM. NJ Exec Order 26.4b1 NJ Exec Ord due at 9:00 AM was administered at 10:28 AM NJ Exec Order 26.4b1 NJ Exec Ord due at 9:00 AM was administered at 10:34 AM <p>The US FC administered the medications and when signing them out she said, "I am late with all his/her meds." The US FC replied, "an hour before and an hour after" when asked when medications should have be administered.</p> <p>A review of Resident # 111 Admission record revealed the resident was admitted to the facility with diagnosis which included but was not limited to NJ Exec Order 26.</p>	F0759	<p>Continued from page 6</p> <p>The Pharmacy Consultant will complete a separate Medication Administration competency of 2 nurses per month.</p> <p>The Staffing Coordinator will post the schedule at the front desk and the nurses' station and will be verified the 11-7 shift supervisor.</p> <p>4. The DON/designee will conduct an audit of EMARs for timeliness and accuracy of medication administration for 5 residents 3X/week x 4 weeks, then 10 residents monthly for 3 months.</p> <p>The DON and/or designee will submit the audit report to the Quality Assurance Performance Improvement Committee.</p>	

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F0759 SS = D	<p>Continued from page 7</p> <p>NJ Exec Order 26.4b1</p> <p>A review of Resident #111's Physician Order Summary (POS) included an order for the following medications:</p> <ol style="list-style-type: none"> NJ Exec Order 26.4b1, give one tablet by mouth in the morning, with a start date of NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 give one tablet by mouth two times a day for NJ Exec Order 26.4b1 with a start date of NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 two times a day for NJ Exec Order 26.4b1 with a start date of NJ Exec Order 26.4b1 NJ Exec Order 26.4b1, give one tablet by mouth in the morning with NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1, with a start date of NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 before meals for NJ Exec Order 26.4b1 with a start date of NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 before meals and at bedtime for NJ Exec Order 26.4b1 with a start date of NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 give one tablet by mouth once a day for NJ Exec Order 26.4b1 <p>During an interview on 8/22/2025 at 10:34 AM with the surveyor, the US FOIA (b)(6) said that medication should be given an hour before to an hour after its scheduled time. The US FOIA also said that NJ Exec Order 26.4b1 ordered before meals should be given on time and prior to the resident eating to prevent spikes in the resident's NJ Exec Order 26.4b1.</p> <p>A review of a facility provided policy updated on 07/2025 titled, "Administering Medications" revealed, "4. Medications are administered in accordance with the prescriber orders, including any required time frame. 7. Medications are administered within 1 hour of their prescribed time, unless otherwise specified... and 11. The individual administering the medication checks the label 3 times to verify the right resident, right medication, right dosage, right time..."</p> <p>NJAC 8:39- 29.2(d)</p>	F0759		
F0761	Label/Store Drugs and Biologicals	F0761	1. The Unit Managers immediately removed and properly	09/30/2025

