STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65A000	A. BUILDING: _____ B. WING _____	C 12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF LEISURE PARK	1400 ROUTE 70 LAKEWOOD, NJ 08701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint Complaint #: NJ 00189355 Date of Survey: 12/4/25 CENSUS: 66 SAMPLE SIZE: 3 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.	A 000		
A 355	8:36-4.1(a)(1) Resident Rights (a) Each assisted living provider shall post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: 1. The right to receive personalized services and care in accordance with the resident's individualized general service and/or	A 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 355	Continued From page 1 health service plan; This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00189355 Based on interview and record review it was determined that the facility failed to provide care and services in accordance with the resident's Service Plan (SP) for 1 of 3 residents reviewed, Resident #1 as evidenced by the following: On 11/25/25, the Department of Health (DOH) received a Facility Reportable Event (FRE) with an event date of [redacted]. According to the FRE report completed by the Executive Director (ED), at 3:45 a.m., during routine rounds, a caregiver arrived at Resident #1's room and observed the resident not in the bed and the room had [redacted] leading to the bathroom. Additionally,the caregiver attempted to gain access to the bathroom; however, the door was locked. The caregiver entered the bathroom and observed Resident #1 [redacted] on the [redacted]. According to the FRE, [redacted] and [redacted] arrived, and [redacted] was performed [redacted] and Resident #1 was [redacted] On 12/4/25 at 11:35 a.m., the surveyor reviewed	A 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 355	Continued From page 2	A 355		

Resident #1's medical record (MR) which revealed that Resident #1 was admitted [redacted]

Surveyor review of the resident's service plan (SP) dated [redacted] revealed that in the "GEN.GENERAL INFORMATION" section, "[redacted]"

Further review of the SP revealed that Resident #1's NJ Exec Order 26.4b1 tatus goal indicated, "***NJ Ex Order 26, 4B1*** [redacted]."
Additionally, the intervention indicated that "[redacted]"

Continued surveyor review of the MR revealed a "Physician Order" dated NJ Exec Order 26.4b1 written by [Nurse Practitioner] "***NJ Ex Order 26, 4B1*** [redacted]"

On 12/4/25 at 2:12 p.m., the surveyor interviewed the Director of Nursing (DON) and inquired about Resident #1's SP. The DON stated that the NJ Ex Order order was documented in the care plan. Additionally, the DON confirmed that NJ Ex Order was initiated on Resident #1 at the facility on NJ Ex Order 26, 4B1 [redacted] order in place.

The facility failed to provide care and services in accordance with Resident #1's SP on NJ Exec Order 26.4b1 when ***NJ Ex Order 26, 4B1*** [redacted] was performed on Resident #1 despite having NJ Ex Order

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 355	Continued From page 3 documented in the SP. The surveyor reviewed the policy titled, "Advanced Directives & DNR status" dated 11/3/22, provided by the DON which revealed, "Policy ... each resident ' s wishes regarding end-of-life decisions will be honored ..."	A 355		
A 363	8:36-4.1(a)(5) Resident Rights (a) Each assisted living provider shall post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: 5. The right to make choices with respect to services and lifestyle; This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00189355 Based on interview and record review it was determined that the facility failed to respect and comply with a resident's *NJ Ex Order 26, 4B1* [redacted] request by failing to immediately notify Emergency Service staff of the resident's *NJ Ex Order* order before *NJ Ex Order 26, 4B1* was initiated for 1 of 4 residents reviewed, Resident #1. This deficient practice was evidenced by the following:	A 363		

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A 363	Continued From page 4 On 12/4/25 at 11:35 a.m., the surveyor reviewed Resident #1's medical record (MR) which revealed that Resident #1 was admitted [redacted] According to Resident #1's "Move-In Record" the NJ Exec Order 26.4b1 documented that Resident #1 was [redacted]. In addition, the surveyor reviewed a "Physician Order" dated [redacted] written by [Nurse Practitioner] "[redacted]." On 12/4/25 at 11:48 a.m., the surveyor interviewed the Assistant Director of Nursing (ADON) and inquired about residents with [redacted] orders. The ADON stated that all resident with [redacted] orders have the order documented on the Face Sheet. Additionally, a copy of the POLST was stored in a binder in the wellness office. At 1:35 p.m., the surveyor interviewed a Licensed Practical Nurse (LPN), who was also on duty on [redacted], the date of the above [redacted], and inquired about the [redacted] when Resident #1 [redacted]. The LPN stated that he was called from the [redacted] unit to the first floor unit by the Resident Assistant (RA) to assist with Resident #1. The LPN stated that the RA notified him that Resident #1 [redacted] in the bathroom, had a [redacted]. The LPN stated that on arrival to Resident #1's room, Resident #1 was [redacted] except for NJ Ex Order 26.4(b)(1) of his/her [redacted] and [redacted]. The LPN stated that he quickly went to call [redacted] and gathered the paperwork to provide to the [redacted] Additionally, the LPN stated that the facility recently went from electronic medical	A 363		

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A 363	Continued From page 5	A 363		

records to paper medical records and that he was unable to locate Resident #1's NJ Exec Order 26, 4B1 [redacted].

During the interview, the LPN stated that the paramedics were provided the MR for Resident #1 and initiated NJ Ex Order. The LPN stated that shortly after initiating NJ Ex Order, one of the NJ Exec Order 26.4b1 reviewed Resident #1's Face Sheet which had a NJ Ex Order documented so the NJ Ex Order was stopped.

At 2:12 p.m., the surveyor interviewed the Director of Nursing (DON) regarding Resident #1 and the resident's NJ Ex Order status. The DON confirmed that the Resident #1 was a NJ Ex Order and that staff was aware of Resident #1's NJ Exec Order 26.4b1. The DON stated that since the facility was currently transitioning from one electronic MR system to another electronic MR system, Resident #1's NJ Exec Order 26.4b1 were documented on the Medication Administration Record (MAR), which was stored in the Wellness Office. Additionally, all POLST forms were stored in a binder located in the Wellness Office.

The facility failed to respect and comply with a Resident #1's ***NJ Ex Order 26, 4B1*** order when the LPN failed to notify NJ Ex Order 26.4(b)(1) of Resident #1's NJ Ex Order order prior to ***NJ Ex Order 26, 4B1*** was performed by NJ Exec Order 26.4b1 on arrival for Resident #1.

The surveyor reviewed the policy titled, "Advanced Directives & DNR status" dated 11/3/22 provided by the DON which revealed, "Policy ... each resident's wishes regarding end-of-life decisions will be honored ..."

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A 537	Continued From page 6	A 537		
A 537	8:36-5.7(a)(1) Policy and Procedure Manual (a) A policy and procedure manual(s) for the organization and operation of the facility or program shall be developed, implemented, and reviewed at least annually. Each review of the manual(s) shall be documented, and the manual(s) shall be available in the facility or program to representatives of the Department at all times. The manual(s) shall include at least the following: 1. An organizational chart delineating the lines of authority, responsibility, and accountability for the administration and resident care services of the facility or program; This REQUIREMENT is not met as evidenced by: Based on observation and record review, it was determined that the facility failed to maintain its policies and procedures in accordance with N.J.A.C. 8:36-5.7, which required that all policies be reviewed at least annually and that such review be documented. This deficient practice was evidenced by the following: On 12/4/25, the surveyor reviewed a facility policy titled, "Advanced Directives and DNR status," with a revision date of 11/3/2022. The policy contained no written evidence that indicated that it had been reviewed or updated.	A 537		

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A 537	Continued From page 7 The surveyor also reviewed a facility policy titled, "Resident Evaluation and Service Plan," with a revision date of 3/10/23. There was no documentation showing that this policy had received an annual review or update. The surveyor reviewed a facility policy titled, "Documentation Standards- Resident Health Record," with a revision date of 3/10/23. There was no documentation showing that this policy had received an annual review or update. Additional policies provided by the Director of Nursing did not contain any documented evidence showing that the facility reviewed its policies at least annually. None of the policies reviewed included review dates, revision dates, administrative approval, or other documentation demonstrating that the policies were maintained and updated as required under N.J.A.C. 8:36-5.7.	A 537		
A 753	8:36-7.3(c) General and Health Service Plans (c) Documentation in the resident's record shall indicate review and any necessary revision of the resident service plan and/or health service plan. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00189355	A 753		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 753	Continued From page 8 Based on interview and record review, it was determined that the facility failed to ensure that resident's Service Plan (SP) was developed and/or updated for [redacted] of 3 residents reviewed, Resident #1. This deficient practice was evidenced by the following. On 11/25/25, the Department of Health (DOH) received a Facility Reportable Event (FRE) with an event date of [redacted]. According to the FRE Resident #1 was [redacted] in the [redacted] On 12/4/25 at 11:35 a.m., the surveyor reviewed Resident #1's medical record (MR) which revealed that Resident #1 was admitted [redacted] Further surveyor review of the Physician Orders for Resident #1 revealed that Resident #1 was ordered [redacted] on [redacted] The surveyor reviewed Resident #1's "Service Plan [redacted] SPO" in the Service Plan which revealed that the section designated for [redacted] was blank indicating that the ordered [redacted] was not documented in the service plan. At 12:58 p.m., the surveyor interviewed the Director of Nursing (DON) and inquired about Resident #1's service plan for [redacted]. The DON stated that the [redacted] order should be documented in the service plan and acknowledged that Resident #1 did not have documentation in the service plan for his/her [redacted].	A 753		

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A 753	Continued From page 9 The surveyor reviewed the policy titled, "Resident Evaluation and Service Plan" dated 3/10/23, provided by the DON which revealed, "Policy ... An individual service plan, addressing all needs identified during the initial evaluation, will be completed for each resident ... Procedure ... 7. Based on the initial evaluation conducted prior to admission, an initial service plan will be developed ..."	A 753		
A1051	8:36-15.2 Record Availability The records required by this subchapter shall be maintained for all residents and shall be kept available on the premises for review at any time by representatives of the Department. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00189355 Based on interview and record review, it was determined that the facility failed to maintain and provide the surveyor with complete access to residents record for 3 of 3 residents, Residents #1, #2 and #3. This deficient practice was evidenced by the following: On 12/4/25 at 9:24 a.m., the surveyor interviewed the Administrator regarding access to resident medical records (MR). The Administrator stated that the residents MRs were both electronic and paper. The Administrator stated that the facility stopped utilizing the old electronic MR system and will be using the new electronic MR system at	A1051		

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A1051	Continued From page 10 a later date. Additionally, the Administrator explained that paper MRs were utilized as the facility transitioned to the new electronic MR system. The Administrator also stated that the facility has access to the old electronic MR system as "Read only" access. The surveyor then requested access to the old electronic MR which was granted. At 11:35 a.m., the surveyor reviewed the closed MR for Resident #1 from the old MR system which revealed that Resident #1 was admitted [redacted] However, the surveyor did not observe any documentation from [redacted] to [redacted], the date of the survey. The surveyor then reviewed Resident #2's electronic medical record from the old MR system which revealed that Resident #2 was [redacted] The surveyor did not observe any documentation from NJ Exec Order 26.4b1, the date of the survey. Additionally, the surveyor reviewed Resident 3's electronic medical record from the old MR system from which revealed that Resident #3 was [redacted]. The surveyor did not observe any documentation from [redacted] to the date of the survey. The surveyor then requested the paper MRs for Resident #1, Resident #2 and Resident #3 from NJ Exec Order 26.4b1 from the Administrator and again from the Director of Nursing for review. However, the Administrator and the DON were	A1051		

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A1051	Continued From page 11 not able to provide the surveyor with the above residents' paper MRs. The facility failed to provide the surveyor the paper MRs for Resident #1, Resident #2 and Resident #3 from NJ Exec Order 26.4b1 in order to complete the investigation. The surveyor reviewed the facility policy titled, " Documentation Standards- Resident Health Record" with a revision date 3/10/2023 which revealed, "It is the policy of the Community to maintain a Resident Health Record that reflects the accurate and progressive condition of the Resident ..."resident's health care plan is the responsibility of the Wellness Director including ... Maintenance of records as required ..."	A1051		

THE TERRACES AT LAKEWOOD

SENIOR LIVING

PLAN OF CORRECTION

Facility: Brighton Gardens of Leisure Park
Complaint #: NJ 00189355
Survey Date: 12/4/25

A 355 – Resident Rights: Care in Accordance with Service Plan [redacted] Accepted 1/28/26.

Tag: A 355
Regulation: N.J.A.C. 8:36-4.17(a)(1)

1. Corrective action for affected resident
Resident #1 was the affected party. Resident #1 [redacted] Upon notification of the concern, community leadership conducted a review of the resident's Service Plan, physician orders, and Advance Directives to confirm documentation accuracy and availability - This was completed and successfully confirmed on 11/25/2025. An internal process review was completed to identify opportunities to strengthen emergency response communication related to [redacted] HSD communicated this information to nursing staff in a Safety Huddle on .

2. Identification of other residents potentially affected
All residents have the potential to be affected by this deficiency, therefore, a 100% review of all current residents' records will be conducted to verify the presence, accuracy, and accessibility of Advance Directives, DNR/POLST orders, and Service Plan documentation.

3. Systemic Corrective Measures

The Community has implemented standardized electronic processes to ensure Advance Directives are consistently documented in the electronic health record (ALIS), readily accessible, and promptly communicated upon arrival of Emergency Medical Services.

Prior to the implementation of ALIS, the Health Services Director established an Emergency Pack for each resident, which includes a face sheet, insurance information, POLST form, Advance Directives, and Power of Attorney documentation, where applicable. Emergency Packs were created 10/01/2025 and remain in the Wellness Office and always accessible to clinical staff for emergencies. HSD provided education to all nursing staff on 10/01/2025 with documented attendance in our Nursing Education Binder.

The Health Services Director provided staff education in a Safety Huddle on 11/25/2025 to reinforce expectations related to honoring resident rights, adherence to individualized Service Plans, and the timely identification and communication of resident-specific wishes, including Advance Directives and POLST forms.

THE TERRACES AT LAKEWOOD

SENIOR LIVING

To further reinforce compliance, the Health Services Director will conduct a Mock Emergency Drill, simulating an assisted living resident experiencing cardiopulmonary arrest. The drill will include review of Resident Rights, Service Plans, identification and use of Advance Directives/POLST documentation, and appropriate communication standards related to resident preferences.

4. Monitoring for Ongoing Compliance

The Director of Nursing or designee will audit 100% of all current residents' records to verify the presence, accuracy, and accessibility of Advance Directives, DNR/POLST orders, and Service Plan documentation. Thereafter, HSD or designee will audit 1/3 of resident records monthly for three (3) months, and quarterly thereafter, to ensure Advance Directives are present, accessible, and accurately documented. Audit results will be reviewed and trended through the facility's Quality Assurance and Performance Improvement (QAPI) process.

Completion Date: 01 /31 / 2026

A 363 – Resident Rights: Respect for Choices (DNR) NJ Ex Order 26, 4 Accepted. 1/28/26.

Tag: A 363
Regulation: N.J.A.C. 8:36-4.1(a)(5)

1. Corrective action for affected resident

The resident in question is Resident #1. Resident #1 NJ Ex Order 26, 4B1 Health Services Director reviewed emergency response procedures to reinforce timely communication of NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 to emergency responders. Signs with th NJ Exec Order 26.4b1 status of each resident will be placed on the inside of the door to their respective apartments as an additional access point to a copy of POLST with residents wishes

2. Identification of other residents potentially affected

All residents have the potential to be affected by this deficiency, therefore, 100% of all residents with DNR/POLST orders will be identified and emergency documentation in each of the residents' paper charts verified for completeness and accessibility.

3. Systemic Corrective Measures

Emergency response protocols were reinforced by HSD with all Nursing Staff on 11/25/2025 to ensure Advance Directives are immediately presented and verbally communicated to emergency personnel. All documented end of life Directives will be verified and confirmed in ALIS

THE TERRACES AT LAKEWOOD

SENIOR LIVING

4. Monitoring to Ensure Ongoing Compliance

The Director of Nursing or designee will audit 100% of all current residents' records to verify the presence, accuracy, and accessibility of Advance Directives, DNR/POLST orders, and Service Plan documentation. Thereafter, HSD or designee will audit 1/3 of resident records monthly for three (3) months, and quarterly thereafter, to ensure Advance Directives are present, accessible, and accurately documented. Audit results will be reviewed and trended through the facility's Quality Assurance and Performance Improvement (QAPI) process.

Completion Date: 01/30/ 2026

A 537 – Policies and Procedures: Annual Review

PROVIDER'S PLAN OF CORRECTION

Tag: A 537
Regulation: N.J.A.C. 8:36-5.7(a)(1)
Deficiency: Failure to ensure that facility policies and procedures were reviewed at least annually and that such review was documented.

[NJ Ex Order 26, 4B] Accepted 1/28/26.

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1. Corrective action for affected resident

Although this deficiency involved administrative policy oversight and not direct resident care delivery, resident #1 was affected by this outdated policy. Resident #1 [NJ Ex Order 26, 4B1]

The facility acknowledges that during the survey, policies provided to the surveyor did not contain documented evidence of annual review or approval as required under N.J.A.C. 8:36-5.7(a)(1).

Brighton Gardens of Leisure Park is part of an organization in which policies and procedures are developed, reviewed, approved, and maintained at the corporate level. At the time of survey, the organization did not have a formalized, documented process requiring annual review and documentation of all policies and procedures.

Effective 1/12/2026, [NJ Exec Order 26,4] corporate quality leadership developed, approved, and implemented an organization-wide Policy and Procedure Review Policy, which requires that all corporate policies and procedures governing facility operations and resident care be reviewed and, where applicable, revised at least annually, with documented evidence of review and approval.

No residents were directly impacted by this deficient practice. Corrective action has been taken at the corporate governance level to address the identified gap.

THE TERRACES AT LAKEWOOD

SENIOR LIVING

2. Identification of other residents potentially affected

Although this deficiency involved administrative policy oversight and not direct resident care delivery, 100% of residents could potentially be affected by this citation, therefore, the corrective action applies organization-wide, impacting all communities operating under Sinceri management, including Brighton Gardens of Leisure Park, to ensure that all governing policies supporting resident care and facility operations are maintained in compliance with regulatory requirements.

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3. Systemic Corrective Measures

To prevent recurrence, [NJ Exec Order 26.4b] corporate quality has implemented an organization-wide policy that establishes a standardized process for policy management across all managed communities. Effective 1/12/2026, [NJ Exec Order 26.4b] corporate quality leadership developed, approved, and implemented an organization-wide Policy and Procedure Review Policy, which requires that all corporate policies and procedures governing facility operations and resident care be reviewed and, where applicable, revised at least annually, with documented evidence of review and approval.

The corporate policy requires:

- All policies and procedures governing facility operations and resident care to be reviewed at least annually
- Documentation of each review, including review date, revision date (if applicable), and approval
- Prompt revision and dissemination of updated policies as needed
- Availability of current policies at each community for review by Department of Health representatives at all times

Corporate quality leadership is responsible for oversight, documentation, and dissemination of policies to all managed communities.

Local communities, including Brighton Gardens of Leisure Park, rely on corporate-issued policies and are responsible for maintaining access to current policies and implementing them as directed.

THE TERRACES AT LAKEWOOD

SENIOR LIVING

4. Monitoring to ensure ongoing compliance

Compliance with the Policy and Procedure Review Policy will be monitored through corporate quality oversight and the organization's Quality Assurance and Performance Improvement (QAPI) program.

Monitoring includes:

- Corporate-level tracking of policy review and approval timelines
- Routine corporate quality audits to verify compliance with annual review requirements
- Review of policy compliance trends through QAPI processes
- Communication of findings and updates to community leadership

Brighton Gardens of Leisure Park will incorporate confirmation of receipt and implementation of updated corporate policies into its local QAPI oversight, as applicable.

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5. Date corrective action will be completed 01/12/2026

- **Corporate policy implemented: 01/12/2026**
- **Ongoing organization-wide monitoring: Corporate QAPI Committee meets monthly**

Responsible Parties

- [redacted]Corporate Quality Leadership
- Executive Director
- Director of Nursing

[redacted] Accepted 1/28/26.

A 753 – Resident Evaluation and Service Plan

Tag: A 753

Regulation: N.J.A.C. 8:36-14.8 (Service Plan Requirements)

Summary: The facility failed to ensure the resident's Service Plan was developed and/or updated to reflect an active physician order for [redacted] for Resident #1.

Corrective Action(s) Taken

1. Corrective action for affected resident

Resident #1 was affected by this citation. Resident #1 [redacted] Immediately upon identification of the deficient practice, the facility conducted a comprehensive review of all Assisted Living residents with physician-ordered [redacted] to ensure that each resident's individualized Service Plan, as documented in [redacted] accurately reflects [redacted] administration, monitoring requirements, safety precautions, and staff responsibilities. Clinical staff were re-educated on the requirement that all physician orders, including [redacted] must be incorporated into the resident-specific Service Plan in [redacted] to ensure care delivery is individualized and consistent with the resident's assessed needs.

2. Identification of other residents potentially affected
Systemic Changes to Prevent Recurrence

100% of residents could potentially be affected by this citation, therefore, the facility has implemented a standardized Service Plan review and verification process requiring that all new admissions, changes in condition, changes in level of care, and receipt of new or revised physician orders trigger an immediate review and update of the resident's individualized Service Plan in ALIS. The Health Services Director (HSD), or designee, is responsible for verifying Service Plan accuracy and completeness upon admission, following any significant change in condition, and upon receipt of physician orders. ALIS system functionality will be utilized to document, monitor, and maintain individualized care interventions for residents requiring oxygen therapy as part of their plan of care, ensuring alignment with assessed needs and physician direction.

3. Systemic Corrective Measures The Health Services Director will provide re-education to all licensed and unlicensed staff regarding individualized Service Plan development, ALIS documentation requirements, and implementation of resident-specific interventions, including oxygen therapy. Education will emphasize adherence to the facility's *Resident Evaluation and Service Plan* policy and reinforce the expectation that Service Plans are individualized, current, and reflective of all physician-ordered treatments and resident needs.

4. Monitoring to ensure ongoing compliance

The Health Services Director, or designee, will conduct monthly audits of one-third (1/3) of Assisted Living resident Service Plans documented in [redacted] for a period of three (3) months to verify that all physician orders, including oxygen therapy, are accurately and individually reflected. Following the initial monitoring period, Service Plan audits will be conducted on a quarterly basis. Audit findings will be reviewed, trended, and addressed through the facility's Quality Assurance and Performance Improvement (QAPI) process to ensure sustained compliance and

prompt corrective action as needed.

Completion Date: 03/15/2026

[redacted] Accepted 1/28/26.

A 1051 – Record Availability

Tag: A 1051

Regulation: N.J.A.C. 8:36-15.2

Summary: The facility failed to maintain and provide complete and accessible paper resident medical records for surveyor review in a timely fashion due to a transition between electronic medical record systems.

1. Corrective action for affected resident

Resident #'s 1,2 and 3 were affected. Resident #1 [redacted] Resident #'s 2 and 3 are [redacted] and continue to reside in this community. On the day of the survey, we were unable to provide the surveyor with paper records for the 3 residents in question in a timely fashion. All paper documents for the 3 residents were located at the time of the exit interview. The facility consolidated resident medical records to ensure continuity and accessibility during the electronic health record transition or [redacted] All available paper documentation for the identified residents was located, organized, and incorporated into the active resident record. Staff were instructed that all documentation must be maintained in a centralized, clearly identifiable location and made immediately available upon request by the Department of Health.

2. Identification of other residents potentially affected

100% of residents have the potential to be affected by this deficiency, therefore, the HSD will ensure that all nursing staff are following the facility's written Medical Record Transition Protocol outlining record maintenance and access requirements during system conversion to include:

- Clear designation of the active record location (electronic and paper)
- A standardized process for scanning and uploading paper records into [redacted]

- Maintenance of a master record tracking log during transitions
- Delineation of responsibility by Job Title with associated timelines

3. Systemic Corrective Measures The HSD or designee will provide in person and written education to the staff on documentation standards, record retention requirements, and immediate availability of resident records for regulatory review, consistent with the facility's "Documentation Standards – Resident Health Record" policy. Signed confirmation of receipt and understanding of roles and responsibilities to be obtained upon completion.

4. Monitoring to ensure ongoing compliance

The Director of Nursing or designee will audit 1/3 of resident records for three (3) months to ensure records are complete, current, and readily accessible. Following this period, audits will occur quarterly until all paper documents have been uploaded to Electronic Health Record. Findings will be reviewed through the QAPI process and corrective actions implemented as necessary. **Completion Date: 03/15/2026**

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
65A000 Y1	A. Building B. Wing Y2	2/3/2026 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF LEISURE PARK	1400 ROUTE 70 LAKEWOOD, NJ 08701

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 A0355	Correction	ID Prefix A0363	Correction	ID Prefix A0537	Correction
Reg. # 8:36-4.1(a)(1)	Completed	Reg. # 8:36-4.1(a)(5)	Completed	Reg. # 8:36-5.7(a)(1)	Completed
LSC	01/31/2026	LSC	01/30/2026	LSC	01/12/2026
ID Prefix A0753	Correction	ID Prefix A1051	Correction	ID Prefix	Correction
Reg. # 8:36-7.3(c)	Completed	Reg. # 8:36-15.2	Completed	Reg. #	Completed
LSC	03/15/2026	LSC	03/15/2026	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	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/4/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

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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	
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