STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL18002	A. BUILDING: _____ B. WING _____	10/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISTAL AT SOMERSET, THE	1870 EASTON AVENUE SOMERSET, NJ 08873

(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: Standard CENSUS: 133 SAMPLE SIZE: 8 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 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;	A 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 310	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and review of other pertinent facility documents, it was determined that the Executive Director (ED) failed to ensure the implementation and enforcement of the facility's policy and procedure titled, "ERS-Emergency Response System," for 7 of 10 residents reviewed, Resident #s 2, 3, 5, 6, 8, 9, and 10. This deficient practice was evidenced by the following: On 10/24/25, the surveyor reviewed the facility's "Resident Council Meeting Minutes," dated 10/14/25, which indicated, "... 13. Concern: What is the actual response time to the call button ... Resolution: There are four aides at a time on each shift. We expect them to answer within 10 minutes ... 17. Concern: There is about an hour during change of shift where a lot of help is needed. Aides do not come to see you or answer your call button for up to 45 minutes ... Resolution: I agree with you and in a perfect situation we would get more staff. We are a higher acuity building. But I cannot hire more staff ..." The surveyor then reviewed the facility's "Call Summary Report," from NJ Exec Order 26.4b1, which revealed call pendant response times of up to two hours, including the following: On NJ Exec Order 26.4b1 staff responded to Resident #2's call pendant in 36 minutes, Resident #8's in 33 minutes, and Resident #9's in 2 hours and 4 minutes. On NJ Exec Order 26.4b1, staff responded to Resident #8's	A 310		

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A 310	Continued From page 2 call pendant in 36 minutes and Resident #9's in 38 minutes. On [NJ Exec Order 26.4b], staff responded to Resident #5's call pendant in 54 minutes, Resident #8's in 35 minutes, and Resident #10's in 1 hour and 12 minutes. On [NJ Exec Order 26.4b], staff responded to Resident #9's call pendant in 30 minutes. On [NJ Exec Order 26.4b], staff responded to Resident #3's call pendant in 36 minutes, Resident #6's in 44 minutes, and Resident #9's in 33 minutes. At 12:53 p.m., the surveyor interviewed the ED to inquire how long staff had to respond to call pendants, and the ED stated 10-13 minutes. The surveyor reviewed the facility's policy titled, "ERS-Emergency Response System," modified on 2/24/25, which indicated, "Policy: Emergency Response System (ERS) alarms shall be responded to in a timely manner ..."	A 310		
A 891	8:36-10.5(a) Dining Services (a) The facility and personnel shall comply with the provisions of N.J.A.C. 8:24, Retail Food Establishments and Food and Beverage Vending Machines Chapter XII of the New Jersey Sanitary Code.	A 891		

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A 891	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to comply with the provisions of Chapter 24, N.J.A.C. 8:24. "Sanitation in Retail Food Establishments and Food and Beverage Vending Machines," which placed 133 of 133 residents at risk for foodborne illnesses. This deficient practice was evidenced by the following: On 10/23/25 at 10:36 a.m., the surveyor toured the facility's kitchen and observed the following: 1. A dirty ice machine with a brown residue inside and a dirty ice scoop. At this time, the Food Service Director (FSD) stated that the ice machine was cleaned quarterly and that the brown residue was due to "hard water". 2. (1) open 3-gallon tub of Vanilla Bean Ice Cream with a label that indicated that it should be used by 10/20/25. (1) open and undated 1-gallon tub of [redacted] Parmesan & Peppercorn Dressing with greenish-black spots all over it, and a manufacturing date of 6/28/24. At this time, the surveyor asked the FSD how long the dressing had been in the walk-in refrigerator. The FSD stated that he was regional support for the company and that he had only been at the facility for a couple days. The FSD then disposed of the dressing. 3. A dirty can opener.	A 891		

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A 891	Continued From page 4 4. (18) boxes of food on the floor of the freezer and (14) boxes of food on the floor of the walk-in refrigerator. 5. A dishwasher that was not reaching the minimum wash and rinse temperatures recommended by the manufacturer. At this time, the surveyor asked a utility worker to run the dishwasher. The utility worker put plates in the dishwasher and started it. The surveyor observed that the wash temperature reached 130 degrees, and the rinse temperature reached 128 degrees. However, the dishwasher's manufacturer label indicated that the wash temperature should reach 160 degrees and the rinse 180 degrees. The surveyor observed that the plates came out dirty and then observed the utility worker wipe food off the plate with his hand. The surveyor asked the utility worker to run the plates through the dishwasher again. The utility worker stated at this time that the dishwasher was just installed on 10/22/25. At 11:13 a.m., the surveyor interviewed the FSD to inquire the reason the dishwasher did not reach the manufacturer's recommended temperatures. The FSD stated that the dishwasher reached the recommended temperatures the night it was installed and the morning of survey (10/23/25). However, the FSD stated that the dishwasher's rinse cycle stopped hitting the recommended temperature, so he added a sanitizer to the final rinse. The FSD confirmed that the dishwasher was installed on 10/22/25. 6. At 11:43 a.m., the surveyor observed the Lifestyle Coordinator (LC) in the kitchen without a hair restraint. The surveyor asked the LC if he was aware that a hair restraint was to be worn in	A 891		

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A 891	Continued From page 5	A 891		

the kitchen, and the LC stated that he was aware and that he forgot.

7. At 12:04 p.m., the surveyor toured the "Bistro" in the facility's memory care unit and observed a dirty refrigerator and a separate ice cream freezer with a brown substance spilled inside.

On 10/24/25 at 11:41 a.m., during an interview with the Executive Director (ED), she stated that the FSD should check for expired food items daily and that the dishwasher needed an electrical breaker. The ED stated that a sanitizer booster would be used until their electrician came to the facility on 10/28/25 or 10/29/25.

8. At 12:36 p.m., the surveyor observed a waitstaff employee on the serving line on his phone while food was being served. At this time, the surveyor asked to observe the waitstaff employee perform hand hygiene, and the employee washed his hands for 12 seconds instead of 20 seconds, as recommended by the U.S. Centers for Disease Control and Prevention (CDC).

The surveyor reviewed the facility's policy titled, "Ice Machine Cleaning Log," dated 5/5/25, which indicated that dining room staff were responsible for cleaning the ice machine monthly, utility staff were responsible for the quarterly cleaning, and a certified ice machine professional was responsible for the annual cleaning.

The surveyor then reviewed the facility's policy titled, "Labeling and Dating," modified on 11/21/24, which indicated, "... 8) Dates of food items should be checked regularly to discard expired food items by all staff members ..."

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A 891	Continued From page 6 Additionally, the surveyor reviewed the facility's policy titled, "Receiving and Storage," revised on 11/21/24, which indicated, "... 16. Food must be stored 6" inches off the floor in the walk-in refrigerator and freezer at all times, even upon delivery of food ...". The surveyor also reviewed the facility's policy titled, "Dish Machine (CLPS66e) Operation and Temperature Log," dated 11/21/24, which indicated that the minimum wash temperature should be 150 and the minimum rinse temperature should be 180. Lastly, the surveyor reviewed the facility's policy titled, "Hair Restraints," dated 1/9/15, which indicated, "... Policy: A hat or hairnet must be worn at all times while in the kitchen and by wait staff during service in the dining room ... Anyone entering the kitchen must be wearing a hat or put on a provided hairnet ..."	A 891		
A 925	8:36-11.2 Pharmaceutical Services The assisted living residence, comprehensive personal care home, or assisted living program shall be capable of ensuring that pharmaceutical services are provided to residents in accordance with the prescriber's orders, each resident's health care plan, and in accordance with the rules of this chapter and all applicable State and Federal laws and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to	A 925		

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A 925	Continued From page 7	A 925		

ensure that pharmaceutical services were provided to residents in accordance with the prescriber's orders for 1 of 10 residents, Resident #2. This deficient practice was evidenced by the following:

On 10/23/25 at 11:01 a.m., the surveyor observed a medication administration with Employee #2 and observed that Resident #2's name was highlighted in red on the electronic Medication Administration Record (MAR).

The surveyor interviewed Employee #2 and inquired what the red indicated on the MAR. Employee #2, a Certified Medication Aide (CMA) #2, stated that the MAR was red because the medication administration was late. CMA #2 stated that Resident #2 does not report to the medication room for ordered 10:00 a.m. medications until 11:30 a.m.

The surveyor further inquired about what time Resident #2's medication was due. CMA #2 stated that Resident #2 was ordered NJ Ex Order 26, 4B1 NJ Exec Order 26.4b1 to be administered at 10:00 a.m.

At 12:50 p.m., the surveyor reviewed Resident #2's medical record (MR), which indicated that the resident was *NJ Ex Order 26, 4B1* . Additionally, the surveyor reviewed the MAR which indicated that NJ Ex Order 26, 4B1 NJ Exec was ordered twice a day at 10:00 a.m. and 9:00 p.m.

On 10/24/25 at 12:46 p.m., the surveyor interviewed the Director of Wellness (DOW) and inquired about the time frame of medication administration and what the facility process was for late Administration of medications. The DOW stated that medications were given one (1) hour

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A 925	Continued From page 8 before the prescribed time and one hour after the prescribed time. The DOW further stated that if medications were administered late, the Registered Nurse was notified of the late administration. Additionally, the DOW stated that she was not aware of Resident #2's late medication administration on [redacted].	A 925		
	The surveyor reviewed a facility policy titled, "Subject: Medication Assistance: Definitions," dated 10/5/13, which revealed, " ... The Director of Wellness will assure integrity of the Medication Assistance program in the Assisted Living Residence by upholding the Eight Rights of Assistance with Medication Administration ... 3. Right Time ..."			
A 963	8:36-11.5(f) Pharmaceutical Services (f) Medications shall be accurately administered and documented by properly authorized individuals, in accordance with prescribed orders.	A 963		
	This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that medication was accurately documented and administered in accordance with prescriber's orders for 1 of 10 residents, Resident #5 as evidenced by the following: On 10/23/25 at 11:01 a.m., the surveyor observed a medication administration with Employee #1, a			

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A 963	Continued From page 9 Certified Medication Aide (CMA) #1. The reviewed Resident #5's Medication Administration Record (MAR) and observed that the resident's MAR was highlighted in red, indicating medications were not administered. The surveyor interviewed CMA #1 and inquired about Resident #5's medication administration. The CMA stated that she administered all medications at the time they were due; however, she did not sign out the administered medications on the MAR. On 10/24/25 at 12:46 p.m., the surveyor interviewed the Director of Wellness (DOW) and inquired about when medication administration documentation was expected to be completed. The DOW stated that all medications administration documentation was expected to be completed immediately after each successful Administration. The surveyor reviewed the facility's policy and procedure dated 10/5/13 titled, "Subject: Medication Assistance: Definitions," which indicated, "... 6. The RIGHT DOCUMENTATION/RECORD: c. Immediately after assisting the Resident with medications administration, the Medication Aide is to initial the MAR in the appropriate corresponding medication field ..."	A 963		
A 983	8:36-11.7(a)(5) Pharmaceutical Services (a) The administrator shall provide an appropriate and safe medication storage area, either in a common area or in the resident's unit, for the storage of medications that are not self-administered by the residents. The storage	A 983		

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A 983	Continued From page 10 area requirement may be satisfied through the use of a locked medication cart. 5. Medications shall be stored in accordance with manufacturer's instructions, and/or extemporaneously applied pharmacy labels and/or directions, and/or United States Pharmacopoeia Drug Information (USP DI) Volume I, Drug Information for the Health Care Professional, 2005, incorporated herein by reference, as amended and supplemented and USP DI Volume II: Advice for the Patient, incorporated herein by reference, as amended and supplemented. USP DI Volume I: Drug Information for the Health Care Professional and USP DI Volume II: Advice for the Patient can be obtained by contacting Thomson-Micromedex, 6200 S. Syracuse Way, Suite 300, Greenwood Village, CO 80111, (303) 486-6400. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure that the resident medications were stored in accordance with the pharmacy labeling for 1 of 10 residents, Resident #8 as evidenced by the following: On 10/24/25 at 9:20 a.m., the surveyor conducted a medication administration observation with a Certified Medication Aide (CMA) and observed a total of eight (8) open medication bottles and 11 unopened medication bottles on the kitchen	A 983		