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F0761 SS = E	<p>Continued from page 8</p> <p>CFR(s): 483.45(g)(h)(1)(2)</p> <p>§483.45(g) Labeling of Drugs and Biologicals</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and facility provided documentation, it was determined that the facility failed to ensure all medications were stored in accordance with professional standards by having expired medications in 2 of 2 medication storage rooms inspected.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 08/21/2025 at 10:42 AM the surveyor in the presence of a Register Nurse (RN)# 1, observed a bottle of Sodium Chloride salt tablets (a medication used to replenish low sodium levels in the body) that had an expiration date of 5/2025. The surveyor also observed a bottle of Aspirin 325 mg (a medication commonly used to treat pain) that had an expiration date of 6/2025 in the 3rd floor medication storage room. The RN # 1 removed the two items and said there should not be expired medications in the medication room.</p>	F0761	<p>Continued from page 8</p> <p>disposed the expired bottle of Sodium Chloride tablet, bottle of Aspirin, and Sodium Chloride 50ml injection bag.</p> <p>No residents were administered medications past their expiration date.</p> <p>The Director of Nursing, Unit Managers, and Assistant Director of Nursing immediately conducted a facility-wide audit of all medication storage areas (including medication rooms, medication carts, emergency boxes, refrigerators, medicine supply room, and Pyxis) for any expired or unused medications and none found.</p> <p>2. All residents have the potential to be affected by this deficient practice.</p> <p>3. The facility educator and/or designee re-educated all license nursing staff on federal guidelines F761 related to storage of drugs and biologicals including but not limited to proper medication storage, disposal of discontinued medications, and timely removal of expired drugs.</p> <p>The pharmacy provider will be in weekly to audit the medication storage areas.</p> <p>The pharmacy consultant will audit all the medication storage area monthly.</p> <p>4. The 11-7 shift supervisor and/or designee will audit all the medication storage areas 3X/week for 4 weeks then monthly for 3 months.</p> <p>The DON and/or designee will submit the audit report to the Quality Assurance Performance Improvement Committee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315268	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/25/2025
NAME OF PROVIDER OR SUPPLIER BROOKHAVEN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 PARK END PLACE , EAST ORANGE, New Jersey, 07018	
(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) COMPLETION DATE
F0761 SS = E	<p>Continued from page 9</p> <p>On 08/22/2025 at 09:28 AM the surveyor in the presence of the Unit Manager Licensed Practical Nurse (UMLPN) #1, observed a 50 milliliter (ML) 0.9% sodium chloride injection bag (a sterile solution for intravenous administration after admixture with a single dose powdered or liquid drug vial) that had an expiration date of 06/2025. The UMLPN #1 said, "I usually clean out the med room on Fridays, there should not be anything expired in here"</p> <p>During an interview on 08/22/2025 at 10:35 AM with the surveyor the US FOIA (b)(6) said that there should not be expired items in the medication storage room.</p> <p>A review of a facility provided policy last reviewed on 1/2024 titled, "Medication Labeling and Storage" revealed, "The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner."</p> <p>N.J.A.C 8:39-29.4 (g)</p>	F0761		
F0812 SS = F	<p>Food Procurement,Store/Prepare/Serve-Sanitary</p> <p>CFR(s): 483.60(i)(1)(2)</p> <p>§483.60(i) Food safety requirements.</p> <p>The facility must -</p> <p>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.</p> <p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p> <p>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p>	F0812	<p>A)</p> <ol style="list-style-type: none"> Larger portion of pepper jack cheese was immediately labeled and dated All residents have the potential to be affected by this practice. Dietary staff were immediately in-serviced on proper labeling and dating procedures. The Food Service Director/Designee will audit weekly x4 weeks and then monthly x 6 months to ensure all items requiring labeling and dating are indeed labeled and dated. Food Service Director will report findings to the Quality Assurance Performance Improvement Committee. <p>B)</p> <ol style="list-style-type: none"> The metal bin with cookies was removed and discarded All residents have the potential to be affected by this practice. Dietary Staff were immediately in-serviced on the importance of separating chemicals from food prep areas. The Food Service Director/Designee will audit weekly 	10/15/2025

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NAME OF PROVIDER OR SUPPLIER BROOKHAVEN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 PARK END PLACE , EAST ORANGE, New Jersey, 07018	
(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) COMPLETION DATE
F0812 SS = F	<p>Continued from page 10</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to handle potentially hazardous food and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following:</p> <p>On 08/19/2025 from 09:33 AM until 10:09 AM, the surveyor observed the following in the kitchen in the presence of the US FOIA (b)(6)</p> <p>1. In the freezer #1 a large block of pepper jack cheese was wrapped in clear plastic with no label and no date. The USFC said that the staff cut a smaller piece off the cheese and labeled the smaller piece but not the large block. She stated the cheese should have been labeled and dated.</p> <p>2. In the prep area on bottom shelf there was a metal bin of prepared cookies next to one red and one green wash and sanitize buckets. The USFC said the best practice is to have them separated.</p> <p>3. In the milk box, the inside thermometer reflected a temperature of 50 degrees Fahrenheit (F). There were approximately 45 small boxes of whole milk and 12 small boxes of skim milk. The USFC checked the temperatures of 3 random milk boxes the temperatures ranged from 46 degrees F to 51 degrees F. The USFC stated the temperatures of the milk is too high. She stated that she will discard the milk and repair the milk box.</p> <p>4. In the walk-in freezer there was a bag of diced green peppers with no label and no date. The USFC said the peppers were removed from a box and once removed should be labeled and dated. There was an opened bag of frozen eggplant with no label and no date. The USFC said the eggplant should have an opened date. She said she will discard the eggplant. There was a box of pierogies with ice on top of the box. The box was dated 2/17/25. The USFC stated the pierogies are good for 6 months and she will discard the pierogies.</p> <p>The surveyor reviewed the facility provided policy titled, "Labeling and dating System Protocol" with no date which reflected: all fresh and frozen foods must be dated with the date it was received into the kitchen and all food in freezer storage 6 months, all opened frozen item must have expiration date of 6 months.</p> <p>The surveyor reviewed the facility provided policy titled, "Milk Holding Box " with no date which reflected the holding box fridge is monitored for</p>	F0812	<p>Continued from page 10</p> <p>x4 weeks and then monthly x 6 months to ensure all foods and wash and sanitize buckets are stored in separate areas. Food Service Director will report findings to the Quality Assurance Performance Improvement Committee.</p> <p>C)</p> <p>1. One and a half cases of milk were immediately discarded. Milk holding box put out of service. Facility ordered a new milk box. All other refrigerators were immediately checked to ensure safe temperatures.</p> <p>2. All residents have the potential to be affected by this practice.</p> <p>3. Dietary staff were in-serviced on the importance of ensuring temperature checks are completed according to regulation and to report if any temperature is out of range.</p> <p>4. The Food Service Director/Designee will audit weekly x4 weeks and then monthly x 6 months to ensure all temperatures are within acceptable range. Food Service Director Will report findings to the Quality Assurance Performance Improvement Committee.</p> <p>D)</p> <p>1. The bag of diced green peppers, the opened bag of frozen eggplant, and the box of perogies were discarded immediately.</p> <p>2. All residents have the potential to be affected by this practice.</p> <p>3. Dietary staff were immediately in-serviced on proper labeling and dating procedures.</p> <p>4. The Food Service Director/Designee will audit weekly x4 weeks and then monthly x 6 months to ensure all items requiring labeling and dating are indeed labeled and dated. Food Service Director will report findings to the Quality Assurance Performance Improvement Committee.</p>	

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NAME OF PROVIDER OR SUPPLIER BROOKHAVEN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 PARK END PLACE , EAST ORANGE, New Jersey, 07018	
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F0812 SS = F	Continued from page 11 temperature twice a day, morning and evening shift and temperature above acceptable range must be reported to the food service director or to the immediate supervisor. NJAC 8:39-17.2(g)	F0812		

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060732	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/25/2025
NAME OF PROVIDER OR SUPPLIER BROOKHAVEN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 PARK END PLACE , EAST ORANGE, New Jersey, 07018	
(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) COMPLETION DATE
S0000	Initial Comments NJ175248 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. 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 the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S0000		09/30/2025
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interviews and review of other facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This was evident for; 1. For the 2 weeks of staffing prior to survey from 8/3/25 to 8/16/25, the facility was deficient CNA staffing for residents on 4 of 14-day shifts, and 2; For the week of complaint staffing from 6/23/24 to 6/29/24, the facility was deficient in CNA staffing for residents on 1 of 7-day shifts. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing	S0560	1. There was no negative outcome to residents on the shifts identified as not meeting the NJ staffing requirements during the 7 am to 3pm shift on 6//13/24, 8/3/25, 8/9/25, 8/10/25, and 8/16/25. Staffing coordinator was reeducated on the proper staffing guidelines as mandated by the state of New Jersey. 2. All residents have the potential to be affected by the deficient practice of not meeting the NJ Staffing requirement ratios. 3. The following measures have been put into place to prevent the deficient practice from recurring: Facility updated and increased sponsorships of advertisements on job search platforms. Offering generous sign on bonus for new hires. b. Incentives are offered to CNAs to work extra shifts such as bonuses and raffles. c. Contract has been signed with CNA school, and they have committed to having their students do their clinicals at the facility. d.	09/30/2025

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060732	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/25/2025
NAME OF PROVIDER OR SUPPLIER BROOKHAVEN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 PARK END PLACE , EAST ORANGE, New Jersey, 07018	
(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) COMPLETION DATE
S0560	<p>Continued from page 1 homes. The following ratio(s) were effective on 02/01/2021:</p> <p>One Certified Nurse Aide (CNA) to every eight residents for the day shift.</p> <p>One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and</p> <p>One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.</p> <p>1. As per the Nurse Staffing Reports completed by the facility for weeks of 6/23/24 to 6/29/24, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows:</p> <p>-6/23/24 had 13 CNAs for 110 residents on the day shift, required at least 14 CNAs.</p> <p>2. For the 2 weeks of staffing prior to survey from 08/03/2025 to 08/16/2025, the facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows:</p> <p>-08/03/25 had 12 CNAs for 115 residents on the day shift, required at least 14 CNAs.</p> <p>-08/09/25 had 12 CNAs for 115 residents on the day shift, required at least 14 CNAs.</p> <p>-08/10/25 had 12 CNAs for 115 residents on the day shift, required at least 14 CNAs.</p> <p>-08/16/25 had 12 CNAs for 111 residents on the day shift, required at least 14 CNAs.</p> <p>During an interview with the Staffing Coordinator (SC) on 8/21/25 at 12:19 PM, the SC stated that they meet the requirements most of the time, however last-minute call outs can leave them short staffed. The SC</p>	S0560	<p>Continued from page 1</p> <p>4. The Administrator/Designee will review the staffing schedule weekly to monitor the staffing ratio on the day shift for 3 months.</p> <p>a) All results of the monitoring will be presented to the QA committee for review and any additional monitoring or modification of this plan monthly for 3 months.</p> <p>b) The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance.</p>	

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NAME OF PROVIDER OR SUPPLIER BROOKHAVEN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 PARK END PLACE , EAST ORANGE, New Jersey, 07018	
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S0560	Continued from page 2 stated that she follows the mandated staffing ratios; Day shift 1:8 (1 CNA to 8 Residents, Evening shift 1:10, and Night shift 1:14. The SC added that when they have call outs, the facility offers bonuses and bargains with the staff to pick up additional shifts. Review of the facility policy titled, "Nursing Services and Sufficient Staff," with a last review date of December 2024, under #1, The facility will supply services by sufficient numbers of each of the following personnel types on a 24-hour basis to provide nursing care to all residents in accordance to New Jersey State guidelines with regards to staffing ratios for all licensed nurses and Certified Nurse Assistants.	S0560		

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NAME OF PROVIDER OR SUPPLIER BROOKHAVEN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 PARK END PLACE , EAST ORANGE, New Jersey, 07018	
(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) COMPLETION DATE
F0000	<p>INITIAL COMMENTS</p> <p>An offsite/desk review of the facility's Plan of Correction was conducted on 11/12/2025 in relation to the 08/25/2025 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.</p>	F0000		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060732	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/12/2025
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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 11/12/2025 in relation to the 08/25/2025 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities	S0000		

Office of Primary Care and Health Systems Management

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/25/2025
NAME OF PROVIDER OR SUPPLIER BROOKHAVEN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 PARK END PLACE , EAST ORANGE, New Jersey, 07018	
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K0000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 08/22/25 and the facility was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies.</p> <p>Brookhaven Health Care Center is a three-story building built in 1987. It is composed of Type II protected construction. The facility is divided into six - smoke zones. The generator powers approximately 50% of the building per the Maintenance Director. The current occupied beds are 118 of 122.</p>	K0000		09/30/2025
K0351 SS = F	<p>Sprinkler System - Installation</p> <p>CFR(s): NFPA 101</p> <p>Spinkler System - Installation</p> <p>2012 EXISTING</p> <p>Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers.</p> <p>In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems.</p>	K0351	<p>A)</p> <p>1. The Facility's Sprinkler company was immediately contacted to provide a list of sprinklers installed in the facility in accordance with NFPA 13 guidelines.</p> <p>The list has since been replaced in sprinkler cabinet on 9/17/25</p> <p>2. All residents have the potential to be affected by this practice.</p> <p>3. US FOIA (b)(6) has been in serviced on the importance of the sprinkler cabinet having a list of sprinklers installed in the facility.</p> <p>4. Director of Maintenance/ designee will conduct monthly audits for 6 months to ensure the spare sprinkler cabinet contains a list of sprinklers installed in the facility and will report findings to the Quality Assurance Performance Improvement Committee Quarterly for 3 quarters.</p> <p>B)</p>	09/30/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/25/2025
NAME OF PROVIDER OR SUPPLIER BROOKHAVEN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 PARK END PLACE , EAST ORANGE, New Jersey, 07018	
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K0351 SS = F	<p>Continued from page 1 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observations and interviews, it was determined that the facility failed to ensure 1.) the spare sprinkler cabinet contained a list of the sprinklers installed in the facility in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (2010 Edition) Section 6.2.9.7 and 6.2.9.7.1. and 2.) that sprinkler deflectors were not damaged in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition) 5.2.1.1.4. These deficient practices had the potential to affect all 122 residents and were evidenced by the following:</p> <p>An observation on 08/22/25 at 12:18 PM of the facility's spare sprinkler cabinet located in the fire sprinkler room revealed the cabinet did not contain a list of sprinklers that were used in the building. A list of the sprinklers installed in the property shall be posted in the sprinkler cabinet.</p> <p>The list shall include the following:</p> <p>Sprinkler Identification Number (SIN) if equipped; or the manufacturer, model, orifice, deflector type, thermal sensitivity, and pressure rating, general description, quantity of each type to be contained in the cabinet and Issue or revision date of the list.</p> <p>Observation on 08/22/25 at 12:58 PM revealed that a sprinkler deflector in the kitchen storage room was damaged. Any sprinkler shall be replaced that has signs of leakage; is painted, other than by the sprinkler manufacturer, corroded, damaged, or loaded; or is in the improper orientation.</p> <p>During an interview at the time of the observation, the US FOIA (b)(6) confirmed that a spare sprinkler list was not present in the sprinkler cabinet and that the sprinkler deflector was damaged in the kitchen storage room.</p> <p>NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25</p>	K0351	<p>Continued from page 1</p> <p>1. The Facility's Sprinkler company was immediately contacted to replace damaged sprinkler deflector in kitchen storage room.</p> <p>The sprinkler has since been replaced on 9/17/2025.</p> <p>2. All residents have the potential to be affected by this practice.</p> <p>3. US FOIA (b)(6) has been in serviced on the importance of ensuring all sprinkler deflectors are not damaged. An audit has been completed to ensure all sprinkler heads are not damaged.</p> <p>4. Director of Maintenance/ designee will inspect all sprinkler heads on a floor monthly for 6 months and will report findings to the Quality Assurance Performance Improvement Committee Quarterly for 3 quarters.</p>	

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NAME OF PROVIDER OR SUPPLIER BROOKHAVEN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 PARK END PLACE , EAST ORANGE, New Jersey, 07018	
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K0351 K0741 SS = F	<p>Smoking Regulations</p> <p>CFR(s): NFPA 101</p> <p>Smoking Regulations</p> <p>Smoking regulations shall be adopted and shall include not less than the following provisions:</p> <p>(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.</p> <p>(2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.</p> <p>(3) Smoking by patients classified as not responsible shall be prohibited.</p> <p>(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.</p> <p>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.</p> <p>(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.</p> <p>18.7.4, 19.7.4</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and interview, it was determined that the facility failed to provide a metal container with a self-closing lid available to the smoking area in accordance with NFPA 101 Life Safety Code (2012 Edition) section 19.7.4 (6). This deficient practice had the potential to affect 122 residents and was evidenced by the following:</p> <p>An observation on 08/22/25 at 12:30 PM of the smoking area outside the laundry room revealed no metal container with a self-closing lid was present in the area into which ashtrays could be emptied.</p> <p>During an interview at the time of observation, the</p>	K0351 K0741	<p>1. Metal Container with self-closing lid was immediately placed in smoking area.</p> <p>2. All residents have the potential to be affected by this practice.</p> <p>3. US FOIA (b)(6) has been in serviced on the importance of having a metal container with a self-closing lid in the smoking area.</p> <p>4. Director of Maintenance/ designee will check weekly x 4 weeks and then monthly x 6 months to ensure metal container is present in smoking area and will report findings to the Quality Assurance Performance Improvement Committee Quarterly for 3 quarters.</p>	09/30/2025

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K0741 SS = F	Continued from page 3 US FOIA (b)(6) confirmed that no metal container was available to the smoking area. NJAC 8:39-31.2(e)	K0741		
K0914 SS = F Bldg. 01	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that the electrical outlet testing was conducted in the resident's rooms in accordance with NFPA 99 Health Care Facilities Code (2012 Edition) section 6.3.4.3. This deficient practice had the potential to affect all 122 residents and was evidenced by the following: A record review on 08/22/25 from 9:00 AM to 12:00 PM revealed that the facility failed to inspect the non-hospital grade electrical outlets in resident rooms. During an interview on 08/22/25 at 3:45 PM, the US FOIA (b)(6) confirmed that the electrical outlet testing was not completed.	K0914	1. The facility immediately initiated electrical outlet testing in resident rooms in accordance with NFPA guidelines. 2. All residents have the potential to be affected by this practice. 3. US FOIA (b)(6) has been in serviced on the importance of ensuring the electrical outlet testing is completed in resident rooms. 4. Director of Maintenance/ designee will audit all electrical outlets in resident rooms to ensure all electrical outlet testing has been conducted in accordance with NFPA guidelines monthly x 6 months and will report findings to the Quality Assurance Performance Improvement Committee Quarterly for 3 quarters.	09/30/2025

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K0914 SS = F Bldg. 01	Continued from page 4 NJAC 8:39-31.2(e) NFPA 99	K0914		

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 08/22/25. The facility was found to be in compliance with 42 CFR 483.73	E0000		09/30/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K0000 Bldg. 01	<p>INITIAL COMMENTS</p> <p>An offsite/desk review of the facility's Plan of Correction was conducted on X11/20/2025 in relation to the 8/25/2025 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.</p>	K0000		

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