

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 85A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2026
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NAME OF PROVIDER OR SUPPLIER UNITED METHODIST COMMUNITIES AT BRIST	STREET ADDRESS, CITY, STATE, ZIP CODE 200 BRISTOL GLEN DRIVE NEWTON, NJ 07860
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	<p>Initial Comments</p> <p>Initial Comments: Type of Survey: Complaint #: NJ 00189738</p> <p>Census: 82</p> <p>Sample Size: 3</p> <p>The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.</p>	A 000		
A 310	<p>8:36-3.4(a)(1) Administrator's Responsibilities</p> <p>(a) The administrator or designee shall be responsible for, but not limited to, the following:</p> <p>1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;</p>	A 310		

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

TITLE

(X6) DATE

04/16/26

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 85A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2026
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A 310	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00189738</p> <p>Based on interview and record review it was determined that the Administrator failed to ensure the development, implementation and enforcement of all facility policies and procedures regarding a medication error by a Certified Medication Aide (CMA) in training, for 1 of 3 residents reviewed, Resident #2. This deficient practice was evidenced by the following:</p> <p>The New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), (a form used by health care facilities to report events), which revealed that on <small>NJ Exec Order 26.1</small>, while the facility Registered Nurse Educator (RNE), was observing medication administration with a Certified Medication Aide (CMA) who was in training, the CMA in training administered medication to the wrong resident.</p> <p>On 3/30/26 at 10:00 a.m., the surveyor interviewed the Administrator who stated he was aware of the medication error incident involving Resident #2 and stated that an investigation was conducted which he would provide to the surveyor. Additionally, the surveyor requested access to the facility policies which included policies and procedures related to medication administration, CMA delegation/ Registered Nurse (RN) oversight, resident assessments and resident services.</p> <p>At 11:20 a.m., the surveyor reviewed the facility investigation regarding the medication error which</p>	A 310		

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A 310	<p>Continued From page 2</p> <p>revealed, "During morning medication pass on the assisted living [redacted]. The RN Nurse instructor was doing medication administration pass with a CMA in training. When reviewing the medication, it was discovered that the resident [Resident #2] received medication for another resident with the [redacted] ..."</p> <p>The surveyor reviewed a written statement by the RNE which revealed that Resident #2 accepted the medications before the CMA in training verified Resident #2's name, date of birth or photo. The written statement by the RNE also documented that it was identified Resident #2 received medications intended for Resident #1.</p> <p>The Administrator provided a policy titled, "Medication Management Program Guidelines", last revised on 8/8/25, which revealed the following, "Policy Statement...Medications shall be administered to residents in a safe effective manner in accordance with physician orders or protocols and prescribed principles and procedures...Procedure..Proper administration of a medication consists of the following: 1. Right drug 2. Right patient 3. Right dose 4. Right time 5. Right route 6. Right reason 7. Right documentation...Assisted Living and CMA Program ...Medication monitoring is to be conducted and documented by the registered professional nurse. Delegation of medication supervision, assistance or administration to other qualified nursing personnel will be done in accordance with specific state requirements ..."</p> <p>Refer to 8:36-11.5 (a) [A 0937], (f) [A 0963]</p>	A 310		
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A 937 A 937	<p>Continued From page 3</p> <p>8:36-11.5(a) Certified Medication Aide Program</p> <p>(a) The administration of medications is within the scope of practice and remains the responsibility of the registered professional nurse.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00189738</p> <p>Based on interview and record review, it was determined that the facility's Registered Nurse (RN), failed to ensure the responsibility of accurate administration of medications by a Certified Medication Aide (CMA) in training, which resulted in a medication error for 1 of 3 residents reviewed, Resident #2. This deficient practice was evidenced by the following:</p> <p>The New Jersey Department of Health (NJDOH), received a Facility Reportable Event (FRE), (a report used by health care facilities to report events), which revealed that on [REDACTED], while the facility Registered Nurse Educator (RNE) was observing medication administration with a CMA who was in training, the CMA in training administered medication to the wrong resident.</p> <p>On 3/30/26 at 10:30 a.m., the surveyor reviewed Resident #2's medical record (MR), which revealed that the resident was admitted to the</p>	A 937 A 937		

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A 937	<p>Continued From page 4</p> <p>facility in [redacted] of [redacted] with diagnoses of [redacted] and [redacted] Resident #2's MR revealed a progress note (PN) dated [redacted] written by a Registered Nurse (RN), who was the former Director of Nursing, which revealed, "Resident was given another resident's medication on [redacted] ..."</p> <p>At 11:20 a.m., the surveyor reviewed the facility investigation regarding the medication error which revealed, "During morning medication pass on the assisted living [redacted]. The RN Nurse instructor was doing medication administration pass with a CMA in training. When reviewing the medication, it was discovered that the resident [Resident #2] received medication for another resident with the [redacted] ..."</p> <p>The surveyor reviewed a written statement by the RNE which revealed that Resident #2 accepted the medications before the CMA in training verified Resident #2's name, date of birth or photo. The written statement by the RNE also documented that it was identified Resident #2 received medications intended for Resident #1.</p> <p>At 11:45 a.m., the surveyor interviewed the RNE who had a hire date of [redacted], and the title, Certified Nursing Aide Instructor. The RNE stated that she was with the CMA in training when the CMA administered medication to the wrong resident on [redacted]. The RNE stated that she supervised the CMA as she prepared the medication to bring to Resident #1's room for administration. The RNE explained that after the CMA prepared the medication, the CMA observed who she thought was Resident #1, walking by the medication room, and the CMA called the resident [Resident #2], by his/her [redacted] and the resident [Resident #2] came into the</p>	A 937		
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A 937	<p>Continued From page 5</p> <p>medication room. The RNE stated that the CMA seemed to recognize and know the resident by his/her first name. The RNE further explained that she observed the CMA administer medications to Resident #2. The RNE stated that when she looked at the resident's name on the NJ Exec Order 26.4b1 which the CMA had not administered yet, the RNE realized that the CMA had administered Resident #1's medication to Resident #2 in error. The RNE explained that Resident #1 and Resident #2 NJ Exec Order 26.4b1.</p> <p>During continued surveyor interview, the RNE stated that she should have ensured the CMA in training checked the resident's photo and followed the rights of medication administration.</p> <p>The surveyor reviewed a facility policy titled, "Medication Management Program Guidelines", last revised, on 8/8/25, which revealed the following: "Policy Statement...Medications shall be administered to residents in a safe effective manner in accordance with physician orders or protocols and prescribed principles and procedures...Procedure..Proper administration of a medication consists of the following: 1. Right drug 2. Right patient 3. Right dose 4. Right time 5. Right route 6. Right reason 7. Right documentation...Assisted Living and CMA Program ...Medication monitoring is to be conducted and documented by the registered professional nurse. Delegation of medication supervision, assistance or administration to other qualified nursing personnel will be done in accordance with specific state requirements ..."</p> <p>Refer to 8:36-11.5 (f) [A0963]</p>	A 937		

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A 963 A 963	<p>Continued From page 6</p> <p>8:36-11.5(f) Certified Medication Aide Program</p> <p>(f) Medications shall be accurately administered and documented by properly authorized individuals, in accordance with prescribed orders.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00189738</p> <p>Based on interview and record review, it was determined that the facility failed to ensure that medications were accurately administered in accordance with prescriber orders, for 1 of 3 residents reviewed, Resident #2. This deficient practice was evidenced by the following:</p> <p>The New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), (a form used by health care facilities to report events), which revealed that on [redacted], while the facility Registered Nurse Educator (RNE) was observing medication administration with a Certified Medication Aide (CMA) who was in training, the CMA administered medication to the wrong resident.</p> <p>On 3/30/26 at 10:30 a.m., the surveyor reviewed Resident #2's medical record (MR), which revealed that the resident was admitted to the facility in [redacted] of [redacted] with diagnoses of [redacted] and [redacted]. Further review of Resident #2's MR revealed a progress note (PN)</p>	A 963 A 963		

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A 963	<p>Continued From page 7</p> <p>dated [redacted], written by a Registered Nurse (RN), who was the former Director of Nursing. The PN revealed, "Resident was given another resident's medication on [redacted]..."</p> <p>At 11:45 a.m., the surveyor interviewed the Registered Nurse Educator (RNE) who had a hire date of [redacted] and the title, Certified Nursing Aide Instructor. The RNE stated that she was with the CMA in training when the CMA administered medication to the wrong resident on [redacted]. The RNE stated that she supervised the CMA as she prepared the medication to bring to Resident #1's room for administration. The RNE explained that after the CMA prepared the medication, the CMA observed who she thought was Resident #1, walking by the medication room, and the CMA called the resident [Resident #2], by his/her [redacted] and accompanied the resident [Resident #2], into the medication room. The RNE stated that the CMA seemed to recognize and know the resident by his/her [redacted]. The RNE further explained that she observed the CMA administer medications to Resident #2. The RNE stated that when she looked at the resident's name on the [redacted] which the CMA had not administered yet, the RNE realized that the CMA had administered Resident #1's medication to Resident #2 in error. The RNE explained that Resident #1 and Resident #2 [redacted]</p> <p>During continued interview with the RNE, the surveyor inquired how the residents were identified for medication administration. The RNE stated that the CMA should have identified the resident's full name and that all medication rights should have been checked, including right person, right medication, right dose and right time. The RNE also stated that there were photo identifications of the residents on the electronic</p>	A 963		

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A 963	<p>Continued From page 8</p> <p>medication administration record (eMAR) but that sometimes it was hard to tell from the photos because NJ Exec Order 26.4b1.</p> <p>At 12:00 p.m. the surveyor interviewed the CMA in training regarding the medication error that occurred on NJ Exec Order 26.4b1. The CMA in training, stated that she currently worked as a Certified Nursing Assistant (CNA), not as a CMA, because she had not completed her training or taken the test yet. The CMA in training stated that she learned from the mistake and understood that she must always properly identify all residents and confirm their first and last name prior to administering any medications.</p> <p>At 1:00 p.m. the surveyor reviewed the facility investigation of the medication error, which revealed that Resident #2 received the following medications in error, that were meant for Resident #1:</p> <p>NJ Exec Order 26.4b1 1 tablet (a medication used to treat NJ Exec Order 26.4b1) NJ Exec Order 26.4b1 1 tablet (a medication used to treat NJ Exec Order 26.4b1) NJ Exec Order 26.4b1 (used to treat NJ Exec Order 26.4b1) NJ Exec Order 26.4b1 1 tablet (a medication used to treat NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1)</p> <p>The surveyor reviewed Resident #1's MR which revealed that the resident was admitted to the facility in NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 with diagnoses of NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. The surveyor reviewed Resident #1's Physician Order Summary Sheet which revealed that the medications which were administered to Resident #2 in error were ordered for Resident #1.</p>	A 963		

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A 963	<p>Continued From page 9</p> <p>At 1:43 p.m., during a follow up interview with the RNE, the surveyor inquired if there was any type of alert system in place when residents had the NJ Exec Order 20.4b1 and the RNE stated "no."</p> <p>The surveyor reviewed a facility policy titled, "Medication Management Program Guidelines", last revised, on 8/8/25, which revealed the following: "Policy Statement...Medications shall be administered to residents in a safe effective manner in accordance with physician orders or protocols and prescribed principles and procedures...Procedure...Residents are identified before medication is administered using [two] methods of identification. Methods of identification include: Checking photograph attached to medical record. Calling resident by name...Having the resident verify his/her last name. If necessary, verifying resident identification with another community staff. Proper administration of a medication consists of the following: 1. Right drug 2. Right patient 3. Right dose 4. Right time 5. Right route 6. Right reason 7. Right documentation..."</p> <p>Refer to 8:36-11.5 (a) [A0937]</p>	A 963		



**United Methodist
Communities**

Abundant Life for Seniors

Bristol Glen
200 Bristol Glen Drive
Newton, NJ 07860

973-300-5788
973-579-2351
UMCommunities.org

POC # 2 Received
4/17/26
acceptable

St-A- 0310-8:36-3.4 (a)(1) – Administrator Responsibilities

1. Resident #2 remains in the community and has had **NJ Exec Order 26.4b1** from the cited practice.
2. All residents receiving medication by the community staff have the potential to be affected by this practice.
3. The Registered Nurse Educator was provided immediate reeducation on **NJ Exec Order 26.4b1** by the Corporate Director of Clinical Services on delegation responsibilities and direct supervision requirements. The Certified Medication Aides in training was also provided immediate re-education by the Registered Nurse Educator and remains at this time as a Certified Medication Aide in training. Starting on March 31st the Wellness and Education Director will be educating All Certified Medication Aides and nursing staff on the community's medication administration policy, with reinforced emphasis on the "Right Resident" verification process, including confirmation of the resident's photograph, full name, and date of birth prior to medication administration. All Registered Nurses participating in Certified Medication Aides medication pass observations will be educated on delegation responsibilities, accountability, and direct supervision requirements. The Administrator will review and reinforce medication management policies and Registered Nurse oversight requirements to ensure sustained compliance by 4/30/26.
4. The Wellness and Education Director will perform monthly direct observations of Certified Medication Aides (CMAs) and Registered Nurses during medication administration passes for three (3) consecutive months. Any identified variances will require immediate retraining and corrective action. Observation results will be reviewed with the Administrator and Executive Director and presented at the quarterly Quality Assurance and Performance Improvement (QAPI) meeting to support sustained compliance and continuous improvement.

Completion Date - 4.30.2026

NJ Exec Order 26.4b1



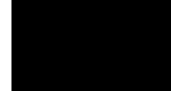


St-A-0937- 8:36-11.5(a) – Certified Medication Aide Program

1. Resident #2 remains in the community and has had **NJ Exec Order 26.4b1** from the cited practice.
2. All residents receiving medication from the community staff have the potential to be affected by this practice.
3. The Registered Nurse Educator was provided immediate reeducation on **NJ Exec Order 26.4b1** by the corporate director of clinical services on delegation responsibilities and direct supervision requirements. The Certified Medication Aide in training was also provided immediate re-education by The Wellness and Education Director will and remains at this time as a Certified Medication Aide in training. Starting March 31st. All Certified Medication Aides and nursing staff will receive in-service education on the community's medication administration policy, with reinforced emphasis on the "Right Resident" verification process, including confirmation of the resident's photograph, full name, and date of birth prior to medication administration. All Registered Nurses participating in Certified medication Aide medication pass observations will be educated on delegation responsibilities, accountability, and direct supervision requirements. The Administrator will review and reinforce medication management policies and Registered Nurse oversight requirements to ensure sustained compliance by 4/30/26.
4. The Wellness and Education Director will perform monthly direct observations and hand on education of Certified Medication Aides (CMAs) and Registered Nurses during medication administration passes for three (3) consecutive months. Any identified variances will require immediate retraining and corrective action. Observation results will be reviewed with the Administrator and Executive Director and presented at the quarterly Quality Assurance and Performance Improvement (QAPI) meeting to support sustained compliance and continuous improvement.

Completion Date - 4.30.2026

NJ Exec Order 26.4b1





United Methodist
Communities

Abundant Life for Seniors

Bristol Glen
200 Bristol Glen Drive
Newton, NJ 07860

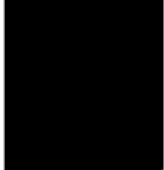
973-300-5788
973-579-2351
UMCommunities.org

St- A- 0963- 8:36-11.5(f) Certified Medication Aide Program

1. Resident #2 remains in the community and has had **NJ Exec Order 26.4b1** from the cited practice.
2. All residents receiving medication from the community staff have the potential to be affected by this cite practice.
3. Starting March 31st, All Registered Nurses participating in Certified Medication Aide (CMA) medication pass observations will receive education on delegation responsibilities, accountability, and direct supervision requirements. The Administrator will review and reinforce medication management policies and Registered Nurse oversight requirements to ensure sustained compliance. A newly implemented policy outlining medication observation guidance for Certified Medication Aides clearly defines the Registered Nurse role and direct supervision expectations and will be reviewed with all Registered Nurses involved in CMA medication observations, with annual acknowledgment required. Wellness and Education Director or Designee will conduct policy review with all Registered Nurses involved in the Certified Medication Aide (CMA) program and will obtain documented acknowledgment to ensure understanding of delegation, oversight, and supervision responsibilities.
4. The Wellness and Education Director will conduct direct observation of CMAs and Registered Nurses during medication administration passes monthly for three (3) months. Any identified variances will require immediate retraining and remediation. Observation results will be reviewed with the Executive Director and presented at the quarterly Quality Assurance and Performance Improvement (QAPI) meeting to ensure ongoing compliance and corrective action as needed.

Completion Date - 4.30.2026

NJ Exec Order 26.4b1



STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 85A001	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 4/21/2026	Y3
NAME OF FACILITY UNITED METHODIST COMMUNITIES AT BRISTOL GLEN			STREET ADDRESS, CITY, STATE, ZIP CODE 200 BRISTOL GLEN DRIVE NEWTON, NJ 07860		

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 <u>A0310</u>	Correction	ID Prefix <u>A0937</u>	Correction	ID Prefix <u>A0963</u>	Correction
Reg. # <u>8:36-3.4(a)(1)</u>	Completed	Reg. # <u>8:36-11.5(a)</u>	Completed	Reg. # <u>8:36-11.5(f)</u>	Completed
LSC _____	<u>04/30/2026</u>	LSC _____	<u>04/30/2026</u>	LSC _____	<u>04/30/2026</u>
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 3/30/2026		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 85A001	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 4/21/2026	Y3
NAME OF FACILITY UNITED METHODIST COMMUNITIES AT BRISTOL GLEN			STREET ADDRESS, CITY, STATE, ZIP CODE 200 BRISTOL GLEN DRIVE NEWTON, NJ 07860		

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 <u>A0310</u>	Correction	ID Prefix <u>A0937</u>	Correction	ID Prefix <u>A0963</u>	Correction
Reg. # <u>8:36-3.4(a)(1)</u>	Completed	Reg. # <u>8:36-11.5(a)</u>	Completed	Reg. # <u>8:36-11.5(f)</u>	Completed
LSC _____	<u>04/30/2026</u>	LSC _____	<u>04/30/2026</u>	LSC _____	<u>04/30/2026</u>
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 3/30/2026		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		