STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30A001	A. BUILDING: _____ B. WING _____	C 05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEST ORANGE	520 PROSPECT AVENUE WEST ORANGE, NJ 07052

(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
H5790	8:43E-13.4(d) UNIVERSAL TRANSFER FORM:MANDATORY USE OF FORM A licensed healthcare facility or program shall retain a completed copy of the Universal Transfer Form sent with a patient when a patient is transferred as part of the patient's medical record. This REQUIREMENT is not met as evidenced by: Complaint NJ00190564 and NJ00190373 Based on interview, record review, and facility policy review, the facility failed to have evidence a Universal Transfer Form (UTF) was sent to the receiving facility on [redacted] for 1 (Resident #1) of 2 residents reviewed for [redacted]. On [redacted], the resident was transferred to the hospital; however, there was no documented evidence that the facility completed and sent a UTF with the resident. On [redacted], the resident was hospitalized for [redacted] Resident #1 [redacted] on [redacted] and final diagnoses included [redacted] and [redacted] It was determined the facility's non-compliance with one or more requirements had caused, or was likely to cause serious injury, serious harm, serious impairment, or death to the resident.	H5790		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/15/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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H5790	Continued From page 1 On 05/20/2026 at 10:10 AM the Executive Director (ED) was verbally informed of the immediacy of the situation involving the failure to have documented evidence that a UTF was completed and sent to the receiving facility on NJ Ex Order 26.4(b)(1) to assist in the evaluation and treatment of the resident. Findings included: A facility policy titled, "Universal Transfer Form Policy," revised in 11/2022, revealed, "A Universal Transfer Form (UTF) shall be completed when transferring a resident to another healthcare facility or program licensed by the Department of Health and Senior Services (DHSS) in New Jersey. Policy Detail - 1. The New Jersey Universal Transfer Form (UTF) is completed in paper form by the Executive Director (ED), Nurse, or designee at the time of the residents transfer to another licensed DHSS healthcare facility or program. A copy of the completed UTI [sic] is retained on the resident's record in the community." An "Admission Record" revealed that the facility admitted Resident #1 on NJ Ex Order 26.4(b)(1). According to the Admission Record, Resident #1 had a medical history that included diagnoses of NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). A "Brief Interview [for] Mental Status (BIMS) Screening and Scoring Tool - Assisted Living Only" dated NJ Ex Order 26.4(b)(1), indicated Resident #1 scored NJ Ex O which indicated the resident had NJ Ex Order 26.4(b)(1) Resident #1's "ED [Emergency Department] Provider Note" dated NJ Ex Order 26.4(b)(1) at 3:22 PM	H5790		

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H5790	Continued From page 2 revealed the resident presented with NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) and a "ED Course" note dated NJ Ex Order 26.4(b)(1) at 8:20 PM revealed the resident was admitted to NJ Ex Order 26.4(b)(services with a final diagnosis of NJ Exec Order 2 NJ Ex Order 26.4(b)(1) Registered Nurse (RN) #3 was interviewed on 05/12/2026 at 11:09 AM. RN #3 stated when she observed Resident #1 on NJ Ex Order 26.4(b)(1) the resident was only NJ Ex Order 26.4(b)(1) when usually the resident was NJ Ex Order 26.4 . RN #3 stated the resident was typically able to NJ Ex Order 26.4(b)(1) , but on this day NJ Ex Order 26.4(b)(1) the resident could not do so. RN #3 stated she did not assess the resident or take their vital signs but called NJ Exec Order 26.4b1 immediately. Review of Resident #1's medical record revealed no evidence of a UTF form fo NJ Ex Order 26.4(b)(1) when the resident was transferred to the hospital. The Health and Wellness Director (HWD) was interviewed on 05/18/2026 at 3:44 PM. The HWD stated he was unable to locate a UTF for Resident #1's NJ Exec Order 26.4 to the NJ Exec Order 26.4 for the date of NJ Ex Order 26.4(b)(1). The HWD stated he expected staff to complete the form when residents were transferred out of the facility. During a follow-up interview with RN #3 on 05/18/2026 at 3:47 PM, she stated that when she sent a resident to the hospital, she always sent the UTF, the medication list, the resident's face sheet, and the NJ Ex Order 26.4(b)(1) form, if applicable. RN #3 stated that on the day she NJ Exec Order 26.4b1 Resident #1 to the NJ Exec Order 26.4 she was in such a rush that she was unsure if she made a	H5790		

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H5790	Continued From page 3 copy of the transfer form. The ED was interviewed on 05/18/2026 at 4:01 PM. The ED stated she expected the transferring nurse to complete the UTF and make a copy to be kept at the facility.	H5790		
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ00190564, NJ00190373, and NJ00189789 CENSUS: 90 SAMPLE SIZE: 10 SURVEY DATE: 05/11/2026 - 05/18/2026 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. 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 607	8:36-5.15(a)(1) Notification Requirements (a) The resident's family, guardian, and/or designated responsible person or community agency shall be notified, when known, and with the resident's consent, immediately after the	A 607		

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A 607	Continued From page 4 occurrence, in the event of the following: 1. The resident acquires an acute illness requiring medical care; This REQUIREMENT is not met as evidenced by: Complaint NJ00190564 and NJ00190373 Based on interview, record review, and facility policy review, the facility failed to notify the responsible party (RP) of a NJ Ex Order 26.4(b)(1) for 1 (Resident #1) of 3 residents reviewed for NJ Ex Order 26.4(b)(1). On 03/27/2026, a nurse failed to notify Resident #1's RP of NJ Ex Order to the resident's NJ Ex Order that was approximately NJ Ex Order 26.4(b)(1). On NJ Ex Order 26.4(b)(1) the resident was NJ Exec Order 26.4b1 for NJ Ex Order 26.4(b)(1)). Approximately seven hours after presentation to the NJ Exec Order 26.4b staff documented that Resident #1 had NJ Ex Order 26.4(b)(1)) to the NJ Ex Order 26.4(b)(1) Resident #1 NJ Ex Order 26.4(at the hospital on NJ Ex Order 26.4(b)(1) and final diagnoses included NJ Ex Order 26. and NJ Ex Order 26.4(b)(1) It was determined the facility's non-compliance with one or more requirements had caused, or was likely to cause serious injury, serious harm, serious impairment, or death to the resident.	A 607		

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A 607	Continued From page 5 On 05/20/2026 at 10:10 AM the Executive Director (ED) was verbally informed of the immediacy of the situation involving the failure to notify the resident's RP of a change of condition. Findings included: A facility policy titled, "Change in Condition," revised 04/20/2025, revealed for non-emergent concerns, "2. The physician/HCP [health care provider] and legally responsible party should be notified of resident's change of condition." A facility policy titled, "Skin Integrity Documentation Policy," revised 12/2025, "1. The associate/care partner should report skin changes if noted for residents who are receiving assistance with a bath or shower. 2. The Health and Wellness Director (HWD) or designee should: b. Notify the physician/healthcare provider (HCP) and family of the skin concern as soon as possible." An "Admission Record" revealed that the facility admitted Resident #1 on NJ Ex Order 26.4(b)(1) According to the Admission Record, Resident #1 had a medical history that included diagnoses of NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) A "Brief Interview [for] Mental Status (BIMS) Screening and Scoring Tool - Assisted Living Only" dated NJ Ex Order 26.4(b)(1), indicated Resident #1 scored NJ Ex O which indicated the resident had NJ Ex Order 26.4(b)(1) . A "Personal Service Plan" dated NJ Ex Order 26.4(b)(1) indicated Resident #1 required NJ Ex Order 26.4(b)(1) with activities of daily living (NJ Ex Order 26.4(b)(1) was NJ Ex Order 26.4(b)(1)	A 607		

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A 607	Continued From page 6 with going to and from the dining room or community activities, and had NJ Ex Order 26.4(b)(1) Resident #1's "Progress Notes" dated NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) revealed no documented evidence that the resident's RP was notified that the resident had NJ Ex Order 26.4(b)(1). Resident #1's hospital record revealed nursing "Flowsheets" that indicated staff completed a "Basic Assessment" on NJ Ex Order 26.4(b)(1) at 10:00 PM, approximately seven hours after presentation to the hospital, which was the date and time hospital staff "First Assessed" the NJ Ex Order 26.4(b)(1) Per the assessment, the resident had NJ Ex Order 26.4(b)(1) to the NJ Ex Order 26.4(b)(1) that NJ Ex Order 26.4(b)(1) and was described as being NJ Ex Order 26.4(b)(1) and the NJ Ex Order 26.4(b)(1) surrounding NJ Ex Order 26.4(b)(1) was NJ Ex Order 26.4(b)(1). Resident #1's "Discharge Summary" note dated NJ Ex Order 26.4(b)(1) at 2:12 AM revealed a "Summary Of NJ Exec Order 26.4(b)(1) Course," that indicated the resident was admitted due to NJ Ex Order 26.4(b)(1) and was found to have NJ Ex Order 26.4(b)(1). The resident's family elected to transition to NJ Ex Order 26.4(b)(1) and the NJ Ex Order 26.4(b)(1) on call later NJ Ex Order 26.4(b)(1) the resident NJ Ex Order 26.4(b)(1) The note revealed NJ Ex Order 26.4(b)(1) diagnoses included NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1) Care Associate (CA) #1 was interviewed on 05/12/2026 at 12:23 PM. CA #1 stated that during provision of care on NJ Ex Order 26.4(b)(1) during the 7:00 AM to 3:00 PM shift, she noticed NJ Ex Order 26.4(b)(1) on the resident's NJ Ex Order 26.4(b)(1) that was approximately the NJ Ex Order 26.4(b)(1) Per CA #1, the NJ Ex Order 26.4(b)(1) was NJ Ex Order 26.4(b)(1)	A 607		

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A 607	Continued From page 7 but was unable to recall whether the [NJ Ex Order 26.4(b)(1)] [redacted] The CA stated she reported the area to Licensed Practical Nurse (LPN) #2. A telephone interview was held with LPN #2 on 05/14/2026 at 8:25 AM. LPN #2 revealed CA #1 notified her of Resident #1's [NJ Ex Order 26.4] [redacted] LPN #2 stated she tried to call Resident #1's RP; however, the call did not go through. LPN #2 stated she forgot to notify the Health and Wellness Director (HWD) about the [NJ Ex Order 26.] [redacted] and had not documented information about the [NJ Ex Order 26.] [redacted] on a facility 24-hour report; subsequently, there were no follow up attempts to notify the RP. The HWD was interviewed on 05/13/2026 at 2:58 PM and stated that he expected to be notified when the [NJ Ex Order 26.] [redacted] was found on Resident #1's [NJ Ex Order 26.4(b)] [redacted] The HWD stated that he was not notified about the [NJ Ex Order 26.4(b)(1)] [redacted] until he had a meeting with Resident #1's responsible party, which was after Resident #1 had been [NJ Exec Order 26.4b1] [redacted] to the [NJ Exec Order 26.4b] [redacted] The ED was interviewed on 05/14/2026 at 1:44 PM and stated she expected a resident's family to be notified if there was a change in the resident's condition. Attempts to interview the RP on 05/11/2026 at 2:20 PM and 05/12/2026 at 12:47 PM, were unsuccessful.	A 607		
A 753	8:36-7.3(c) General and Health Service Plans (c) Documentation in the resident's record shall indicate review and any necessary revision of the resident service plan and/or health service plan.	A 753		

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A 753	Continued From page 8 This REQUIREMENT is not met as evidenced by: Complaint NJ00190564 and NJ00190373 Based on interview and record review, the facility failed to ensure a health service plan was revised for 1 (Resident #1) of 3 residents reviewed for NJ Ex Order 26.4(b)(1). On NJ Ex Order 26.4(b)(1) staff reported to a licensed practical nurse (LPN) that Resident #1 had NJ Ex Order 26.4(b)(1) to their NJ Ex Order 2 however, there was no documented evidence that the facility revised the resident's health service plan to address care and treatment of NJ Ex Order 26.4(b)(1). On NJ Ex Order 26.4(b)(1), the resident was hospitalized for NJ Ex Order 26.4(b)(1), and approximately seven hours after presentation to the NJ Exec Order 26.4 NJ Exec Order 26.4 staff documented that Resident #1 had NJ Ex Order 26.4(b)(1) to the NJ Ex Order 26.4(b)(1) Resident #1 NJ Ex Order 26.4(b)(1) the hospital on NJ Ex Order 26.4(b)(1) and NJ Ex Ord diagnoses included NJ Ex Order 26 and NJ Ex Order 26.4(b)(1). It was determined the facility's non-compliance with one or more requirements had caused, or was likely to cause serious injury, serious harm, serious impairment, or death to the resident.	A 753		

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A 753	Continued From page 9 On 05/20/2026 at 10:10 AM the Executive Director (ED) was verbally informed of the immediacy of the situation involving the failure to revise health service plans to address care and treatment of NJ Ex Order 26.4(b)(1). Findings included: An "Admission Record" revealed that the facility admitted Resident #1 on NJ Ex Order 26.4(b)(1) According to the Admission Record, Resident #1 had a medical history that included diagnoses of NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1). A "Brief Interview [for] Mental Status (BIMS) Screening and Scoring Tool - Assisted Living Only" dated NJ Ex Order 26.4(b)(1), indicated Resident #1 scored NJ Ex O which indicated the resident had NJ Ex Order 26.4(b)(1) A "Personal Service Plan" dated NJ Ex Order 26.4(b)(1) indicated Resident #1 required NJ Ex Order 26.4(b)(1) with activities of daily living (ADLs including NJ Ex Order 26.4(b)(1)), was NJ Ex Order 26.4(b)(1) with going to and from the dining room or community activities, and had NJ Ex Order 26.4 Resident #1's "Personal Service Plan" revealed that on NJ Ex Order 26.4(b)(1) the Health and Wellness Director (HWD) made a revision that indicated Resident #1's ADL ability had NJ Ex Order 26.4(b)(1) and Resident #1 required NJ Ex Order 26.4(b)(1) Resident #1's "Resident Health Care Plan," dated NJ Ex Order 26.4(b)(1) indicated Resident #1 received NJ Ex Order 26.4(b)(1) to promote NJ Ex Order 26.4(b)(1) and safety due to a NJ Ex Order 26.4(b)(1) Per the Resident	A 753		

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A 753	Continued From page 10 Health Care Plan, Resident #1 was at NJ Exec Order 26.4b1 risk of NJ Ex Order 26.4(b)(1) due to NJ Ex Order 26.4(b)(1) [redacted] An "RN Health Assessment" dated NJ Ex Order 26.4(b)(1) indicated the assessment was completed due to a NJ Exec Order 26. in Resident #1's NJ Exec Order 26.4b1 The assessment indicated Resident #1 needed additional NJ Exec O with NJ Ex Order 26.4(b)(1) [redacted] and that NJ Exec Order 26.4b and/or a NJ Ex Order 26.4(b)(1) were needed for NJ Ex Order 26.4(b)(1) The assessment revealed Resident #1 had no observed NJ Ex Order 26.4(b)(Per the assessment, Resident #1 scored NJ Ex on a NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1) which indicated mild risk for NJ Ex Order 26.4(b)(1) [redacted] Resident #1's NJ Ex Order 26.4(b)(1) Medication Administration Record revealed no documented evidence that a treatment was ordered or provided to NJ Ex Order 26.4(b)(. During an interview on 05/12/2026 at 12:23 PM, Care Associate (CA) #1 stated that during provision of care on NJ Ex Order 26.4(b)(1) during the 7:00 AM to 3:00 PM shift, she noticed NJ Ex Order 26.4(b)(1) on the resident's NJ Ex Orde that was approximately the NJ Ex Order 26. [redacted]. Per CA #1, the NJ Ex Order 26. was red and she was unable to recall whether the NJ Ex Order 26. was open. The CA stated she reported the area to Licensed Practical Nurse (LPN) #2. Per CA #1, she also worked on NJ Ex Order 26.4(b)(1) and someone had put NJ Ex Order 26.4(b)(1). During a telephone interview on 05/14/2026 at 8:25 AM, LPN #2 revealed that CA #1 notified her that Resident #1 had NJ Ex Order 26.4(b)(. The LPN stated that she did not recall what the NJ Ex Order 26. looked like. LPN #2 stated she forgot to notify the HWD about	A 753		

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A 753	Continued From page 11	A 753		

the [redacted] and was off work the next day and did not follow up.

Resident #1's "Personal Service Plan," last revised[redacted] and the resident's "Resident Health Care Plan," dated[redacted] revealed no documented evidence the facility made any revisions to the resident's service plan and/or health service plan that addressed care and treatment for the identified[redacted]

Resident #1's "ED [Emergency Department] Provider Note" dated[redacted] at 3:22 PM revealed the resident presented to the hospital with[redacted]) and an "ED Course" note dated[redacted] at 8:20 PM revealed the resident was admitted to inpatient services with a[redacted] diagnosis of[redacted] The ED Provider Note did not indicate that the resident had[redacted].

Resident #1's hospital "History and Physical" physician note dated[redacted] at 10:28 PM revealed the resident's chief complaint was[redacted] and one of the resident's active diagnoses was[redacted] The History and Physical note did not indicate that the resident had a[redacted].

Resident #1's nursing "Flowsheets" revealed a "Basic Assessment" was completed on[redacted] at 10:00 PM (approximately seven hours after the resident presented to the hospital) that indicated the resident had[redacted] that[redacted] and was described as being[redacted] and the[redacted] According to the assessment, this was the "First Assessed"

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 753	Continued From page 12 date and time for the resident's NJ Ex Order 26.4(b)(1) [redacted] Resident #1's "Discharge Summary" note dated NJ Ex Order 26.4(b)(1) [redacted] at 2:12 AM revealed the resident's family elected to NJ Ex Order 26.4(b)(1) and the NJ Ex Order 26.4(b)(1) on call later NJ Ex Order 26.4(b)(1) the resident NJ Ex Order 26.4(b)(1) The note revealed NJ Ex Ord diagnoses included NJ Ex Order 26.4(b)(1) [redacted] and NJ Ex Order 26.4(b)(1) [redacted] During an interview on 05/12/2026 at 11:09 AM, Registered Nurse (RN) #3 stated when NJ Ex Order 26.4(b)(was identified, they notified the resident's physician, and any treatment orders were transcribed into the resident's electronic medical record. RN #3 stated that she was not notified that Resident #1 had NJ Ex Order 26.4(b)(until after the resident was discharged to the hospital. Per RN #3 after the resident went to the hospital a family member mentioned NJ Ex Order 26.4(b)(1) to the facility staff. During an interview on 05/13/2026 at 2:58 PM, the HWD stated that he expected to be notified when staff found NJ Ex Order 26.4(b)(1) to Resident #1's NJ Ex Order 26.4(so that a treatment plan could have been implemented. The HWD stated he was not sure how lack of treatment affected NJ Ex Order 26.4(b)(1) . The HWD stated the resident's NJ Ex Order 26.4(b)(1) and lack of treatment impacted NJ Ex Order 26.4(b)(1)	A 753		
A 779	8:36-7.5(c) Provision of Health Care Services (c) The registered professional nurse shall be called at the onset of illness, injury or change in condition of any resident to arrange for assessment of the resident's nursing care needs	A 779		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30A001	A. BUILDING: _____ B. WING _____	C 05/18/2026

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A 779	Continued From page 13 or medical needs and for needed nursing care intervention or medical care. This REQUIREMENT is not met as evidenced by: Complaint NJ00190564 and NJ00190373 Based on interview, record review, and facility policy review, the facility failed to ensure a registered nurse (RN) was notified of a change in condition to arrange for an assessment and for needed nursing or medical care for 1 (Resident #1) of 3 residents reviewed for [NJ Ex Order 26.4(b)(1) redacted]. On [NJ Ex Order 26.4(b)(1)] direct care staff identified [NJ Ex Order 26.4(b)(1)] to Resident #1's [NJ Ex Orde] that was approximately the NJ Ex Order 26.4(b)(1). Staff reported [NJ Ex Order 26.4(b)(1)] to a licensed practical nurse (LPN); however, the LPN failed to notify an RN that the resident had developed [NJ Ex Order 26.4(b)]. There was no documented evidence that the facility assessed [NJ Ex Order 26.4(b)(1)] or provided any type of treatment to the area. On [NJ Ex Order 26.4(b)(1)] the resident was [NJ Exec Order 26.4b1] for [NJ Ex Order 26.4(b)(1) redacted]), and approximately seven hours after presentation to the [NJ Exec Order 26.4b] [NJ Exec Order 26.4] staff documented that Resident #1 had NJ Ex Order 26.4(b)(1) [redacted] to the NJ Ex Order 26.4(b)(1) [redacted]. Resident #1 [NJ Ex Order 26.4(] or [NJ Ex Order 26.4(b)(1)] and	A 779		

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A 779	Continued From page 14 final diagnoses included NJ Ex Order 26. and NJ Ex NJ Ex Order 26.4(b)(1) . It was determined the facility's non-compliance with one or more requirements had caused, or was likely to cause serious injury, serious harm, serious impairment, or death to the resident. On 05/20/2026 at 10:10 AM the Executive Director (ED) was verbally informed of the immediacy of the situation involving the failure to ensure an RN was notified and assessed a resident's change of condition. Findings included: A facility policy titled, "Change in Condition," revised 04/20/2025, revealed for non-emergent concerns, "1. Care partners are responsible for reporting subtle changes in a resident's condition to the HWD [Health and Wellness Director]/nurse/designee. A facility policy titled, "Skin Integrity Documentation Policy," revised 12/2025, indicated, "B. 2. A new Skin Observation Form should be completed at a minimum quarterly, upon a change of condition, and upon return from a hospitalization/emergency department/rehab visit. Skin observation may be completed more frequently, after a change of condition, based on the individual resident's need and the nurse/designee's clinical judgement." The policy further revealed. "4. Any actual or potential skin problems should be reported according to [the facility] Change of Condition policy and documented in the Resident Log/PCC [Point Click Care is an electronic medical record] Progress Notes." According to the policy, "6. The Skin Observation Form is completed on paper and	A 779		

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A 779	Continued From page 15	A 779		

should then be filed in the Resident Record or completed electronically in PointClickCare (PCC)."

An "Admission Record" revealed that the facility admitted Resident #1 on NJ Ex Order 26.4(b)(1) According to the Admission Record, Resident #1 had a medical history that included diagnoses of NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1)

A "Brief Interview [for] Mental Status (BIMS) Screening and Scoring Tool - Assisted Living Only" dated NJ Ex Order 26.4(b)(1) indicated Resident #1 scored NJ Ex O which indicated the resident had NJ Ex Order 26.4(b)(1)

A "Personal Service Plan" dated NJ Ex Order 26.4(b)(1) indicated Resident #1 required NJ Ex Order 26.4(b)(1) with activities of daily living NJ Ex Order 26.4(b)(1)), was NJ Ex Order 26.4(b)(1) with going to and from the dining room or community activities, and had NJ Ex Order 26.4(b)(1)

A "Resident Health Care Plan," dated NJ Ex Order 26.4(b)(1), indicated Resident #1 received NJ Ex Order 26.4(b)(1) to promote NJ Ex Order 26.4(b)(1) and safety for NJ Ex Order 26.4(b)(1) Per the Resident Health Care Plan, Resident #1 was at increased risk of NJ Ex Orde due to NJ Ex Order 26.4(b)(1)

An "RN Health Assessment" completed on NJ Ex Order 26.4(b)(1) indicated the assessment was completed due to a change in Resident #1's condition. The assessment indicated Resident #1 needed additional help with NJ Ex Order 26.4(b)(1) , with NJ Ex Order 26.4(b)(1) needed for NJ Ex Order 26.4(b) and/or NJ Ex Order 26.4(b)(1) The assessment revealed

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A 779	Continued From page 16 Resident #1 had NJ Ex Order 26.4(b)(1), Resident #1 scored NJ Ex on the NJ Ex Order 26.4(b)(1) Resident #1's "Progress Notes" for the timeframe from NJ Ex Order 26.4(b)(1) through NJ Ex Order 26.4(b)(1) when the resident was transferred to the hospital revealed no documentation related to the identification of a NJ Ex Order 26.4 on NJ Ex Order 26.4(b)(1) Resident #1's "ED [Emergency Department] Provider Note" dated NJ Ex Order 26.4(b)(1) at 3:22 PM revealed the resident presented with NJ Ex Order 26.4(b)(1) and a "ED Course" note dated NJ Ex Order 26.4(b)(1) at 8:20 PM revealed the resident was admitted to inpatient services with a NJ Ex Orde diagnosis of NJ Ex Order 26.4(b)(1) . The ED Provider Note did not indicate that the resident had a pressure sore. Resident #1's hospital "History and Physical" physician note dated NJ Ex Order 26.4(b)(1) at 10:28 PM revealed the resident's chief complaint was NJ Ex Order 26.4(b)(1) and one of the resident's active diagnoses was NJ Ex Order 26.4(b)(1) The History and Physical note did not indicate that the resident had NJ NJ Ex Order 26.4(b)(1) Resident #1's hospital record revealed nursing "Flowsheets" that indicated staff completed a "Basic Assessment" on NJ Ex Order 26.4(b)(1) at 10:00 PM, approximately seven hours after presentation to the hospital, which was the date and time hospital staff "First Assessed" NJ Ex Order 26.4(b)(. Per the assessment, the resident had NJ Ex Order 26.4(b)(1) to the NJ Ex Order 26.4(that NJ Ex Order 26.4(b)(1) and was described as NJ Ex Order 26.4(b)(1) and the NJ Ex Orde	A 779		

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A 779	Continued From page 17 NJ Ex Order 26.4(b)(1) Resident #1's "Discharge Summary" note dated NJ Ex Order 26.4(b)(1) at 2:12 AM revealed a "Summary Of NJ Exec Order 26.4(Course," that indicated the resident was admitted due to NJ Ex Order 26.4(b)(1) and was found to have NJ Ex Order 26.4(b)(1) The resident's family elected to NJ Ex Order 26.4(b)(1) and the NJ Ex Order 26.4(b)(1) on call later NJ Ex Order 26.4(b)(1) the resident NJ Ex Order 26.4(b)(1) The note revealed NJ Ex Orde diagnoses included NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1)). Care Associate (CA) #1 was interviewed on 05/12/2026 at 12:23 PM. CA #1 stated that during provision of care on NJ Ex Order 26.4(b)(1) during the 7:00 AM to 3:00 PM shift, she noticed NJ Ex Order 26.4(b)(on the resident's NJ Ex Orde that was approximately NJ Ex Order 26.4(b)(1) Per CA #1, the NJ Ex Order 26.4(b)(1) but was unable to recall whether the NJ Ex Order 26.4(b)(1) . The CA stated reported the area to Licensed Practical Nurse (LPN) #2. Per CA #1, she also worked on NJ Ex Order 26.4(b)(1) and someone had NJ Ex Order 26.4(b)(1) A telephone interview was held with LPN #2 on 05/14/2026 at 8:25 AM. LPN #2 revealed CA #1 notified her of Resident #1's NJ Ex Order 26.4(The LPN stated that she did not recall what the NJ Ex Order 26.(. LPN #2 stated she forgot to notify the Health and Wellness Director (HWD), who was an RN, about NJ Ex Order 26.4(b)(1) and had not documented information about NJ Ex Order 26.4(b)(1) on the 24-hour report. LPN #2 stated she was off work the next day and did not follow up. Registered Nurse (RN) #3 was interviewed on 05/12/2026 at 11:09 AM. RN #3 stated that she	A 779		

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A 779	Continued From page 18 and the HWD were responsible for conducting [NJ Ex Order 26.4(b)(1)] and when [NJ Ex Order 26.4(b)] was identified the physician was notified and treatment orders were obtained. RN #3 stated she was unaware of Resident #1's [NJ Ex Order 26.4(b)(1)] until a family member mentioned [NJ Ex Order 26.4(b)(1)] after the resident had been discharged from the facility. The HWD was interviewed on 05/13/2026 at 2:58 PM and stated that he expected staff to notify him when [NJ Ex Order 26.4(b)] identified so a treatment plan could be implemented. The HWD stated he was not sure how lack of treatment affected the [NJ Ex Order 26.4] The HWD stated the resident's [NJ Ex Order 26.4(b)] and lack of treatment impacted [NJ Ex Ord] The ED was interviewed on 05/14/2026 at 1:44 PM and stated she expected LPN #2 to notify the HWD about Resident #1's [NJ Ex Order 26.] as soon as the LPN became aware.	A 779		
A 781	8:36-7.5(d) Provision of Health Care Services (d) The resident's physician or the physician's designee, that is, another physician or an advanced practice nurse or physician assistant, shall be notified by the licensed professional nurse of any significant changes in the resident's physical or cognitive/mental condition and any intervention by the physician shall be recorded. This REQUIREMENT is not met as evidenced by:	A 781		

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A 781	Continued From page 19 Complaint NJ00190564 and NJ00190373 Based on interview, record review, and facility policy review, the facility failed to notify a physician of a newly identified [NJ Ex Order 26.4(b)(1)] for 1 (Resident #1) of 3 residents reviewed for NJ Ex Order 26.4(b)(1). On [NJ Ex Order 26.4(b)(1)] direct care staff identified [NJ Ex Order 26.4(b)(1)] to the resident's back that was approximately NJ Ex Order 26.4(b)(1) [redacted]. Staff reported [NJ Ex Order 26.4(b)(1)] to a nurse; however, the nurse failed to notify the physician of the change in condition. On [NJ Ex Order 26.4(b)(1)] the resident was hospitalized for [NJ Ex Order 26.4(b)(1)] [redacted] and staff documented that Resident #1 had [NJ Ex Order 26.4(b)(1)] [redacted] to the NJ Ex Order 26.4(b)(1) [redacted] Resident #1 [NJ Ex Order 26.4(b)(1)] on [NJ Ex Order 26.4(b)(1)] and final diagnoses included [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)(1)]. It was determined the facility's non-compliance with one or more requirements had caused, or was likely to cause serious injury, serious harm, serious impairment, or death to the resident. On 05/20/2026 at 10:10 AM the Executive Director (ED) was verbally informed of the immediacy of the situation involving the failure to notify the physician in a change of condition. Findings included: A facility policy titled, "Change in Condition," revised 04/20/2025, revealed for non-emergent concerns, "2. The physician/HCP [health care provider] and legally responsible party should be notified of resident's change of condition."	A 781		

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A 781	Continued From page 20 A facility policy titled, "Skin Integrity Documentation Policy," revised 12/2025, "1. The associate/care partner should report skin changes if noted for residents who are receiving assistance with a bath or shower. 2. The Health and Wellness Director (HWD) or designee should: b. Notify the physician/healthcare provider (HCP) and family of the skin concern as soon as possible." An "Admission Record" revealed that the facility admitted Resident #1 on NJ Ex Order 26.4(b)(1). According to the Admission Record, Resident #1 had a medical history that included diagnoses of NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1). A "Brief Interview [for] Mental Status (BIMS) Screening and Scoring Tool - Assisted Living Only" dated NJ Ex Order 26.4(b)(1), indicated Resident #1 scored NJ Ex which indicated the resident had NJ Ex Order 26.4(b)(1) A "Personal Service Plan" dated NJ Ex Order 26.4(b)(1) indicated Resident #1 required NJ Ex Order 26.4(b)(1) with activities of daily living NJ Ex Order 26.4(b)(1)), was NJ Ex Order 26.4(b)(1) with going to and from the dining room or community activities, and had NJ Ex Order 26.4(b)(1). Resident #1's "Progress Notes" dated NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) revealed no documented evidence that the resident's physician was notified of NJ Ex Order 26.4(b)(1). Resident #1's "ED [Emergency Department] Provider Note" dated NJ Ex Order 26.4(b)(1) at 3:22 PM revealed the resident presented with NJ Ex Order 26.4(b)(1) and a "ED Course" note	A 781		

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A 781	Continued From page 21 dated NJ Ex Order 26.4(b)(1) at 8:20 PM revealed the resident was admitted to NJ Exec Order 26.4b services with a NJ Ex Ord diagnosis of NJ Ex Order 26.4(b)(1) The ED Provider Note did not indicate that the resident had NJ Ex Order 26.4(b)(1) Resident #1's hospital "History and Physical" physician note dated NJ Ex Order 26.4(b)(1) at 10:28 PM revealed the resident's chief complaint was NJ Ex Order 26.4(b)(1) and one of the resident's active diagnoses was NJ Ex Order 26.4(b)(1) The History and Physical note did not indicate that the resident had NJ NJ Ex Order 26.4(b)(1). Resident #1's nursing "Flowsheets revealed a "Basic Assessment" was completed on NJ Ex Order 26.4(b)(1) at 10:00 PM that indicated the resident had NJ Ex Order 26.4(b)(1) that NJ Ex Order 26.4(b)(1) and was described as NJ Ex Order 2 and the NJ Ex Order 26.4(b)(1) Resident #1's "Discharge Summary" note dated NJ Ex Order 26.4(b)(1) at 2:12 AM revealed the resident's family elected to NJ Ex Order 26.4(b)(1) and the NJ Ex Order 26.4(b)(1) on call later NJ Ex Order 26.4(b)(1) the resident NJ Ex Order 26.4(b)(1) The note revealed NJ Ex Ord diagnoses included NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) Care Associate (CA) #1 was interviewed on 05/12/2026 at 12:23 PM. CA #1 stated that during provision of care on NJ Ex Order 26.4(b)(1) during the 7:00 AM to 3:00 PM shift, she noticed NJ Ex Order 26.4(b)(on the resident's NJ Ex Orde that was approximately NJ Ex Order 26.4(b)(1) Per CA #1, the NJ Ex Order 26. was NJ Ex O but was unable to recall whether the NJ Ex Order 26. was	A 781		

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A 781	Continued From page 22 NJ Ex Order 2 The CA stated reported the area to Licensed Practical Nurse (LPN) #2. Per CA #1, she also worked on NJ Ex Order 26.4(b)(1) and someone had put NJ Ex Order 26.4(b)(1) A telephone interview was held with LPN #2 on 05/14/2026 at 8:25 AM. LPN #2 revealed CA #1 notified her of Resident #1's NJ Ex Order 26.4(The LPN stated that she did not recall what the NJ Ex Order 26 looked like. LPN #2 stated she attempted to notify the physician twice and left messages for the physician. LPN #2 stated she forgot to notify the Health and Wellness Director (HWD) about the NJ Ex Order 26. and had not documented information about the NJ Ex Order 26. on the 24-hour report, so there had been no follow-up. LPN #2 stated she was off work the next day; subsequently, there was no follow up to get NJ Ex Order 26. care orders for treatment of NJ Ex Order 26.4(b)(1). The HWD was interviewed on 05/13/2026 at 2:58 PM and stated that he expected to be notified when the NJ Ex Order 26. was found to Resident #1's NJ Ex Order 26.4(so that he could have followed up with the physician and a treatment plan would have been implemented. The HWD stated he was not sure how lack of treatment affected the NJ Ex Order 26.4(The HWD stated the resident's NJ Ex Order 26.4(b)(1) and lack of treatment impacted NJ Ex Ord The ED was interviewed on 05/14/2026 at 1:44 PM and stated she expected LPN #2 to notify the HWD about Resident #1's NJ Ex Order 26. as soon as the LPN became aware. The ED stated she expected the LPN to continue to try to reach the physician, and when she was unable to contact the physician expected the nurse to notify the HWD for direction. The ED stated that the danger in not starting NJ Ex Order 26. treatment or not completing	A 781		

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A 781	Continued From page 23 [redacted] treatments as ordered could include [redacted] of [redacted]. Attempts to interview Resident #1's primary care physician made on 05/14/2026 at 8.59 AM and 05/15/2026 at 8:42 AM, were unsuccessful.	A 781		
A1077	8:36-15.7(a)(2) Record of Death (a) Whenever a resident dies in the assisted living residence, the administrator or the administrator's designee shall: 2. Include in the resident's record written documentation from the physician of the date and time of death, the name of the person who pronounced the death, disposition of the body, and a record of notification of the family. The administrator or administrator's designee shall include in the record of notification of the family confirmation and written documentation of that notification. This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility document and policy review, the facility failed to ensure staff documented a resident's death in their medical record for 1 (Resident #4) of 3 residents reviewed for death. Findings included:	A1077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30A001	A. BUILDING: _____ B. WING _____	C 05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEST ORANGE	520 PROSPECT AVENUE WEST ORANGE, NJ 07052

(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
A1077	Continued From page 24 A facility policy titled, "Death of a Resident," revised in 12/2022, indicated, "B. Documentation 1. Information pertaining to a resident's death shall be recorded in the resident record (e.g. [exempli gratia, for example] date time of death, name/title of the individual pronouncing the resident's death, notifications, etc. [et cetera, and so forth]) 2. Document the completion and filing of the Release of Deceased Resident to Mortician/Funeral Director Form" [sic] in PointClickCare (PCC) progress note/ resident's record." An "Admission Record" indicated the facility admitted Resident #4 on NJ Ex Order 26.4(b)(1). According to the Admission Record, the resident had a past medical history that included diagnoses of NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1). A "Hospice Certification and Plan of Care," dated NJ Ex Order 26.4(b)(1), identified Resident #4's certification period from NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1) and their primary diagnosis as NJ Ex Order 26.4(b)(1). The document revealed the resident's NJ Ex Order 26.4(b)(1) as NJ Ex Order 26.4(b)(1). A hospice "Visit Note Report" dated NJ Ex Order 26.4(b)(1) indicated the hospice nurse was called to the facility by a medication technician (MT) due to a NJ Exec Order 26. in status of Resident #4. The note revealed Resident #4 was NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(1) at 12:15 AM by the NJ Exec Order 26.4 nurse. The note revealed Resident #4's family was present. The note further revealed the medical director and NJ Ex Order 26.4(b)(1) were notified by the NJ Exec Order 26.4 agency.	A1077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30A001	A. BUILDING: _____ B. WING _____	C 05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEST ORANGE	520 PROSPECT AVENUE WEST ORANGE, NJ 07052

(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
A1077	Continued From page 25 Resident #4's "Progress Notes," dated for the timeframe from [NJ Ex Order 26.4(b)(1)] through [NJ Ex Order 26.4(b)(1)] revealed no documentation regarding the resident's [NJ Ex Order 2] on [NJ Ex Order 26.4(b)(1)] The Health and Wellness Director (HWD) was interviewed on 05/13/2026 at 3:16 PM. The HWD stated that since Resident #4 received [NJ Exec Order 26.4] services, the staff of the [NJ Exec Order 26.4] agency was responsible for the NJ Ex Order 26.4(b)(1) The HWD stated he expected the resident's medical record to contain documentation that indicated when the resident [NJ Ex Order 26.4(b)(1)] and who had [NJ Ex Order 26.4(b)(1)] the resident. The HWD reviewed Resident #4's medical record and was unable to find documentation regarding the resident's [NJ Ex Order 26] The Executive Director (ED) was interviewed on 05/14/2026 at 1:57 PM. The ED stated if a resident [NJ Ex Order 2] occurred at night, she expected staff to notify the HWD with NJ Ex Order 26.4(b)(1), the name of the person that [NJ Ex Order 26.4(b)(1)] the resident, and the name of the person that notified the family. The ED said the HWD would document the information in the resident's record the following day.	A1077		

POC#2 received 6/24/26
Accepted 6/25/26

BROOKDALE
SENIOR LIVING SOLUTIONS

Brookdale West Orange
520 Prospect Ave
West Orange, NJ 07052

Survey Date- 5/18/2026

H5790 8:43E-13.4(d)- Universal Transfer Form- Mandatory Use Form

- **HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?**

  Resident #1 was identified as being affected by this deficient practice. On 5/20/26, the Health and Wellness Director (HWD) reviewed Resident #1's transfer record and completed corrective documentation from the available transfer record, resident record, and applicable supporting information, and placed the completed/corrected universal transfer form (UTF) documentation in Resident #1's medical record.

- **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFIEICIENT PRACTICE?**

  All residents had the potential to be affected by this deficient practice. On 5/20/26, the Health and Wellness Director (HWD) reviewed recent resident transfers and discharges to verify that a universal transfer (UTF) for had been completed for each transfer and that a copy was retained in each resident's medical record. Any missing or incomplete documentation identified during the review was corrected at that time.

- **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?**

  On 6/4/26, the Director of District Clinical Services (DDCS); revised the transfer procedure. The revised procedure includes: mandatory completion of the universal transfer form (UTF) for every resident transfer to an outside provider or acute care setting; confirmation that the universal transfer form (UTF) accompanies the resident at the time of transfer when feasible; retention of a copy of the universal transfer form (UTF) in the resident's medical record; documentation of the staff member completing the form and the date/time of completion; and leadership review of the transfer documentation after the transfer.

  On 5/20/26, the Health and Wellness Director (HWD) provided re-education to RNs, and medication technicians regarding mandatory use of the universal transfer form (UTF), required contents of the universal transfer form, retention of a copy in the record, and when to notify the Health and Wellness Director (HWD), Registered Nurse (RN) or Executive Director (ED).

The facility does not have a Registered Nurse (RN) physically on-site 24 hours per day/7 days per week. If a Registered Nurse (RN) is not physically present at the time of transfer, the medication technician initiates the transfer process, gathers the required transfer information, verifies the universal transfer form (UTF) accompanies the resident or is provided to the receiving provider, as applicable, and notifies the Health and Wellness Director (HWD), or Registered Nurse (RN). The Health and Wellness Director (HWD), or Registered Nurse (RN), reviews the transfer documentation for completeness and verifies that a copy of the completed universal transfer form is retained in the resident's medical record.

- **HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?**

Beginning 5/20/26, the Health and Wellness Director (HWD), Executive Director (ED), or designee will audit all resident transfers weekly for four weeks and monthly for two additional months to verify that the universal transfer form was completed, accompanied the resident or was provided to the receiving provider as applicable, and was retained in the resident record. Audit findings will be reviewed in Collaborative Care/ Quality Assurance and Performance Improvement (QAPI). Any noncompliance will be corrected immediately through document completion, staff counseling, re-education, and additional corrective action as indicated.

COMPLETION DATE: 6/30/2026

A607- 8:36-5.15 (a)(1)- Notification requirements

- **HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?**

Resident #1 was identified as being affected by this deficient practice. On 5/20/26, the Executive Director (ED) reviewed Resident #1's record and verified the required notification documentation related to the deficient practice. Any missing or incomplete notification documentation was corrected in the resident record to reflect the applicable notification, including the date, time, person notified, method of notification, and staff member completing the notification.

On 5/20/26, the Health and Wellness Director (HWD), provided re-education to direct care associates, medication technicians, and RN regarding required notifications.

- **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFIEICIENT PRACTICE?**

All residents had the potential to be affected by this deficient practice. On 5/20/26, the Executive Director (ED); reviewed recent incidents, transfers, acute illnesses, significant changes in condition, and other applicable resident records to verify that required notifications were completed and documented. Any missing or incomplete notification documentation identified during the review was corrected.

- **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?**

On 5/20/26, the Health and Wellness Director (HWD), re-educated direct care associates, medication technicians, and Registered Nurse (RN), on timely notification of the physician, resident's legal representative, family/responsible party, and/or guardian when there is a change in condition, transfer, incident, acute illness requiring medical care, accident, or other reportable event.

The education also addressed the requirement that all notifications be documented in the designated record, including date, time, person notified, relationship/role, method of notification, summary of

information communicated, and staff member completing the notification. The Health and Wellness Director (HWD), Registered Nurse (RN), is responsible for completing and/or verifying notification documentation. The Executive Director (ED) is responsible for oversight and follow-up when a notification issue is identified.

- **HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?**

Beginning 5/20/26, the Health and Wellness Director (HWD), Executive Director (ED), or designee will audit resident records for all reportable incidents, transfers, significant changes in condition, acute illnesses requiring medical care, accidents, and hospital transfers to verify that the resident's legal representative, family member/responsible party, guardian, and physician were notified as required and that the notification was documented in the resident's record.

Audits will be completed weekly for four weeks and monthly for two additional months. Findings will be reviewed during Collaborative Care/ Quality Assurance and Performance Improvement (QAPI). Any identified concerns will be corrected immediately through completion of documentation, staff counseling, re-education, and corrective action as appropriate.

COMPLETION DATE: 6/30/2026

A753- 8:36-7.3(c) - General and Health Service Plans

- **HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?**

Resident #1 was identified as being affected by this deficient practice. On 5/20/26, the Health and Wellness Director (HWD) reviewed Resident #1's general and health service plans, and revised the plans as needed to reflect Resident #1's current condition, needs, services, interventions, monitoring, and follow-up requirements. The updates included clarification of current care needs, required services/interventions, change-in-condition follow-up, provider/responsible-party notification as applicable, and documentation expectations.

- **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFIEICIENT PRACTICE?**

All residents had the potential to be affected by this deficient practice. On 5/20/26, the HWD reviewed current resident records and service plans to verify that general and health service plans were current and reflected each resident's condition, needs, services, and interventions. Any plans identified as incomplete or not current were updated by the HWD or designee.

- **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?**

The Health and Wellness Director (HWD), re-educated Registered Nurse (RN), and medication technicians, and direct care associates on 5/20/2026, on the requirement that general and health service

plans are to be reviewed and updated to reflect the resident's current needs, services, interventions, and changes in condition.

The Health and Wellness Director (HWD) and Registered Nurse are responsible for reviewing and updating health service plans. Direct care associates and medication technicians are responsible for reporting observed changes in condition or changes in service needs to the Health and Wellness Director (HWD), or licensed nurse so that the service plan may be updated

- **HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?**

Beginning 5/20/26, the Health and Wellness Director (HWD), Executive Director (ED), or designee will audit a sample of resident service plans weekly for four weeks and monthly for two additional months to verify that the plans are complete, current, and reflective of resident needs, services, interventions, and changes in condition. Audit results will be reviewed in Collaborative Care/ Quality Assurance and Performance Improvement (QAPI). Any identified issues will be corrected immediately, and responsible staff will receive counseling, re-education, and corrective action as appropriate.

COMPLETION DATE: 6/30/2026

A 779- 8:36-7.5 (c)- Provision of Health Care Services-

- **HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?**

Resident #1 was identified as being affected by this deficient practice. On 5/20/26, the Health and Wellness Director (HWD), reviewed Resident #1's record, physician/provider orders, treatment documentation, progress notes, and service plan. Resident #1's service plan was updated to verify completion of current ordered services, required follow-up, monitoring, documentation requirements, communication with the provider, and notification of the legal representative/responsible party.

- **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFIEICIENT PRACTICE?**

All residents had the potential to be affected by this deficient practice. On 5/20/26, the Health and Wellness Director (HWD), reviewed current resident records, orders, treatment records, progress notes, and service plans to identify any resident whose health care services required follow-up, clarification, documentation, provider communication, or service plan update. Any concerns identified during the review were corrected by the HWD or designee.

- **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?**

The re-education scheduled for 5/20/26 was completed by the Health and Wellness Director (HWD). The HWD re-educated nursing staff, medication technicians, and direct care associates on providing health care services in accordance with physician/provider orders, community policy, and the resident's service plan.

The Health and Wellness Director (HWD), and licensed nurses are responsible for communicating with the provider, obtaining clarification of orders, completing required follow-up, and updating the service plan. Direct care associates and medication technicians are responsible for reporting changes in

condition, missed/refused services, or concerns regarding ordered services to the Health and Wellness Director (HWD), registered nurse or licensed nurse. Education was provided to the responsible staff members.

- **HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?**

Beginning 5/20/26, the Health and Wellness Director (HWD), Executive Director (ED), or designee will audit a sample of resident records weekly for four weeks and monthly for two additional months to verify that health care services are provided and documented in accordance with physician/provider orders, community policy, and the resident's service plan. Audit findings will be reviewed with community leadership and during Collaborative Care/ Quality Assurance and Performance Improvement (QAPI). Identified issues will be corrected immediately through provider follow-up, service plan revision, staff counseling, re-education, and corrective action as needed.

COMPLETION DATE: 6/30/2026

A 781- 8:36-7.5(d)- Provision of Health Care Services-

- **HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?**

Resident #1 was identified as being affected by this deficient practice. On 5/20/26, the HWD reviewed Resident #1's health service orders, treatment orders, notes, and service plan to verify that services were provided and documented as required. If documentation or follow-up was incomplete, the Health and Wellness Director (HWD) or designee, corrected the record as applicable, obtained clarification/follow-up with the provider as needed, notified the legal representative/responsible party as applicable, and updated the resident's service plan to reflect current care needs and interventions.

- **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFIEICIENT PRACTICE?**

All residents had the potential to be affected by this deficient practice. On 5/20/26, the Health and Wellness Director (HWD), reviewed current resident records, notes, treatment documentation, health service orders, and service plans to identify residents needing follow-up, clarification, updated documentation, provider communication, or service plan revision. Any identified concerns were corrected by the HWD or designee.

- **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?**

On 5/20/26, the Health and Wellness Director (HWD), re-educated Registered Nurse (RN), and medication technicians, and direct care associates regarding the requirement to provide and document health care services in accordance with physician/provider orders, resident needs, community policy, and the resident's health service plan.

The Health and Wellness Director (HWD), and licensed nurses are responsible for communicating with the provider and/or legal representative/responsible party, documenting the communication, and updating the care/service plan when resident needs change. Direct care associates and medication

technicians are responsible for promptly reporting changes in condition, refusal of services, missed services, or other concerns to the Health and Wellness Director (HWD), or licensed nurse. The HWD re-education was provided to the staff members responsible for communication, documentation, and plan updates.

- **HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?**

Beginning 5/20/26, the Health and Wellness Director (HWD), ED, or designee will audit a sample of resident records weekly for four weeks and monthly for two additional months to verify that services are provided, documented, communicated, and reflected in the resident's service plan as required. Audit findings will be reviewed with community leadership and during Collaborative Care/ Quality Assurance and Performance Improvement (QAPI)I. Any identified issues will be corrected immediately, and additional staff education or corrective action will be provided as applicable.

COMPLETION DATE: 6/30/2026

A 1077- 8:36-15.7(a)(2)- Record of Death-

- **HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?**

Resident #4 was identified as being affected by this deficient practice. On 5/21/26, the Health and Wellness Director (HWD), reviewed Resident #4's [NJ Ex Order 26.4(b)(1)] documentation for completeness. Any missing or incomplete documentation was completed or corrected as applicable by the HWD or designee, and retained in Resident #4's record.

- **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFIEICIENT PRACTICE?**

All residents had the potential to be affected by this deficient practice. On 5/21/26, the Health and Wellness Director (HWD), reviewed resident death records to verify that required death documentation was completed and maintained. Any missing or incomplete documentation identified during the review was corrected by the HWD or designee.

- **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?**

On 5/21/26, the Health and Wellness Director (HWD), re-educated Registered Nurse (RN), and medication technicians regarding required documentation for a resident death record, required notifications, completion of required forms, and retention of all required documentation in the resident's record.

The licensed nurse or Registered Nurse (RN), at the time of death is responsible for initiating and completing required death documentation and notifications. The Health and Wellness Director (HWD), or Registered Nurse (RN), is responsible for reviewing the death record for completeness and verifying that all required forms and notifications are maintained in the resident record. Re-education was provided to the staff members responsible for completing and verifying the documentation by the HWD or designee.

- **HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?**

  Beginning 5/21/26, the Health and Wellness Director (HWD), Executive Director, Registered Nurse (RN), or designee will review each resident death record within the month of death to verify that all required documentation and notifications are complete and retained in the resident record. This monthly death-record review will continue for three months and then will be incorporated into Collaborative Care/ Quality Assurance and Performance Improvement (QAPI), monitoring. Any identified issue will be corrected by the HWD or designee, and associates will receive additional re-education or corrective action as applicable.

COMPLETION DATE: 6/30/2026

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
30A001	A. Building B. Wing	6/25/2026

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEST ORANGE	520 PROSPECT AVENUE WEST ORANGE, NJ 07052

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 H5790 Reg. # 8:43E-13.4(d) LSC	Correction Completed 06/30/2026	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
5/18/2026	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
30A001 Y1	A. Building B. Wing Y2	6/25/2026 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEST ORANGE	520 PROSPECT AVENUE WEST ORANGE, NJ 07052

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 A0607	Correction	ID Prefix A0753	Correction	ID Prefix A0779	Correction
Reg. # 8:36-5.15(a)(1)	Completed	Reg. # 8:36-7.3(c)	Completed	Reg. # 8:36-7.5(c)	Completed
LSC	06/30/2026	LSC	06/30/2026	LSC	06/30/2026
ID Prefix A0781	Correction	ID Prefix A1077	Correction	ID Prefix	Correction
Reg. # 8:36-7.5(d)	Completed	Reg. # 8:36-15.7(a)(2)	Completed	Reg. #	Completed
LSC	06/30/2026	LSC	06/30/2026	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
5/18/2026	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO