

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 90122	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/21/2025
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NAME OF PROVIDER OR SUPPLIER BRIGHTON GARDENS OF MOUNTAINSIDE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 ROUTE 22 WEST MOUNTAINSIDE, NJ 07092
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A 000	<p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ00188802, NJ00183185, NJ00183619 CENSUS: 116 SAMPLE SIZE: 3 SURVEY DATE: 11/20/2025-11/21/2025</p> <p>The facility is not in substantial compliance with all the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs, based on this Complaint Survey.</p> <p>The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.</p>	A 000		
A 389	<p>8:36-4.1(a)(16) Resident Rights</p> <p>(a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights:</p> <p>16. The right to be free from physical and mental abuse and/or neglect;</p>	A 389		

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

TITLE

(X6) DATE

01/07/26

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A 389	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #NJ00183185</p> <p>Based on facility policy review, record review, facility document review, and interview, the facility failed to ensure residents had the right to be [redacted] from [redacted] which affected 1 (Resident #2) of 3 residents reviewed for [redacted] or [redacted]. Specifically, Resident #2 [redacted] on [redacted], activated the facility's nurse call system, and had to wait 22 minutes for staff to respond.</p> <p>Findings included:</p> <p>A facility policy titled, "Abuse, Neglect & Exploitation - Prevention, Reporting and Investigation," revised 04/24/2025, revealed, "It is the policy of the community that," which included, "Every reasonable effort within its control is taken to prevent the abuse, neglect, and exploitation of residents. Team Members must not engage in, nor tolerate anyone else to engage in, abuse, neglect or exploitation of any resident."</p> <p>Medication Care Manager (MCM) #8's personnel record revealed a "Position Details," signed by MCM #8 and dated 04/08/2021, that included job duties for a care manager. The document indicated that "Essential Duties: Resident Care" included, "Responds to security system and resident call bells promptly and immediately. Takes appropriate action including resetting call bells."</p> <p>A "Move In Record" indicated the facility admitted Resident #2 on [redacted]. According to the Move In Record, the resident had a medical history that included diagnoses of [redacted]</p>	A 389		
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A 389	<p>Continued From page 2</p> <p>NJ Exec Order 26.4b1 of a NJ Exec Ord and NJ Exec Order 26.4b1</p> <p>Resident #2's Brief Interview for Mental Status (BIMS), dated NJ Exec Order 26.4b1, indicated the resident had a BIMS score of NJ Exec which indicated the resident had NJ Exec Order 26.4b1.</p> <p>Resident #2's "Service Plan Report" included a focus area initiated NJ Exec Order 26.4b1 and revised NJ Exec Order 26.4b1 related to "NJ Exec Order 26.4b1" The Service Plan Report indicated that resident had NJ Exec Order 26.4b1 related to a NJ Exec Order 26.4b1 Interventions initiated NJ Exec Order 26.4b1 directed staff to notify the resident's doctor of any changes in their overall NJ Exec Order 26.4b1, observe the resident and report any change in NJ Exec Order 26.4b1, and observe the resident and report any NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 during care and NJ Exec Order 26.4b1</p> <p>Resident #2's "Service Plan Report" included a focus area initiated NJ Exec Order 26.4b1 that indicated the resident was a NJ Exec risk. Interventions initiated on NJ Exec Order 26.4b1 directed staff to inform the resident and caregivers about safety reminders and what to do if a NJ Exec occurred.</p> <p>Resident #2's "Service Plan Report" included a focus area initiated on NJ Exec Order 26.4b1, that indicated that the resident had an NJ Exec Order 26.4b1. Interventions initiated NJ Exec Order 26.4b1 directed staff to immediately report any NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 NJ Exec Order 26.4b1, or NJ Exec Order 26.4b1</p> <p>Resident #2's "Progress Notes" included a NJ Exec Progress Note," dated NJ Exec Order 26.4b1 at 2:00 PM, that revealed that Resident #2's had an NJ Exec Order 26.4b1 in the resident's room on NJ Exec Order 26.4b1 at 6:45 AM. The note indicated that a</p>	A 389		
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A 389	<p>Continued From page 3</p> <p>care manager stated she NJ Ex Order 26.4b1 Resident #2 NJ Ex Order 26.4b1 when she went in to provide care at 6:45 AM. The note indicated that the care manager called a medication technician and indicated that a licensed practical nurse (LPN) was notified and responded immediately. Per the note, upon assessment, the resident stated they were NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 on the NJ Exec Order 26.4b1. The note indicated that the resident complained of NJ Exec Order 26.4b1. The note indicated that emergency services were called, the family was notified via telephone, the Resident Care Director (RCD) was notified, and a nurse practitioner was notified. The note indicated that the resident was taken to the local hospital.</p> <p>Resident #2's "Progress Notes" revealed a "Health Status Note," dated NJ Exec Order 26.4b1 at 1:46 PM, that revealed that emergency room staff were contacted for an update on Resident #2's condition. Per the note, the resident had two NJ Exec Order 26.4b1, NJ Exec Order 26.4b1, and would require NJ Exec Order 26.4b1.</p> <p>An undated facility document titled, "Report Summary" "[Resident #2's Name]" indicated that on NJ Exec Order 26.4b1 at 6:44 AM, a care manager went to Resident #2's room to provide care and observed the resident NJ Ex Order 26.4(b)(1) in their kitchenette area. Per the document, the resident was previously seen at 6:10 AM. The document indicated that the resident said they were NJ Exec Order 26.4b1. The document indicated that the resident was NJ Exec Order 26.4b1.</p> <p>During an interview on 11/20/2025 at 1:28 PM, Resident #2 stated that in NJ Exec Order 26.4b1, they (the resident) were NJ Exec Order 26.4b1. The resident stated that they were NJ Exec Order 26.4b1 for</p>	A 389		
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A 389	<p>Continued From page 4</p> <p>about 45 minutes. Resident #2 stated that they used a call button, and after waiting for a long time, an aide came into their room and called an ambulance.</p> <p>A facility call light report indicated that on NJ Exec Order 26.4b1, Resident #2's alarm by their bed was activated at 6:24:12 AM and was not reset until 6:46:36 AM, 22 minutes and 24 seconds later.</p> <p>During an interview on 11/20/2025 at 2:46 PM, MCM #8 stated that at the start of her shift, she received report from the overnight shift staff, completed rounds, and checked on the residents. She stated that her shifts started at 6:00 AM, and usually most residents were still in bed. She stated that if there was an accident in one of the resident rooms, there was a call bell next to each resident's bed, in the resident's bathroom next to the toilet, and for some, they had a call pendant. She stated that when the resident pressed the call bell, it was activated on a facility-issued cell phone, where everyone could hear the alert and see which resident was calling and their room number. MCM #8 stated that she was assigned to Resident #2 the day of the resident's NJ Exe and that while completing her first rounding, Resident #2 was in bed. She stated that at some point, she saw that the resident called for assistance. She stated that she NJ Ex Order 2 the resident NJ Ex Order 26.4(b)(1) near their plants. MCM #8 stated that at 6:45 AM the morning of the NJ Exe was the first time the resident had called that morning, and the resident stated that they had NJ Exec Order 26.4b1. MCM #8 stated that she called a medication technician for help.</p> <p>During an interview on 11/21/2025 at 11:47 AM, MCM #8 stated that every time a resident used their call bell, it showed on the telephone with the</p>	A 389		

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A 389	<p>Continued From page 5</p> <p>resident's name and room number. She stated that if the call came in, she would go to the resident's room to turn off the alarm, then clear it on the phone. MCM #8 stated that as soon as she came on duty, she got a telephone. She stated that if she was in another room working, she would not be able to check the phone right away. She stated that on the day of Resident #2's NJ Exec she had just come out of another resident's room and saw that the telephone was activated. She stated she did not remember what she was doing at that time, but if she was providing incontinent care, she would not check the phone until her hands were free. She stated that the first time she saw the alert for Resident #2, it was at 6:45 AM and stated that she could not remember all the details of that morning.</p> <p>During an interview on 11/21/2025 at 11:32 AM, Care Manager (CM) #7 stated that she was the lead care manager on duty the day of Resident #2's fall. She stated that she rounded with the overnight staff some time before 6:15 AM, and at that time, Resident #2 was in bed. She stated that during the morning, they were notified when residents called for help from an alert on the telephone. She stated that if she needed someone else to check on one of the residents she was assigned to if she was busy with someone else, she would communicate with a two-way radio.</p> <p>During an interview on 11/20/2025 at 4:06 PM, RCD stated that Resident #2 was at risk of NJ Exec Or and the morning the resident NJ Exec the resident was up early, NJ Exec Order 26.4b1. She stated that staff responded to the resident's call bell and NJ Ex Order 2 them NJ Ex Order 26.4(b)(1), and that it was an NJ Exec Order 26.4b1. The RCD stated that her expectation was that if staff got an alert on the</p>	A 389		
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A 389	<p>Continued From page 6</p> <p>tablet/telephone, they must respond. She stated that she expected staff to do NJ Ex Order 26.4(b)(1) every NJ Ex Order 26.4(b)(1) and give reminders to use the call bell if the resident wanted to be NJ Ex Order 26.4(b)(1). She stated that Resident #2 was NJ Exec Order 26.4b1. The RCD stated that she did not expect residents to wait 22 minutes before they got a response from staff.</p> <p>During an interview on 11/21/2025 at 3:42 PM, the Executive Director (ED) stated that Resident #2 was NJ Exec Order 26.4b1 in their room the morning of NJ Exec Order 26.4b1. She stated that the resident NJ Exec Order 26.4b1. She stated that until that day, she was not aware of the 22-minute lapse in time from when the resident first initiated the call system to when it was cleared, and the resident was NJ Ex Order 26.4(b)(1). She stated that she expected call lights to be responded to within seven minutes and not more than 10 minutes.</p>	A 389		
A 563	<p>8:36-5.10(a)(2) General Requirements</p> <p>(a) The facility shall notify the Division of Health Facility Survey and Field Operations immediately by telephone at (609) 633-9034 (609) 392-2020 if after business hours, followed within 72 hours by written confirmation, of the following:</p> <p>2. Any major occurrence or incident of an unusual nature, including, but not limited to, all fires, disasters, any elopements; and all deaths resulting from accidents or incidents in the facility or related to facility services. Reports of such incidents shall contain information about injuries to residents and/or personnel, disruption of services, and</p>	A 563		

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A 563	<p>Continued From page 7</p> <p>extent of damages;</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #NJ00188802 and #NJ00183619</p> <p>Based on facility policy review, record review, facility document review, and interview, the facility failed to notify the state survey agency immediately by telephone, followed by written confirmation within 72 hours, of ^{NJ Exec Order 26.4(b)(1)} [REDACTED] for 2 (Resident #1 and Resident #3) of 3 residents reviewed for ^{NJ Exec Order 26.4} [REDACTED] ^{NJ Exec Order 26.4} or NJ Exec Order 26.4b1.</p> <p>Findings included:</p> <p>A facility policy titled, "Incident and Event Reporting," revised 04/24/2024, revealed, "It is the policy of the community to ensure that [the facility's name] team members promptly and accurately report and document incidents to promote early intervention, improve quality of care for our residents, improve safety for residents, team members and visitors, and reduce the risk of harm." The policy revealed the "Procedure" included, "4. In addition to and separate from the internal reporting, the ED [Executive Director]/designee is responsible for validating all incidents/events are reported timely in accordance with the state/federal/provincial</p>	A 563		

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A 563	<p>Continued From page 8</p> <p>laws and regulations, using the state/province mandated form or online portal, where available."</p> <p>1. A "Move In Record" indicated the facility admitted Resident #1 on [redacted NJ Exec Order 26.4b1]. According to the Move In Record, the resident had a medical history that included a diagnosis of [redacted NJ Exec Order 26.4b1].</p> <p>Resident #1's Brief Interview for Mental Status (BIMS), dated [redacted NJ Exec Order 26.4b1], revealed Resident #1 had a BIMS score of [redacted NJ] which indicated the resident had [redacted NJ Exec Order 26.4b1].</p> <p>Resident #1's "Service Plan Report" included a focus area initiated [redacted NJ Exec Order 26.4b1] to the resident's [redacted NJ Exec Or] Interventions initiated [redacted NJ Exec Order 26.4b1] directed staff to observe and report any changes to the resident's [redacted NJ Exec Or] and observe for and report any [redacted NJ Exec Order 26.4b1].</p> <p>Resident #1's "Progress Notes" revealed a "Health Status Note," dated [redacted NJ Exec Order 26.4b1] at 2:42 PM, that indicated that Resident #1 was noted with [redacted NJ Exec Order 26.4b1] to their [redacted NJ Exec Order 26.4b1]. The note indicated that the [redacted NJ Exec Order] was "[redacted NJ Exec Order 26.4b1]," and [redacted NJ Exec C] was noted upon [redacted NJ Exec Order 26.4b1].</p> <p>Resident #1's "Progress Notes" revealed a late entry "Health Status Note," dated [redacted NJ Exec Order 26.4b1], that indicated that Resident #1 was noted with [redacted NJ Exe].</p> <p>[redacted] The note also indicated that there was [redacted NJ Exec Order 26.4b1] to the [redacted NJ Exec Order 26.4b1]. The note indicated that an [redacted NJ Exec Order 26.4b1] was ordered.</p> <p>Resident #1's "Progress Notes" revealed a "Health Status Note," dated [redacted NJ Exec Order 26.4b1] at 10:05</p>	A 563		
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A 563	<p>Continued From page 9</p> <p>AM, that indicated that Resident #1 had an [redacted] of their [redacted] that revealed [redacted] the resident's [redacted] NJ Exec Order 26.4b1), with [redacted] NJ Exec Order 26.4b1 noted.</p> <p>A "New Jersey Department of Health and Senior Services Division of Long Term Care Systems Assessment and Survey Program/Compliant Unit" "Reportable Event Record/Report" indicated that the facility reported [redacted] NJ Ex Order 26.4(b)(1) [redacted] NJ Ex Order 26.4b1 for Resident #1 that was discovered by the facility on [redacted] NJ Exec Order 26.4b1. The report indicated that the "Significant Event" was called in to the state survey agency on [redacted] NJ Exec Order 26.4b1 and the written confirmation was submitted to the state survey agency on [redacted] NJ Exec Order 26.4b1, seven days after [redacted] NJ Ex Order 26.4(b)(1) was discovered.</p> <p>During an interview on 11/21/2025 at 12:30 PM, the Reminiscence Coordinator (RC) #3 stated that in [redacted] NJ Ex Order 26.4(b)(1) Resident #1 had [redacted] NJ Exec Order 26.4b1 and [redacted] NJ Exec Order 26.4b1 on their [redacted] NJ Exec Order 26.4b1 on their [redacted] NJ Exec Order 26.4b1. She stated that they were not able to determine how the resident got the [redacted] NJ Exec Order 26.4b1.</p> <p>During an interview on 11/21/2025 at 4:35 PM, the Resident Care Director (RCD) stated that Resident #1 was found to have [redacted] NJ Exec Order 26.4b1 and [redacted] NJ Exec Order 26.4b1 to their [redacted] NJ Exec Order 26.4b1 on the [redacted] NJ Exec Order 26.4b1 and an [redacted] NJ Exec Order 26.4b1. She stated that the [redacted] NJ Exec Order 26.4b1 was noted around [redacted] NJ Exec Order 26.4b1 or [redacted] NJ Exec Order 26.4b1 and then immediately investigated. She stated that she was unaware as to why the [redacted] NJ Exec Order 26.4b1 was not reported to the state survey agency until [redacted] NJ Exec Order 26.4b1. The RCD stated that her expectation was that all reporting should be completed timely.</p> <p>During an interview on 11/21/2025 at 3:32 PM, the ED stated that she was responsible for</p>	A 563		
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A 563	<p>Continued From page 10</p> <p>investigating incidents and reporting to the appropriate entities. The ED stated that Resident #1 was found to have ^{NJ Exec Order 26.4b1} and ^{NJ Exec Order 26.4b1} to their ^{NJ Exec Order 26.4b1} on ^{NJ Exec Order 26.4b1}. She stated that the incident was not reported to the state survey agency until ^{NJ Exec Order 26.4b1}. She stated that that was something that they would need to work on. The ED stated that she expected that all incidents be reported to the appropriate entity timely.</p> <p>2. A "Move In Record" indicated the facility admitted Resident #3 on ^{NJ Exec Order 26.4b1}. According to the Move In Record, the resident had a medical history that included diagnoses of ^{NJ Exec Order 26.4b1}.</p> <p>Resident #3's Brief Interview for Mental Status (BIMS), dated ^{NJ Exec Order 26.4b1}, revealed the resident had a BIMS score of ^{NJ} which indicated the resident had ^{NJ Exec Order 26.4b1}.</p> <p>Resident #3's "Service Plan Report" included a focus area initiated on ^{NJ Exec Order 26.4b1}, related to the resident's ^{NJ Exec Order 26.4b1} Interventions initiated ^{NJ Exec Order 26.4b1} directed staff to observe and report any changes to the resident's ^{NJ Exec Order 26.4b1}.</p> <p>A "New Jersey Department of Health" "LTC [Long-Term Care] Reportable Event Survey," dated ^{NJ Exec Order 26.4b1} and completed by the ED, indicated that on ^{NJ Exec Order 26.4b1}, care managers noticed ^{NJ Exec Order 26.4b1} on Resident #3, who was unable to ^{NJ Ex Order 26.4(b)(1)} leading to the ^{NJ Exec Order 26.4b1}. The report indicated that the resident had not ^{NJ Ex Order 26.4b1} recently and was ^{NJ Ex Order 26.4(b)(1)} if they had ^{NJ Exec Order 26.4b1}. The report indicated that ^{NJ Exec Order 26.4b1} to the resident's ^{NJ Exec Order 26.4b1} was not noted during prior shifts, per care managers. The report indicated that the resident's physician was notified, and an ^{NJ Exec Order 26.4b1} was ordered,</p>	A 563		
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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 90122	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/21/2025
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NAME OF PROVIDER OR SUPPLIER BRIGHTON GARDENS OF MOUNTAINSIDE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 ROUTE 22 WEST MOUNTAINSIDE, NJ 07092
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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
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A 563	<p>Continued From page 11</p> <p>which was [redacted] Per the report, the "Significant Event" was called in to the state survey agency on [redacted], the day after discovery of the [redacted]</p> <p>A written statement by Medication Care Manager (MCM) #5, dated [redacted], indicated that while administering medication to a resident, Care Manager (CM) #6 approached her with Resident #3 and questioned if she was aware of a [redacted] on Resident #3's [redacted]. The statement indicated that MCM #5 responded and told her she was not aware of the [redacted] and directed her to call the nurse. The statement indicated that CM #6 immediately called the nurse and informed him of the resident's [redacted]</p> <p>A written statement by CM #6, dated [redacted] indicated that at about 8:22 AM, she started to do her morning care with Resident #3. The statement indicated that she noticed that when trying to help the resident get up from bed, the resident [redacted] of [redacted] to [redacted]. The statement indicated that upon taking off the resident's [redacted] CM #6 saw a [redacted] on the resident's [redacted]. The statement indicated that CM #6 continued the morning care with Resident #3 and when done, reported to the medication technician about what she had seen. The statement indicated that the medication technician directed her to call and report the concern to the nurse on duty. Per the statement, she reported it, and the nurse said he would report to the physician.</p> <p>A written statement by Reminiscence Coordinator (RC) #3, dated [redacted], indicated that on [redacted] at 3:30 PM, CM #1 informed her about Resident #3. The statement indicated that</p>	A 563		
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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 90122	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/21/2025
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NAME OF PROVIDER OR SUPPLIER BRIGHTON GARDENS OF MOUNTAINSIDE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 ROUTE 22 WEST MOUNTAINSIDE, NJ 07092
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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
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A 563	<p>Continued From page 12</p> <p>RC #3 went to the resident's room to check on them and [redacted] on the resident's [redacted]. The statement indicated that RC #3 spoke to staff about Resident #3's [redacted] and directed them to write statements. The statement indicated that on [redacted] (the following day), she spoke to the Resident Care Director (RCD) about Resident #3's [redacted].</p> <p>During an interview on 11/20/2025 at 3:08 PM, RC #3 stated that she was informed of [redacted] to Resident #3's [redacted]. She stated that she checked on Resident #3 and found [redacted] to the resident's [redacted]. She stated that she interviewed staff, and they all denied knowledge of the [redacted] or an incident involving Resident #3. RC #3 stated that she informed the RCD and presented the concern during the morning meeting. She stated that she was not aware of any other notifications.</p> <p>During an interview on 11/21/2025 at 4:25 PM, the RCD stated that the investigation into Resident #3's [redacted] included interviewing staff who worked with Resident #3 on the days leading up to the identification of the [redacted]. The RCD stated that her expectation was that all reporting should be done timely.</p> <p>During an interview on 11/21/2025 at 3:32 PM, the ED stated that she was responsible for investigating incidents and reporting to the appropriate entities. The ED stated that Resident #3 was found to have [redacted] to their [redacted] on [redacted]. She stated that she expected all incidents to be reported to the appropriate entity timely. She stated that reporting was something they would need to work on.</p>	A 563		
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POC #1 received 1/7/20
Accepted 1/9/20



Plan of Correction

Name of Facility: Brighton Gardens of Mountainside
Address of Facility: 1350 Route 22 West Mountainside, NJ 07092
License number: 90122
Inspection date(s): 11/21/2025
Name and Title of Legal Entity
Representative Signing the Plan of Correction: NJ Ex Order 26.4(b)(1) Executive Director

Signature of Sunrise Representative: NJ Exec Order 26.4b1 NJ Exec Order 26.4b1
Date of Submission: 1/7/2026

Deficiency for Tag A-389, Regulation 8:36-4.1(a)(16)

1. Resident #2 is alive and still living in community. Resident returned to the community on NJ Exec Order 26.4b1
2. All residents have the potential to be affected by this deficient practice. Pull cord report was pulled and reviewed on 2/5/2025 by the Assisted Living Coordinator.
3. The Executive Director trained and in-service Licensed Practical Nurses, Registered Nurses, Assisted Living Coordinator, and Reminiscence Coordinator on Operating and answering call bells and pendants in a timely manner on 2/5/2025. Education on 2/5/2025 was provided by the Assisted Living Coordinator and Reminiscence Coordinator to care managers on call bell resetting, device operation, and appropriate responsiveness to resident's needs in a timely manner. An Audit for residents pull cord and pendant devices was completed by the Maintenance Coordinator on 12/26/2025 to ensure that all call bells and pendants are working and transmitted to team member devices when resident pulls call bell or presses pendant for assistance. An in-service was conducted by the Executive Director to care managers, Licensed Practical Nurses, and Registered Nurses on "Resident's Rights" policy. This in service was initiated on 1/2/2026 and to be completed by 1/8/2026.
4. The Maintenance Coordinator will conduct monthly audits for 2 months beginning 1/8/2026 to ensure call bell devices do not have low batteries and there are no delayed transmissions to devices. The Executive Director will review call bell response time during monthly department head for 2 months beginning 1/8/2025. Report will be reviewed and discussed with all department heads and any issues will be addressed and corrected timely. This Plan of Correction to ensure

compliance of the "Resident's Rights" policy will be reviewed and evaluated quarterly for two quarters by the Executive Director at Quality Assurance Performance Improvement (QAPI) meeting to verify compliance. If not compliant, it will be amended, and a new Plan of Correction and training will be implemented and monitored to verify that the violation does not occur again. Quality Assurance Performance Improvement (QAPI) meeting scheduled for 1/9/2026 by the Executive Director with the coordinators.

Completion Date: 1/8/2026

NJ Exec Order 26.4b1

approved 1/9/26

Deficiency for Tag A-563, Regulation 8:36-5.10(a)(2)

Completion Date: 12/31/2025

1. Resident #1 is alive and still resides in the community. Resident #1 was assessed on [redacted] by the Registered Nurse in the community following notification of a [redacted] NJ Exec Order 26.4b1 The Department of Health was notified of event on [redacted] NJ Exec Order 26.4b1 Resident #3 is alive and still resides in the community. Resident #3 was assessed by the Registered Nurse on [redacted] NJ Exec Order 26.4b1 in the community following the notification of a [redacted] NJ Exec Order 26.4b1 The Department of Health was notified of the event on [redacted] NJ Exec Order 26.4b1
2. All residents have the potential to be affected by this deficient practice. The Executive Director and Resident Care Director conducted an audit of incident reports within the last four months September 2025 through December 2025 to ensure that required progress notes have been entered into the affected resident's medical records and that any reportable event was reported to the Department of Health. The audit was started on 12/30/2025 and completed on 12/31/2025. No other significant events were found upon completing audit.
3. The Executive Director reviewed the "Incident and Event Reporting" Policy with the Resident Care Director, Care managers, Assisted Living Coordinator, and Reminiscence Coordinator on 9/11/2025. The Resident Care Director provided re-education on the "Incident and Event Reporting" Policy including documentation to Registered Nurses and Licensed Practical Nurses The re-education was started on 12/29/2025 and completed by 12/31/2025
4. A weekly audit of incidents and reportable events will be conducted by Executive Director and Resident Care Director weekly for 4 weeks beginning 12/30/2025 and then monthly for 2 months to ensure that the required documentation and reporting have been completed. This Plan of Correction to ensure compliance of the "Incident and Event Reporting" policy and review of conducted audits will be reviewed and evaluated quarterly for two quarters by the Executive Director at Quality Assurance Performance Improvement (QAPI) meeting to verify compliance. If not compliant, it will be amended, and a new Plan of Correction and training will be implemented and monitored to verify that the violation does not occur again. Quality Assurance Performance Improvement (QAPI) meeting scheduled for 1/8/2026 by the Executive Director with the coordinators.

Completion Date: 12/31/2025

NJ Exec Order 26.4b1

approved 1/9/26

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 90122 Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 1/9/2026 Y3
NAME OF FACILITY BRIGHTON GARDENS OF MOUNTAINSIDE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 ROUTE 22 WEST MOUNTAINSIDE, NJ 07092	

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 A0389	Correction	ID Prefix A0563	Correction	ID Prefix	Correction
Reg. # 8:36-4.1(a)(16)	Completed	Reg. # 8:36-5.10(a)(2)	Completed	Reg. #	Completed
LSC	01/08/2026	LSC	12/31/2025	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 11/21/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 90122	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 1/9/2026
NAME OF FACILITY BRIGHTON GARDENS OF MOUNTAINSIDE		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 ROUTE 22 WEST MOUNTAINSIDE, NJ 07092

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
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Reg. # 8:36-4.1(a)(16)	Completed	Reg. # 8:36-5.10(a)(2)	Completed	Reg. #	Completed
LSC	01/08/2026	LSC	12/31/2025	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 11/21/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		