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A 983	Continued From page 11 counter and table in Resident #8's apartment. At 9:45 a.m., the surveyor reviewed Resident #8's medical record (MR) which revealed that Resident #8 was *NJ Ex Order 26, 4B1* [redacted]. Further review of Resident #8's MR revealed a "Resident NJ Exec Order 26.4b1 Review" ([redacted] dated for [redacted]. Section [redacted] of the [redacted] was the evaluation of safely storing medications. On section 7f, "[redacted]" was documented indicating that Resident #8 can NJ Exec Order 26.4b1 . At 9:54 a.m., the surveyor interviewed Resident #8 and inquired about the medications on the kitchen counter and table. Resident #8 stated that he/she stored his/her medications on the counter and table, because it was a reminder to take his/her medication. Additionally, Resident #8 stated that the NJ Exec Order 26.4b1 have [redacted] therefore he/she NJ Exec Order 26.4b1 . During continued interview with Resident #8, the surveyor inquired about education provided to the resident by a clinical staff on safe storage of medications. Resident #8 stated that he/she did not receive education on NJ Exec Order 26.4b1 of his/her medications. At 12:46 p.m., the surveyor interviewed the Director of Wellness (DOW) and inquired about medication storage in resident apartments. The DOW stated that residents who were deemed to be self-medicating were required to ensure medications in pill bottles and ensure caps remain closed. The surveyor reviewed the facility's policy and procedure dated for 1/31/2017 titled,	A 983		

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A 983	Continued From page 12 "Assessment of Residents Self Administering" which indicated, "... D. The Resident's ability to continue to safely self-manage and/or self-administer medications will also include a demonstration of the following, to the satisfaction of the person performing the assessment: ... 6. Proper storage of all medications ..." The surveyor reviewed the facility's policy and procedure dated for 8/2013 titled, "Storage and Control of Non-Controlled Medication" which indicated, "... Procedure A. The Director of Wellness/appropriate Designee will assure medication storage areas (medication carts, rooms, cabinets) are: 1. Locked when not in use ..."	A 983		
A 999	8:36-11.7(e) Pharmaceutical Services (e) Discontinued or expired medications shall be destroyed within 30 days in the facility, or, if unopened and properly labeled, returned to the pharmacy for credit, if allowable, and in conformance with N.J.A.C. 13:39 and other State and Federal laws, codes, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to destroy discontinued medications for 1 of 10 residents reviewed, Resident #8. This deficient practice was evidenced by the following: On 10/24/25 at 9:20 a.m., the surveyor observed a medication administration with a Certified Medication Aide (CMA). The surveyor observed a bingo card of [redacted]	A 999		

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A 999	Continued From page 13 NJ Ex Order 26.4(b)(1) with NJ Ex Order 26, 4B1 capsules in the pocket of Resident #8's NJ Exec Order 26,4B chair in the resident's apartment. At 9:45 a.m., the surveyor reviewed Resident #8's medical record (MR) which revealed that Resident #8 was *NJ Ex Order 26, 4B1* . The surveyor reviewed Resident #8's Medication Administration Record (MAR) dated for NJ Exec Order 26, 4B1 , which revealed an order for *NJ Ex Order 26, 4B1* mg give to NJ Ex Or NJ Ex Order 26.4(b)(1) NJ Ex Order times a day for *NJ Ex Order 26, 4B1* days. At 12:46 p.m., the surveyor interviewed the Director of Wellness (DOW) and inquired about the destruction of medications following the completion or discontinuation of medications. The DOW stated that once the medication was completed or discontinued, the medications were expected to be destroyed by either the DOW or the Assistant Director of Wellness (ADOW). The surveyor reviewed the facility's policy and procedure dated for 2/11/2019 titled, "Medication Storage" which indicated, "... L. Medications that are discontinued ... disposed of ..."	A 999		
A1011	8:36-11.7(k) Pharmaceutical Services (k) Controlled dangerous substances shall be stored, and records shall be maintained, in accordance with the Controlled Dangerous Substances Acts, N.J.S.A. 24:21-1 et seq. and all other Federal and State laws and regulations concerning the procurement, storage, dispensation, administration, and disposition of same.	A1011		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL18002	A. BUILDING: _____ B. WING _____	10/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISTAL AT SOMERSET, THE	1870 EASTON AVENUE SOMERSET, NJ 08873

(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
A1011	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure that the Eight (8) Hour Controlled Substance Count (EHCSC) shift-to-shift signature log used to ensure accountability of controlled substances was consistently completed and signed by staff for 2 of 2 medication carts (MC), MC #2 and MC #3. This deficient practice was evidenced by the following: On 10/23/25 at 10:45 a.m., following a narcotic count with Employee #2, a Certified Medication Aide (CMA) #2, the surveyor reviewed the EHCSC for MC #2. Upon review, the surveyor observed that there were blank spaces in the EHCSC where staff signed to indicate that the controlled narcotic count was correct upon change of shift. Continued surveyor review of the EHCSC, revealed that there were two (2) missing on-coming and out-going signature blanks for September 2025. At 11:01 a.m., following a narcotic count with CMA #2, the surveyor reviewed the EHCSC for MC #3. Upon review, the surveyor observed that there were three (3) blank missing on-coming and off going signatures in the EHCSC for September 2025 and two (2) missing on-coming and out-going signatures in the EHCSC for October 2025. On 10/24/25 at 12:46 p.m., the surveyor interviewed the Director of Wellness (DOW) regarding the missing staff signatures on the EHCSC. The DOW stated that a narcotic count	A1011		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL18002	A. BUILDING: _____ B. WING _____	10/24/2025

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A1011	Continued From page 15 was expected to be completed between the on-coming and out-going nurse to ensure the medication count. Once count was completed, both nurses signed the EHCSC. The surveyor reviewed the facility's policy and procedure dated 5/29/19 titled, "Counting and Reconciling Controlled Substances," which indicated, "... Procedure I. Two staff members, one who is completing his/her shift and one who is starting his/her shift, will perform the controlled substance count ... c. If everything matches, the two staff members sign the Controlled Substance Eight Hour Declination Sheet verifying the count is correct ..."	A1011		
A1045	8:36-14.3(c) Emergency Services and Procedures (c) The facility shall test at least one manual pull alarm each month of the year and maintain documentation of test dates, location of each manual pull alarm tested, persons testing the alarm, and its condition. This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 10/24/2025 in the presence Regional Maintenance Director (RMD), it was determined that the facility failed to ensure that manual alarm pull stations were tested and documented monthly. This deficient practice had the potential to affect all residents and was evidenced by the following: A review of facility's Fire/Emergency drills at	A1045		

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A1045	Continued From page 16 10:15 a.m. with the RMD revealed that no record indicating manual pull alarm monthly testing was conducted. No further documentation was provided. In an interview at the time, the RMD confirmed the finding. The facility's Administrator and RMD were notified of the deficient practice at Life Safety Code survey exit conference at 2:35 p.m. NJAC 8:36-14.3 (C)	A1045		
A1089	8:36-16.3(b) Physical Plant (b) Means of ventilation shall be provided for every bathroom or water closet (toilet) compartment. Ventilation shall be provided either by a window with an openable area or by mechanical ventilation. This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 10/23/2025 in the presence of the Regional Maintenance Director (RMD), it was determined that the facility failed to ensure residents bathroom ventilation systems for rooms were functionally maintained. This deficient practice	A1089		

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A1089	Continued From page 17 had the potential to affect all residents and was evidenced by the following: Observations during the tour from 9:13 a.m. to 3:35 p.m. in the presence of the RMD, revealed that all 136 resident's bathrooms observed had no windows and relies on mechanical ventilation system, All the ventilation systems were not functioning when tested by the RMD. In an interview at the time, the RMD confirmed the findings. The facility's Administrator and RMD were notified of the deficient practice at Life Safety Code survey exit conference on 10/24/2025 at 2:35 p.m. NJAC 8:36-16.3 (b)	A1089		
A1095	8:36-16.5(b) Physical Plant (b) All fire detection systems shall be installed in accordance with the Uniform Construction Code, N.J.A.C. 5:23, N.J.A.C. 5:70 and the National Fire Alarm Code, National Fire Protection Association (NFPA) 72, 1999 Edition, incorporated herein by reference, as amended and supplemented. National Fire Protection Association publications are available from: NFPA, One Batterymarch Park, Quincy, MA, 02269-9101. This REQUIREMENT is not met as evidenced by: Based on documentation review and interviews	A1095		

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A1095	Continued From page 18 on 10/24/2025 in the presence of the Regional Maintenance Director (RMD), it was determined that the facility failed to ensure that the fire alarm system was installed, repaired and maintained in accordance with the Uniform Construction Code, N.J.A.C.5:23,5:70. And the requirements of NFPA 70, National Electrical Code, NFPA 72, National Fire Alarm and Signaling Code. This deficient practice had the potential to affect all residents and was evidenced by the following: A review of Facility's Fire Alarm Annul Inspection report dated 07/08/2025 at 10:05 a.m., revealed that the booster power batteries located on second floor electrical room failed inspection, and no record was provided indicating replacement has been completed. In an interview at the time, the RMD confirmed the finding. The facility's Administrator and RMD were notified of the deficient practice at Life Safety Code survey exit conference at 2:35 p.m. N.J.A.C 8:36-16.5 (b).	A1095		
A1219	8:36-17.3(b)(5) Housekeeping-Sanitation-Safety-Maintenance (b) The following safety conditions shall be met: 5. Combustible materials shall be stored in accordance with fire safety requirements specified in the New Jersey Uniform Fire Code, N.J.A.C. 5:70;	A1219		

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A1219	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 10/23/2025 in the presence of the Regional Maintenance Director (RMD), it was determined that the facility failed to ensure that hazardous areas were protected in accordance with the fire safety requirements N.J.A.C 5:70. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 10:13 a.m. revealed central supply combustible room door was not self-closing or automatic closing. An observation at 3:16PM, revealed combustible storage room # 3-061 door was not self-closing or automatic closing. In an interview at the time, the RMD confirmed the findings. The facility's Administrator and RMD were notified of the deficient practice at Life Safety Code survey exit conference on 10/24/2025 at 2:35 p.m. N.J.A.C 8:36-17.3 (b)(5)	A1219		
A1249	8:36-17.7 Housekeeping-Sanitation-Safety-Maintenance The building and grounds shall be well maintained at all times. The interior and exterior of the building shall be kept in good condition to ensure an attractive appearance, provide a pleasant atmosphere, and safeguard against	A1249		

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A1249	Continued From page 20 deterioration. The building and grounds shall be kept free from fire hazards and other hazards to resident's health and safety. This REQUIREMENT is not met as evidenced by: Based on observations, documentation review and interviews on 10/23/2025 and 10/24/2025 in the presence of the Regional Maintenance Director (RMD), it was determined that the facility failed (A) to ensure that the ceiling level was smoke resistant in accordance with the Uniform Construction Code. (B) to properly inspect, test and maintain 3 of 3 elevators in accordance with the New Jersey Department of Community Affairs Elevator Safety Division, New Jersey Uniform Construction Code, ASME A 17.1/CSA B 44, Safety Code for Elevators and Escalators and NFPA 101: 2012 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 10/23/2025 revealed the following: At 11:34 a.m. storage room #1-103 had two (2Ft by 2Ft) ceiling tiles not in place. At 12:22 p.m. storage room 2 -016 had four (2Ft by 2Ft) ceiling tiles not in place. In an interview at the time, the RMD confirmed the findings.	A1249		

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A1249	Continued From page 21 A record review on 10/24/2025 at 1:25 p.m. revealed the following: 1.The annual elevator Certificate of Use for 3 of 3 elevators provided were expired on 08/31/2024. 2. No documentation was provided for 3 of 3 elevators annual Fire Service Operations Phase 1 and Phase 2 testing. In an interview at the time, the RMD confirmed the findings. The facility's Administrator and RMD were notified of the deficient practice at Life Safety Code survey exit conference at 2:35 p.m. N.J.A.C 8:36-17.7	A1249		

The Bristal
ASSISTED LIVING

NLD 2/2/26
accepted
POC #4

NJ Ex Order 26, 4B1 [redacted]

The Bristal at Somerset

New Jersey Department of Health – Survey 10/24/2025

A310/8:36-3.4 (a)(1) Administration

Element 1- Resident #9 and Resident #10 were not identified on inspection worksheet.

Immediately upon identification of deficient practice staff were re-educated on the facilities Emergency Response System (ERS) policy with specific emphasis on the expectation that all pendant calls be answered in a timely manner consistent with the facilities internal policy. Re-education was conducted by the Executive Director and the Director of Wellness on 12/8/2025, 12/9/2025,12/11/2025, 12/16/2025,12/17/2025.

Director of Wellness and Assistant Director of Wellness completed Vitals/ wellness check on Resident's - # 2, #3, #5, #6, #8, to ensure the delayed response time did not NJ Exec Order 26.4b1 effect. This was completed in the month of NJ Exec Order 26.4b1 nd was documented in point click care.

Corrective action for Resident #2 -Targeted review of the call history by the Director of Wellness (DOW) and Executive Director (ED) for resident #2 was completed to ensure no unresolved needs, injuries, or adverse outcomes occurred due to delayed response times. Corrected action completed on 10/27/2025

Corrective action for Resident #3 - Targeted review of the call history by the Director of Wellness (DOW) and Executive Director (ED) for this resident was completed to ensure no unresolved needs, injuries, or adverse outcomes occurred due to delayed response times. Corrected action completed on 10/27/2025

Corrective action for Resident #5 - Targeted review of the call history by the Director of Wellness (DOW) and Executive Director (ED) for this resident was completed to ensure no unresolved needs, injuries, or adverse outcomes occurred due to delayed response times. Corrected action completed on 10/27/2025

Corrective action for Resident #6 - Targeted review of the call history by the Director of Wellness (DOW) and Executive Director (ED) for this resident was completed to ensure no unresolved needs, injuries, or adverse outcomes occurred due to delayed response times. Corrected action completed on 10/27/2025

The Bristal
ASSISTED LIVING

Corrective action for Resident #8 - Targeted review of the call history by the Director of Wellness (DOW) and Executive Director (ED) for this resident was completed to ensure no unresolved needs, injuries, or adverse outcomes occurred due to delayed response times. Corrected action completed on 10/27/2025

Element 2- All residents have the potential to be affected by the deficient practice.

Element 3- To ensure this deficient practice does not occur again the corrective action included in -servicing of all nursing team members including Resident Service Aides (RSA), Registered Nurses (RN) and Licenses Practical Nurses' (LPN) on facility ERS policy with specific emphasis on responding to call bells in a timely manner. In-servicing started on 10/27/25. Executive Director in-serviced DOW and Assistant Director of wellness (ADOW) on Policy. DOW and ADOW in-serviced Nursing team members. Executive Director In-serviced Concierge staff team members on facility ERS policy. In-service started 10/27/2025. Concierge will monitor the ERS system and will now announce over the internal communication system (walkie talkie) when a call bell has been going off for 9 minutes – previous practice was 15 minutes. This announcement will go to all nursing team members including RSA's, RN's, LPNs. This practice was implemented on 10/27/2025.

Element 4- The Executive Director, Director of Wellness or Designee will monitor the practice Daily with review of the call summary report for the next 60 days.-(12/26/2025) to ensure call bells have been answered in a timely manner. All audit results will be reviewed during the Quality Assurance and performance meetings (QAPI) and tracked for trends for the next two QAPI meetings- April 15,2026.

Deficiency corrected /completed 4/15/2026 accepted 12/31/25

[redacted] NJ Ex Order 26, 4B1

The Bristal
ASSISTED LIVING

A891/8:36-10.5(a)Dining Services

Element 1- No residents identified to be [redacted] by this deficiency.

Including Item #1, #2, #3, #4, #5, #6, #7 #8

Element 2- All residents have the potential to be affected by the deficient practice.

Including Item #1, #2, #3, #4, #5, #6, #7 #8

Element 3-

#1- In response to this deficiency the ice machine was emptied and cleaned on 10/23/2025. The Ice Scoop was removed, cleaned and replaced on 10/23/2025. Dietary team in serviced by the Regional Director of Food Servies. Dining Team includes, Assistant Director of Food Services , Cooks, Servers, Director of Dining Services and Dishwashers. In-service on the ice machine cleaning log policy was conducted on 10/27/2025. Dining team members will now be required to conduct general surface cleaning and wiping of external parts of the ice machine.

- Monthly general cleaning includes:
  - Wiping external surfaces with food safe sanitizer
  - Checking for visible signs of mold or residue
  - Documenting cleaning completion on the ice machine cleaning log
- Quarterly Deep cleaning
  - Dishwashers are responsible for a detailed internal and external cleaning – which includes.
    - Emptying ice machine, cleaning and sanitizing internal components, inspecting water lines and filters that are visible and accessible.

- Documenting cleaning completion on the ice machine cleaning log

- Annual Professional cleaning
  - A certified ice machine cleaning professional will perform a comprehensive inspection, deep cleaning of the ice machine.
  - Documenting cleaning completion on the ice machine cleaning log
  - Annual Cleaning to be conducted January 2026

#2- In response to this deficiency ,the 3 -gallon tub of ice cream was removed from the freezer and disposed of on 10/23/2025. The 1-gallon Tub of [redacted] dressing was removed from the refrigerator and disposed of on 10/23/2025. Dietary team in serviced on food labeling and dating by the Regional Director of Food Services. Dining Team includes, Food Service Director Assistant Director of Food Services , Cooks, Servers, Director of Dining Services and Dishwashers. In-service conducted on 10/27/2025 and 11/4/2025. This includes Daily inspections of all food items to ensure proper labeling and dating. The Food Service Director or Designee will be responsible for the daily checking of the food storage.

#3- In response to this deficiency the can opener was cleaned on 10/23/2025. Dietary team was in- serviced on General Cleaning and Sanitizing by the Regional Director of Food Services. Dining Team includes, Food Service Director, Assistant Director of Food Services , Cooks, Servers, Director of Dining Services and Dishwashers. In-service conducted on 10/27/2025 and 11/4/2025.

#4. In response to this deficiency the 18 boxes and in the freezer and the 14 boxes in the refrigerator were removed off the floor and placed on the shelves on 10/23/2025. Dietary team in serviced on receiving and storage by the Regional Director of Food Services. Dining Team includes, Assistant Director of Food Services , Cooks, Servers, Director of Dining Services and Dishwashers. In-service conducted on 10/27/2025 and 11/4/2025. This includes Daily inspections that all food items are 6inches off the floor . The Food Service Director or Designee will be responsible for the daily walk though of storage of food items.

#5. In response to this deficiency the dishwasher vendor returned on 10/28/2025 to inspect Dishwasher equipment. It was determined a new electrical breaker was needed to support the new dish machine. Dish machine was completely fixed and operational within compliance on 12/19/2025. As described to the surveyor the Food Service Director implement a pre- rinse and then an added sanitizer to the rinse cycle in accordance to our General cleaning and sanitizing policy. This process remained in place until dish machine was fully operational. Dietary team in serviced on General cleaning and Sanitizing by the Regional Director of Food Services. Dining Team includes, Assistant Director of Food Services, Cooks, Servers, Director of Dining Services and Dishwashers. In-service conducted on 10/27/2025 and 11/4/2025.Dishwasher mentioned in deficiency was in-serviced on re- washing dishes if they appear dirty. Inservice conducted by Regional Director of Dietary and was completed on 10/23/2025.

#6. In response to this deficiency all Lifestyle team members were in-serviced on the facilities Hair Restraints policy which includes use of hairnets. In-service conducted by the Executive Director on 10/27/2025. The Food Service Director, the Assistant Director of Food Service, and The Director Dining Services or Designee will ensure daily compliance of the use of Hair restraints .

#7. In response to this deficiency the memory care bistro refrigerator was cleaned by the Dining room manager on 10/24/2025. The Ice cream freezer in the memory care was cleaned and is no longer in use as of 10/24/2025. Dietary team in- serviced on General Cleaning and Sanitizing using the current policy by the Regional Director of Food Services. Dining Team includes Food Service Director, Assistant Director of Food Services, Cooks, Servers, Director of Dining Services and Dishwashers. In-service conducted on 10/27/2025 and 11/4/2025. The Food Service Director, the Assistant Director of Food Service, and The Director Dining Services or Designee will ensure daily compliance of the general Cleaning and Sanitizing of all equipment.

#8. In response to this deficiency all Dietary Team members were in-serviced on proper handwashing using the current handwashing policy. In-service conducted by the Executive Director on 10/27/2025 and 11/4/2025. The use of cellphones while handling food or serving was addressed during the in-service as well. Dining Team includes the Food Service Director, Assistant Director of Food Services, Cooks, Servers, Director of Dining Services and Dishwashers. In-service conducted on 10/27/2025 and 11/4/2025. The Food Service Director, the Assistant Director of Food Service, and The Director Dining Services or Designee will ensure daily compliance of handwashing.

Element 4-

Food Service Director or Designee will complete a daily food storage audit. Food Service Director or Designee will complete a daily temperature log review for the Dish machine. Food Service Director, Director of Dining Services or Designee will complete a daily General cleaning and sanitation inspection. Executive Director or Designee will complete a weekly walk through of Kitchen and memory care bistro. Random spot checks of handwashing and hair restraints compliance will be conducted by Executive Director or Designee weekly for the next 60 days. All Dietary audits, temperature logs and sanitation checklist will be reviewed during the Quality Assurance and performance meetings (QAPI) and tracked for compliance for the next two QAPI meetings- April 15,2026.

Deficiency corrected /completed 4/15/2026. Accepted 12/31/25 [redacted]

The Bristal
ASSISTED LIVING

A925: 8:36-11.2 Pharmaceutical Services

Element 1- Immediately upon identification of the deficient practice for Resident #2 -the resident's schedule of medication was reviewed by the DOW. The Dow assessed resident # 2 for adverse effects related to the late administration of the [redacted] and confirmed continued appropriateness of the prescribed dosing schedule. On 10/27/2025 The CMA involved was interviewed, counseled, and re-educated on the facility's medication administration and timing policy. Staff were instructed to inform the RN's if a resident does not present for their medications during the scheduled time, so appropriate follow-up can occur. Staff instruction began on 10/27/2025 and concluded o 11/16/2025.

Element 2- All residents have the potential to be affected by the deficient practice.

Element 3- To ensure this deficient practice has been corrected the Certified Medication aides, and the Licensed Practical Nurses were In-serviced on the 8 rights of Medication Administration with emphasis of correct right time and management of late or missed dosages. In-service completed by the Director of Wellness and the Assistant Director of Wellness on 10/27/ 2025, 11/7/2025, 11/9/2025, 11/16/2025. In-service starting on 10/27/24 and was completed on 11/16/2025. A full audit of the communities Medication administration times was completed by the Regional Director of Clinical Services, DOW and ADOW 11/30/2025 to ensure adequate staffing levels based on findings. Resident #2 was informed of [redacted] medication times and importance of receiving medications during the appropriate medication time frame. Resident instructed to use call bell to receive medications if [redacted] s unable to come to the medication room. Resident conversation took place with the DOW on 10/27/2025.

Element 4- Director of Wellness will conduct weekly audits of the EMAR for the next 30 days, starting December 15,2025. Followed by Monthly audits for 3 additional month concluding on 4/15/2026 to monitor for medication administration times and missed or late administration doses. Findings will be documented and reviewed during QAPI meetings. Any variances will result in immediate staff education and corrective action as needed.

Deficiency corrected /completed 4/16/2026.

[redacted]

The Bristal
ASSISTED LIVING

A963: 8:36-11.5 (f) Pharmaceutical Services

Element 1- Immediately upon identification of the deficiency, the Director of Wellness (DOW) conducted a comprehensive review of Resident #5's Medication Administration Record (MAR) and compared it to physician orders and medication delivery records to verify that all prescribed medications were administered as ordered.
On 10/29/2025 the CMA involved was interviewed, counseled, and re-educated on the facility's medication administration and documentation policy, including the requirement that medications be documented immediately after administration. The DOW verified that Resident #5 experienced NJ Exec Order 26.4b1 related to the documentation lapse. Correct documentation was completed, and the resident's clinical status was monitored to ensure continued safety and compliance with prescribed medication regimens.

Element 2- All residents have the potential to be affected by the deficient practice.

Element 3- To ensure this deficient practice has been corrected the Certified Medication aides, and the Licensed Practical Nurses were In-serviced on the 8 rights of Medication Administration with emphasis on immediate documentation following each successful medication administration per facility policy and state regulation. In-service completed by the Director of Wellness and the Assistant Director of Wellness on 10/27/ 2025, 11/7/2025, 11/9/2025, 11/16/2025. In-service starting on 10/27/24 and was completed on 11/16/2025. The LPN supervisor will review the EMAR dashboard for any missed medications before the close of shift, they will follow up according with CMA on shift. This will encompass all three shifts and started on 12/15/2025.

Element 4- Director of Wellness with conduct weekly audits of the EMAR for the next 30 days, starting December 15,2025. DOW or designee will observe medication passes to ensure compliance with the 8 rights including the right documentation at time of administration.

Followed by Monthly audits for 3 additional months concluding on 4/15/2026 to monitor for missed documentation. Findings will be documented and reviewed during QAPI meetings. Any variances will result in immediate staff education and corrective action as needed.

Deficiency corrected /completed 4/15/2026. NJ Ex Order 26, 4B1

12/30/25

The Bristal
ASSISTED LIVING

A983: 8:36-11.7 (a) (5) Pharmaceutical Services

Element 1- Immediately upon identification of the deficiency, the Director of Wellness (DOW) met with Resident #8- and reviewed the requirements for NJ Exec Order 26.4b1n accordance with facility policy. DOW met with resident on 10/24/2025. All medications for Resident #8 were reviewed and secured/locked per facility policy. Reassessment of Resident #8'S ability to safely ***NJ Ex Order 26, 4B1*** was completed and documented on NJ Exec Order 26.4b1

Element 2- All residents have the potential to be affected by the deficient practice.

Element 3- To ensure this deficient practice has been corrected and will not reoccur. Community staff including, Housekeepers, Certified Medication aides, LPN's, RSA's ,Porters, received In-service/education on Self-medication storage requirements in a residents apartment. in-service conducted on 10/27/ 2025, 11/7/2025, 11/9/2025, 11/16/2025. In-servicing was completed on 11/16/2025. Staff instructed to inform DOW or ADOW if they encounter open or unsecured medications in a resident apartment. Regional Director of Clinical services re-educated DOW and ADOW on resident education expectations related to safe medication storage. Re-education conducted on 10/24/2025.

Element 4- Director of Wellness or designee will conduct monthly medication storage audits for residents approved for Self-Administration of medication, for a period of four month. Findings will be documented and reviewed during QAPI meetings. Any variances will result in immediate staff education and corrective action as needed.

Deficiency corrected /completed 4/15/2026

NJ Ex Order 26, 4B1

12/30/25

The Bristal
ASSISTED LIVING

A999: 8:36-11.7 (e) Pharmaceutical Services

Element 1-

Upon identification of the deficient practice involving Resident #8, the Director of Wellness (DOW) immediately removed the discontinued [redacted] capsules from the resident's apartment. The medication was secured and destroyed in accordance with facility policy, pharmacy guidance, and applicable State and Federal regulations. Completed on 10/24/2025

The resident was assessed by DOW/ADOW to ensure no adverse effects or risk occurred as a result of the medication remaining in the apartment-Completed on 10/24/2025.

Element 2- All residents have the potential to be affected by the deficient practice.

Element 3- To ensure this deficient practice has been corrected and will not reoccur the medication policy and procedure titled "Medication Storage" has been reviewed with all LPNs and CMAs, with emphasis on timely removal of discontinued medications from resident apartments. This re-education was provided by the DOW on 10/27/ 2025, 11/7/2025, 11/9/2025, 11/16/2025. In-servicing completed on 11/16/2025

Element 4-

The DOW or designee will conduct monthly random medication storage audits of five resident apartments that self-administer medications for two months.

Audit findings will be documented and reviewed as part of the community's Quality Assurance and Performance Improvement (QAPI) process. Any identified noncompliance will result in immediate corrective action, staff re-education, and follow-up monitoring.

Deficiency corrected /completed 2/20/26

[redacted]

The Bristal
ASSISTED LIVING

A1011: 8:36-11.7 (k) Pharmaceutical Services

Element 1-

No residents identified to be adversely affected by this deficiency.

Element 2-

All residents have the potential to be affected by the deficient practice.

Element 3-

The DOW completed a retrospective review of all Eight (8) Hour Controlled Substance Count (EHCSC) logs for all medication carts for the previous 60 days to identify any additional missing signatures or incomplete documentation on 11/6/25. A full facility-wide narcotic count and reconciliation was performed by the DOW and ADOW for all controlled substances to ensure accuracy and compliance. (11/14/25)

All LPNs and Certified Medication Aides (CMAs) have been re-educated, by the DOW and ADOW, on controlled substance handling, counting, documentation, and signature requirements per NJ Controlled Dangerous Substances Acts and facility policy, and the Counting and Reconciling Controlled Substances community policy. Reeducation commenced on 10/27/2025 and concluded 11/16/2025.

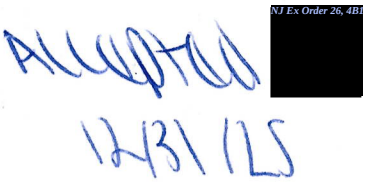
The LPN Supervisor on duty will verify that EHCSC logs are completed and signed at the end of each shift.

Element 4-

The DOW or designee will review EHCSC logs weekly for completeness and accuracy, including verification of required on-coming and out-going staff signatures for two months.

Findings from EHCSC audits will be reviewed at the QAPI meetings to identify trends and ensure compliance. Any identified noncompliance will result in immediate corrective action, staff re-education, and follow-up monitoring.

Deficiency corrected /completed 2/20/2026



12/31/25

The Bristal
ASSISTED LIVING

A1045: 8:36-14.3 (c) Emergency Services and Procedures

Element 1-

No residents identified to be adversely affected by this deficiency.

Element 2-

All residents have the potential to be affected by the deficient practice.

Element 3-

In response to this deficiency, fire drill vendor, was informed that all fire drills conducted during normal business hours require the manual alarm to be pulled, per NJ regulation 8:36-14.3(c). Fire The Fire Safety Professional was informed verbally on 10/26/2025 during a fire drill. A follow-up email was sent by Regional Director of Maintenace to fire drill representative- Fire Safety Professional on 12/8/2025 confirming manual pulls are required for fire drills during normal business hours. Executive Director In serviced Director of Maintenaced Fire drill form and area alarm pull should be indicated. Inservice conducted and completed on 10/27/2025 On-going, Director of Maintenance or designee will review monthly Fire Drill report after each drill to ensure compliance with standard.

Element 4-

The Executive Director or designee will monitor compliance through audits of the monthly fire drill reports presented during the next two (QAPI) meetings (4/15/2026).

Deficiency corrected /completed 10/26/2025 accepted 1/23/26 [redacted]

The Bristal
ASSISTED LIVING

A1089: 8:36-16.3 (b) Physical plant

Element 1-

No residents identified to be adversely affected by this deficiency.

Element 2-

All residents have the potential to be affected by the deficient practice.

Element 3-

Upon identification of this deficiency, October 27,2025 the Regional Director of Maintenance (RDM) reset the electrical breaker to restore the ventilation system for all 136 rooms that was tripped in error. All Rooms had working ventilation after the reset. Regional Director of Maintenace and Maintenance team check all resident apartment on 10/27/2025 Maintenance staff were reeducated by the Regional Director of Maintenance on the requirements of NJ regulation 8:36-16.3(b) Physical Plant as it pertains to functionality of bathroom ventilation systems 10/27/2025

Director of Maintenance or designee will check bathroom ventilation room by room weekly during building inspections. Weekly task has been added to the community's electronic maintenance task tracking tool [redacted]

Element 4- The Executive Director or designee will monitor compliance through the TELS program weekly for the next two months. All audit results will be reviewed during the community's QAPI meetings and tracked for compliance for the next two QAPI meetings. (4/15/2026).

[redacted]

Deficiency corrected /completed 10/27/2025

The Bristal
ASSISTED LIVING

A1095: 8:36-16.5 (b) Physical Plant

Element 1-

No residents identified to be adversely affected by this deficiency.

Element 2-

All residents have the potential to be affected by the deficient practice.

Element 3-

In response to this deficiency, on 11/6/2025 Fire Protection company replaced the two batteries. Director of Maintenance or designee will review the inspection reports with the Executive Director following the monthly/quarterly/annual inspection(s). Inspection reports will be uploaded into TELS on a monthly/quarterly/annual basis for review by the Regional Director of Maintenance. The Executive Director In-service Maintenace Director on reviewing reports and taking corrective action as need. In-service conducted on 11/9/2025.

Element 4-

The Executive Director or designee will monitor compliance through the [NJ Exec Order 26] program monthly for the next two months. All audit results will be reviewed during the community's QAPI meetings and tracked for compliance for the next two QAPI meetings. (4/15/2026).

Deficiency corrected /completed 11/9/2025

[NJ Ex Order 26, 4]

The Bristal
ASSISTED LIVING

A1219: 8:36-17.3 (b)(5) Housekeeping -Sanitation- Safety -Maintenance

Element 1-

No residents identified to be adversely affected by this deficiency.

Element 2-

All residents have the potential to be affected by the deficient practice.

Element 3-

In response to this deficiency, self-closing door closures were installed on 12/8/2025 to the central supply combustible room door and the combustible storage room #3-061 to ensure hazardous areas are protected. The Regional Director of maintenance checked inspection of all doors and no other doors found without self closing/auto doors. Inspection complete on 10/27/2025. Executive Director In serviced maintenance team on door checks. Inservice conducted and completed on 10/27/2025 The Director of Maintenance or designee will check door closures are operating monthly during building inspections. Monthly task has been added to the community's electronic maintenance task tracking tool [redacted]

Element 4-

The Executive Director or designee will monitor compliance through the [redacted] program weekly for the next two months. All audit results will be reviewed during the community's QAPI meetings and tracked for compliance for the next two QAPI meetings. (4/15/2026).

Deficiency corrected /completed 12/8/2025

[redacted]

The Bristal
ASSISTED LIVING

A1249: 8:36-17.7 Housekeeping -Sanitation- Safety -Maintenance

Finding (A)

Element 1-

No residents identified to be adversely affected by this deficiency.

Element 2-

All residents have the potential to be affected by the deficient practice.

Element 3-

In response to this deficiency, the ceiling tiles in storage room #1-103 were immediately placed back in their proper position, completed on 10/23/2025. The ceiling tiles in storage room 2-016 were immediately placed back in their proper position, completed on 10/23/2025. All Ceiling tiles were checked on 10/24/2025 by the Maintenance team. The Director of Maintenance or designee will check ceiling tiles monthly during building inspections. Executive Director In serviced maintenance team including Director of Maintenance on ceiling tile checks. Inservice conducted and completed on 10/27/2025. Monthly task has been added to the community's electronic maintenance task tracking tool [redacted].

Element 4-

The Executive Director or designee will monitor compliance through the [redacted] program weekly for the next two months. All audit results will be reviewed during the community's QAPI meetings and tracked for compliance for the next two QAPI meetings. (4/15/2026).

Deficiency corrected /completed 10/27/2025

[redacted]

The Bristal
ASSISTED LIVING

A1249: 8:36-17.7 Housekeeping -Sanitation- Safety -Maintenance

Finding (B)

Element 1-

No residents identified to be adversely affected by this deficiency.

Element 2-

All residents have the potential to be affected by the deficient practice.

Element 3-

In response to this deficiency, the New Jersey Department of Community Affairs Division of codes and standards Elevator Safety unit conducted the Annual Inspection on 10/24/2025. The annual Elevator Certificate of Use (1) was issued to the Bristal at Somerset on 11/9/2025. Proof of Fire Service Operations Phase 1 and Phase 2 annual testing (2) was also provided 11/9/2025. Via Inspection/Service report. The Director of Maintenance or designee will track the annual inspections for elevators through the community's electronic maintenance task tracking tool (TELS) to ensure compliance. The Director of Maintenance is responsible for the monthly Phase 1 and Phase 2 testing. Director of Maintenance in serviced on the requirement by the Executive Director on 11/9/2025. The monthly phase 1 and Phase 2 testing is tracked through the [NJ Exec Order 26] program.

Element 4-

The Executive Director or designee will monitor compliance weekly by reviewing [NJ Exec Order 26] Task Reports. These reports include all Daily, Weekly, Monthly, Quarterly, and Annual tasks (e.g., annual elevator inspections). All audit results will be reviewed during the Quality Assurance and performance meetings (QAPI) and tracked for trends for the next two QAPI meetings (4/15/2026).

The Bristal
ASSISTED LIVING

Deficiency corrected /completed 11/9/2025

Updated 1/23/26

[redacted]

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL18002 Y1	A. Building B. Wing Y2	2/2/2026 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISTAL AT SOMERSET, THE	1870 EASTON AVENUE SOMERSET, NJ 08873

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 A0310	Correction	ID Prefix A0891	Correction	ID Prefix A0925	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-10.5(a)	Completed	Reg. # 8:36-11.2	Completed
LSC	12/31/2025	LSC	12/31/2025	LSC	12/18/2025
ID Prefix A0963	Correction	ID Prefix A0983	Correction	ID Prefix A0999	Correction
Reg. # 8:36-11.5(f)	Completed	Reg. # 8:36-11.7(a)(5)	Completed	Reg. # 8:36-11.7(e)	Completed
LSC	12/18/2025	LSC	12/18/2025	LSC	12/18/2025
ID Prefix A1011	Correction	ID Prefix A1045	Correction	ID Prefix A1089	Correction
Reg. # 8:36-11.7(k)	Completed	Reg. # 8:36-14.3(c)	Completed	Reg. # 8:36-16.3(b)	Completed
LSC	12/31/2025	LSC	01/23/2026	LSC	01/23/2026
ID Prefix A1095	Correction	ID Prefix A1219	Correction	ID Prefix A1249	Correction
Reg. # 8:36-16.5(b)	Completed	Reg. # 8:36-17.3(b)(5)	Completed	Reg. # 8:36-17.7	Completed
LSC	02/02/2026	LSC	01/23/2026	LSC	01/23/2026
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	
10/24/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO