STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL16002	A. BUILDING: _____ B. WING _____	C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTVIEW WAYNE	1139 HAMBURG TURNPIKE WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: Type of Survey: Complaint Complaint #: NJ 00154324, NJ 00186600 Census: 105 Sample Size: 4 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 310	Continued From page 1 This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00154324 Based on observation, interview, and record review, it was determined that the Executive Director (ED) failed to develop and implement a policy and procedure to ensure dining staff wore hair restraints while entering the facility kitchen. This deficient practice was evidenced by the following: On 6/4/2025 at 12:15 p.m., while conducting a meal observation on the third-floor, the surveyor observed dining staff entering the kitchen without hair restraints. The surveyor then interviewed the Dining Service Manager (DSM), who was also observed without a hair restraint coming out of the kitchen, regarding the need for a hair restraint. The DSM stated that he was unaware that the staff were required to use hair restraints. At 2:00 p.m., the surveyor requested a hair restraint policy and procedure from the ED and the Associate Director of Hospitality Service (AD). The ED and AD stated that there was no policy and procedure for hair restraints, and provided the surveyor with a document titled, "Dining Uniform (Best Practice)". The surveyor reviewed the document titled, "Dining Uniform (Best Practice)" which revealed " Dining Servers ... may elect to wear a [facility] baseball cap. ...Chefs and Cooks ... may elect to wear a chef's hat ..."	A 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 310	Continued From page 2 Reference: A0891 Reg 8:36-10.5(a)	A 310		
A 401	8:36-4.1(a)(22) Resident Rights (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: 22. The right to live in safe and clean conditions in a facility that does not admit more residents than it can safely accommodate while providing services and care; This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00186600 Based on observation, interview, and record review, it was determined that the facility failed to ensure a safe environment was maintained for [redacted] of 4 residents reviewed, Resident #1. This deficient practice was evidenced by the following: On 6/4/25, the Department of Health (DOH) investigated a facility reportable event (FRE -a document used by a facility to report event to the DOH) regarding a resident [redacted]. On 6/4/25 at 9:36 a.m., the surveyor interviewed the Health Service Director (HSD), a Registered Nurse (RN) regarding Resident #1's [redacted]. The HSD stated that Resident #1	A 401		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 401	Continued From page 3 lived in the NJ Ex Order 26. 4B1 unit prior to the NJ Ex Order 26. 4B1. The HSD stated that on NJ Exec Order 26. at 1:39 p.m., the resident NJ Exec Order 26.4b1 and was observed by the Resident Aide (RA) NJ Exec Order 26. NJ Ex Order 26. 4B1. The HSD explained that the resident had a NJ Ex Order 26. 4B1. At 11:00 a.m., the surveyor reviewed the medical record (MR) of Resident #1, which revealed a NJ Ex Order 26. 4B1. According to the resident's initial assessment dated NJ Exec Order 26., Resident #1 was NJ Exec Order 26.4 to NJ Exec Order 26. NJ Exec Order NJ Exec Ord and NJ Exec Order 26.4b with no NJ Ex Order 26. 4B1. During MR review, the surveyor noted that a on NJ Exec Order 26. at 6:11 a.m., a Wellness Nurse (WN) documented in the resident PN that at 1:00 a.m., Resident #1 NJ Exec Order 26.4b1 and was noted to NJ Ex Order 26. 4B1, with a NJ Exec Order on and NJ Exec Order 26.4b1, but was stopped and NJ Exec Order 26.4b1. The WN documented that she reminded the resident that he/she was NJ Ex O. In addition, the surveyor reviewed the documentation in the PN dated NJ Exec Order 26.4 at 6:31 a.m., which revealed that the Concierge called the WN at approximately 3:20 a.m., to notify her that Resident #1 was in the NJ Exec Order. The WN documented that the resident NJ Ex Order 26. 4B1 and was NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 to time. Continued review of the resident MR revealed that on NJ Exec Order 26. at 5:06 p.m., the HSD documented that Resident #1 was NJ Ex Order 2 NJ Exec Order 26.	A 401		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 401	Continued From page 4 NJ Ex Order 26. 4B1 when an RA NJ Exec Order 26.4 the resident and asked where he/she NJ Ex Order 26. 4B1 . "NJ Ex Order 26. 4B1 ." The resident NJ Ex Order 26. 4B1 was notified.. At 1:15 p.m., the surveyor interviewed Resident #1 regarding the NJ Ex Order 26. 4B1 . The resident upon interview, was NJ Exec Order 26.4 to NJ Exec but was NJ Ex Order 26. 4B1 . In addition, the resident stated that he/she NJ Ex Order 26 The resident also stated that NJ Ex Order 26. 4B1 . The resident explained that NJ Ex Order 26. 4B1 . At 1:45 p.m., the surveyor interviewed the Executive Director (ED) regarding the NJ Exec Order 26. FRE and the ED stated that the resident NJ Exec Order 26 NJ Ex Order 26. 4B1 . The ED also stated that the resident knew he/she was NJ Ex Order 26. 4B1 , and that the resident had been with the facility since NJ Ex Order 26. 4B1 . The surveyor reviewed the facility investigation summary provided by the HSD, which revealed in conclusion that the resident has a NJ Ex Order 26. 4B1 . At 3:03 p.m., the surveyor interviewed the RA who NJ Ex Order 2 the resident on NJ Ex Order 26. 4B1 . The RA stated that she worked the 7 a.m., to 3:00 p.m., shift and NJ Ex Order 26.4(b)(1)	A 401		

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A 401	Continued From page 5 observed the resident NJ Ex Order 26.4(b)(1) NJ Ex Order 26. 4B1 [redacted]. At that time, the RA stated that she NJ Ex Order 26.4(b)(1) and the resident NJ Ex Order 26. 4B1 [redacted]. The RA then stated that she NJ Ex Order 26.4 the resident NJ Ex Order 26. 4B1 and notified the HSD and ED. In addition, the RA stated that she was not aware of the resident's NJ Ex Order 26. 4B1 [redacted]. Upon surveyor arrival to the facility, the surveyor observed that the facility was situated on a NJ Exec Order 26.4b1 [redacted]. In addition, the surveyor observed that the NJ Exec Order 26.4b1 was NJ Ex [redacted]. The surveyor also observed that the NJ Ex Order 26. 4B1 [redacted], which placed the resident in NJ Ex Order 26. 4 way. The surveyor reviewed the policy and procedure titled' "Resident Rights" which revealed documentation that the resident has "... The right to live in safe ... conditions ..." In addition, the surveyor reviewed the facility policy and procedure titled, "Elopement and Missing Resident" which revealed "...All residents will be assessed for elopement risk by a licensed professional ...upon significant change in condition, and at regularly scheduled assessment intervals to identify risk factors that could lead to elopement. ...The resident's service/support plan will identify if the resident is determined to be at risk for elopement and interventions to minimize risk will be included in the service/support plan. ..."	A 401		
A 749	8:36-7.3(a) Resident Assessments and Care Plans	A 749		

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A 749	Continued From page 6 (a) The resident general service plan shall be reviewed and, if necessary, revised semi-annually, and more frequently as needed based upon the resident's response to the care provided and any changes in the resident's physical or cognitive status. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00186600 Based on interview and record review, it was determined that the facility failed to develop and implement intervention(s) on the resident [redacted] of 4 residents, Resident #1. This deficient practice was evidenced by the following: At 11:00 a.m., the surveyor reviewed the medical record (MR) of Resident #1 which revealed a move [redacted]. According to the SP dated [redacted], completed by a Registered Nurse (RN), the RN documented that the resident was [redacted] within the facility and may [redacted] The SP also revealed documentation under [redacted] with [redacted] that the resident [redacted] Additionally, the SP indicated that the resident was on [redacted] a day [redacted]	A 749		

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A 749	Continued From page 7 per shift at 8:00 a.m., 3:30 p.m., and 12:01 a.m. During MR review, the surveyor noted that a Wellness Nurse (WN) on [redacted] at 6:11 a.m., documented in the resident PN that at 1:00 a.m., the Concierge stated that Resident #1 came [redacted], with a [redacted] and [redacted] the [redacted], but was [redacted] and [redacted] The WN reminded the resident that [redacted]. Continued review of the resident MR revealed that on [redacted] at 5:06 p.m., the Health Service Director (HSD) documented that Resident #1 was [redacted] when a Resident Aide (RA) [redacted] the resident and asked [redacted] he/she [redacted] The resident was [redacted] in the RA's [redacted]. While reviewing the resident's [redacted] SP, the surveyor did not identify any documentation or interventions on the SP that reflected or indicated that the resident was [redacted]. At 1:32 p.m., the surveyor interviewed the HSD regarding the residents SP and intervention(s) in place for the resident's [redacted]. The HSD stated that the resident lived in the [redacted] unit and was [redacted]. The surveyor reviewed the facility policy and procedure titled, "Service Levels" provided by the ED which indicated "... Service level changes will	A 749		

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A 749	Continued From page 8 be reflected in the resident's individualized Service or Support plan. ... Services are individually tailored to best suit each Resident. ..." Reference: A0401, 8:36-4.1(a)(22)	A 749		
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. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00154324 Based on observation and interview, it was determined that the facility failed to ensure dining and kitchen staff wore hair restraints in compliance with "Chapter 24, Retail Food Establishment and Food and Beverage Vending Machines and Cottage Food Operations." The deficient practice was evidenced by the following: Reference: 8:24-2.4(c)(1) "The following requirements shall apply to hair restraints: ... food employees shall wear hair restraints such as hats, hair coverings, or nets ...that are designed	A 891		

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A 891	Continued From page 9 and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, linens, and unwrapped single use and single-service and single-use articles." On 6/4/2025 at 12:15 p.m., while conducting a meal observation on the third-floor, the surveyor observed dining staff entering the kitchen without hair restraints. The surveyor then interviewed the Dining Service Manager (DSM) who was also observed without a hair restraint coming out of the kitchen regarding the need for a hair restraint. The DSM stated that he was unaware that the staff were required to use hair restraints. At 12:42 p.m., the surveyor interviewed the facility's Executive Chef (EC) regarding the procedure for wearing hair restraints. The EC stated that the facility kitchen and dining staff should know to wear hair restraints. At 2:00 p.m., the surveyor requested the policy and procedure for hair restraints from the Executive Director (ED) and the Associate Director of Hospitality Service (AD). The (AD)stated that there was no policy and procedure but provided the survey with a document titled, "Dining Uniform (Best Practice)". The surveyor reviewed the document titled, "Dining Uniform (Best Practice)" that revealed " Dining Servers ... may elect to wear a [facility] baseball cap. ...Chefs and Cooks ... may elect to wear a chef's hat ..."	A 891		

POC#3
Rcd 9/26/25

BRIGHTVIEW
SENIOR LIVING

1139 Hamburg Turnpike Wayne, NJ 07470
973.988.2582 BrightviewSeniorLiving.com

accepted
9/26/25
NJ Ex Order 26, 4B1
[redacted]

BRIGHTVIEW
SENIOR LIVING
WAYNE

Plan of Correction for Complaint Visit 6/4/25

A310

1. All dining servers re-educated on June 5th of the requirement to wear hair nets when in the server areas, regardless as to whether they are actively preparing foods by the Dining Services Director referencing the Personal Appearance policy. Dining Services Director ensured that hair nets are provided and donned by servers.
2. All residents have the potential to be impacted by this deficiency; re-education was provided to all dining servers to ensure compliance in all dining spaces.
3. Mandatory in-service training on hair restraint and food safety standards was provided to all dining and dietary associates. Hair net supply is readily available in every kitchen and servery at the entry point. Supervisors will reinforce expectations during pre-meal huddles.
4. New associate's orientation updated about "appropriate attire" for work to include hairnets as food handlers in the servery.
   The Dining Services Director or designee will conduct random spot checks at least three times a week during meal preparation and service for the next 90 days and share findings and corrective actions at the weekly operations meeting. Noncompliance will result in immediate re-education and, if repeated, progress into disciplinary action. The Executive Director will execute additional spot checks at five meals monthly and incorporate findings into the Quality Assurance and Performance Improvement meeting to ensure sustained compliance.
5. June 5th 2025

accepted
NJ Ex Order
[redacted]
9/26/25

A891

1. All dining servers re-educated on June 5th of the requirement to wear hair nets when in the server areas, regardless as to whether they are actively preparing foods by the Dining Services Director referencing the Personal Appearance policy. Dining Services Director ensured that hair nets are provided and donned by servers.
2. All residents have the potential to be impacted by this deficiency; re-education was provided to all dining servers to ensure compliance in all dining spaces.
3. Mandatory in-service training on hair restraint and food safety standards was provided to all dining and dietary associates. Hair net supply is readily available in every kitchen and servery at the entry point. Supervisors will reinforce expectations during pre-meal huddles.
4. The Dining Services Director or designee will conduct random spot checks at least three times a week during meal preparation and service for the next 90 days and share findings and corrective actions at the weekly operations meeting. Noncompliance will result in immediate re-education and, if repeated, progress into disciplinary action. The Executive Director will execute additional spot checks at five meals monthly and incorporate findings into the Quality Assurance and Performance Improvement meeting to ensure sustained compliance.

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5. June 5th 2025 accepted 9/26/25 [redacted]

A401

1. Resident #1's [redacted] plan was updated to reflect their current [redacted] needs, including [redacted] interventions to sustain [redacted] following the event by the Health Services Director and Assisted Living Director. The family was notified and worked towards a sustainable intervention to ensure the resident's [redacted].
2. All residents have the potential to be impacted by this deficiency; a full review of all residents' service plans was conducted to identify those with documented changes in cognition within the past 60 days. Any identified residents had their service plans updated to ensure changes in cognition were reflected with escalated interventions as appropriate.
3. All nurses and care associates received re-education on timely recognition, documentation and reporting of changes in cognition beginning on 5/21/25 by the Health Services Director and on 5/28/25 they conducted an in-service on our elopement policy, resident rights, incidents and accidents with the Health and Wellness team.
4. The Executive Director-will audit five random charts per month for the next three months to ensure cognitive changes are being communicated and reflected appropriately in service plans. Results of the audits will be reported to the Quality Assurance Performance Improvement committee for tracking and oversight.
5. June 6th, 2025 accepted 9/26/25

A749

1. Resident #1's [redacted] plan was updated to reflect their current health status, needs, and interventions on [redacted] by the Health Services Director. A [redacted]. The service plan was reviewed with the family to ensure understanding.
2. A full review of all residents' service plans was conducted; residents who had recent changes in condition or hospitalizations, and falls were prioritized. Any discrepancies identified were corrected immediately.
3. Nursing and the interdisciplinary leadership team was re-educated on documentation requirements and the importance of timely service plan updates by the Health Services Director beginning on 5/22/25.
4. The Executive Director will audit five random charts a month for the next three months to ensure cognitive changes are being communicated and reflected appropriately in service plans. Results of the audits will be reported to the Quality Assurance Performance Improvement committee for tracking and oversight.
5. June 6th 2025 accepted 9/26/25.

[redacted]

9/26/25
Date

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL16002	A. BUILDING: _____ B. WING _____	R-C 09/26/2025

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{A 000}	Initial Comments Initial Comments: Type of Survey: Complaint Complaint #: NJ 00154324, NJ 00186600 Census: 105 Sample Size: 4 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}		

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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL16002 Y1	A. Building B. Wing Y2	9/26/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTVIEW WAYNE	1139 HAMBURG TURNPIKE WAYNE, NJ 07470

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 A0401	Correction	ID Prefix A0749	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(22)	Completed	Reg. # 8:36-7.3(a)	Completed
LSC	06/05/2025	LSC	06/06/2025	LSC	06/06/2025
ID Prefix A0891	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-10.5(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	06/05/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
6/4/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL16002 Y1	A. Building B. Wing Y2	9/26/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTVIEW WAYNE	1139 HAMBURG TURNPIKE WAYNE, NJ 07470

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 A0401	Correction	ID Prefix A0749	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(22)	Completed	Reg. # 8:36-7.3(a)	Completed
LSC	06/05/2025	LSC	06/06/2025	LSC	06/06/2025
ID Prefix A0891	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-10.5(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	06/05/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
6/4/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO