STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	55A001	A. BUILDING: _____ B. WING _____	C 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF MIDDLETOWN	620 STATE HIGHWAY 35 SOUTH MIDDLETOWN, NJ 07748

(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 0018827, NJ 00188537 CENSUS: 91 SAMPLE SIZE: 3 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 355	8:36-4.1(a)(1) Resident Rights comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, 1. The right to receive personalized services and care in accordance with the resident's individualized general service and/or health service plan;	A 355		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/14/25

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 355	Continued From page 1	A 355		

This REQUIREMENT is not met as evidenced by:
Complaint # NJ00188527, NJ00188537

Based on interview, record review and review of pertinent facility documents it was determined that the facility failed to provide care and services to 1 of 3 residents, Resident #2, in accordance with physician's orders for medication administration. This deficient practice was evidenced by the following:

On [redacted] a Facility Reportable Event (FRE) was called into the New Jersey Department of Health (NJDOH) complaint hotline. The FRE indicated that the incorrect medication was packaged in the bingo card by the pharmacy for one of the facility residents, Resident #2.

On 8/27/25 at 10:00 a.m. the surveyor reviewed the Medical Record (MR) of Resident #2 which revealed an admission date of [redacted] with diagnoses that included [redacted].

Surveyor review of Resident #2's Medication Administration Record (MAR) in the MR revealed that [He/She] was prescribed [redacted] two times a day for [His/Her] [redacted], with a start date on [redacted].

Surveyor review of Resident #2's MR also revealed that [He/She] was sent to the [redacted] on [redacted] for evaluation, at [His/Her] family request, and returned to the facility the same day.

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A 355	Continued From page 2 At 10:17 a.m., the surveyor reviewed the [redacted] sign out sheet for Resident #2 which revealed that 60 pills of the [redacted] were received on [redacted]. Each bingo card contains 30 pills. The surveyor observed that the first pill from the second card of 30 pills was administered from [redacted] at 7:52 p.m. The remaining pills from the same bingo card were administered to Resident #2 from [redacted] at 9:00 a.m. through [redacted] at 9:00 a.m. by facility Certified Medication Aides (CMA) and Licensed Practical Nurses (LPN) for a total of 28 doses. At 3:21 p.m., the surveyor interviewed a facility CMA who stated that she was in the process of administering the evening dose of Resident #2's evening dose of [redacted] and noticed the [redacted] in the bingo card was [redacted] and [redacted] with numbers on one side of the [redacted] She stated that the [redacted] appeared different from previous doses of the same medication she previously administered to Resident #2. The medication that was in the Resident #2's bingo card was identified as [redacted], a medication used to treat [redacted]. The facility failed to ensure Resident #2 received medication care services in accordance with physician orders for maintenance of [His/Her] [redacted].	A 355		
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	A 925		

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A 925	Continued From page 3 of this chapter and all applicable State and Federal laws and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00188527, NJ00188537 Based on observation, interview, and record review it was determined that the facility failed to provide safe pharmaceutical services and ensure a significant medication was properly and accurately labeled before it was administered to 1 of 3 residents, Resident #2. This deficient practice was evidenced by the following: On [NJ Exec Order 26.4], a Facility Reportable Event (FRE) was called into the New Jersey Department of Health (NJDOH) complaint hotline. The FRE indicated that the incorrect medication was packaged in the bingo card by the pharmacy for one of the facility residents, Resident #2. On 8/27/25 at 10:00 a.m., the surveyor reviewed the Medical Record (MR) of Resident #2 which revealed an admission date of [NJ Exec Order 26.4] with diagnoses which included [NJ Exec Order 26.4b1] [redacted] According to the Progress Notes (PN) in the MR dated [NJ Exec Order 26.4] and timed 17:07 (5:07 p.m.), the Certified Medication Aide (CMA) documented that the medication in Resident #2's bingo card labeled [NJ Exec Order 26.4b1] did not appear as usual. The card and the individual [NJ Exec] slots were labeled correctly. The PN went on to describe the [NJ Exec] in the card was [NJ Exec Order 26.4b1]	A 925		

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A 925	Continued From page 4	A 925		

The CMA did not administer the NJ Exec which was the last NJ Exe in the bingo card and notified the Resident Care Director/Registered Nurse (RCD/RN).

At 10:17 a.m., the surveyor reviewed the NJ Exec Order 26.4 sign out sheet for Resident #2 which revealed that 60 pills of the NJ Exec Order 26.4b1 were received on NJ Exec Order . Each bingo card contained 30 NJ Ex Orde The surveyor observed that the first NJ Exe from the second card of 30 NJ Exec O was administered on NJ Exec Order 26. at 7:52 p.m. The remaining NJ Exec O from the same bingo card were administered by facility CMAs and Licensed Practical Nurses (LPN), totaling 28 doses, to Resident #2 from NJ Exec Order 26. at 9:00 a.m. through NJ Exec Order 26.4 at 9 a.m.

At 2:30 p.m., the surveyor reviewed a pertinent facility document titled "Pharmacy Medication Error Reportable Timeline and Conclusion" which revealed that on NJ Ex Order 26.4(at 9:00 a.m., the RCD, after reviewed the bingo card, NJ Exe and documentation, notified the pharmacist from the pharmacy that supplied the incorrect medication for Resident #2.

Further review of facility documents revealed that the pharmacy provided the facility with a letter of apology in addition to a document titled "Plan of Action" which revealed a scope of care for dispensing medication with accuracy.

At 3:21 p.m., the surveyor interviewed the facility CMA who stated that at that time, she was in the process of administering the evening dose of Resident #2's NJ Exec Order 26.4b1 and noticed that the NJ Exec Order 26.4b and the number on the NJ Exe appeared different from previous doses of the same medication she had administered. The NJ Exe in the bingo card was identified as NJ Exec Order 26.4b1

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A 925	Continued From page 5 NJ Exec Order 26.4b1) and was used for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. The resident was sent to the hospital for evalua5tion, as per request of the resident's family. The resident returned to the facility after evaluation, the same day.	A 925		
A 935	8:36-11.4(b) Pharmaceutical Services (b) All medications shall be administered by qualified personnel in accordance with prescriber orders, facility or program policy, manufacturer's requirements, cautionary or accessory warnings, and all Federal and State laws and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00188527, NJ00188537 Based on observation, interview and review of records, it was determined the facility failed to ensure that medications were given in accordance with prescriber orders for 1 of 3 residents reviewed, Resident # 2. This deficient practice was evidenced by the following: On NJ Exec Order 26., a Facility Reportable Event (FRE) was called into the New Jersey Department of Health (NJDOH) complaint hotline. The FRE indicated that the incorrect medication was	A 935		

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A 935	Continued From page 6	A 935		

packaged in the bingo card by the pharmacy for one of the facility residents, Resident #2.

On 8/27/25 at 10:00 a.m. the surveyor reviewed the Medical Record (MR) of Resident #2 which revealed an admission date of [redacted] with diagnoses that included [redacted]

Surveyor review of Resident #2's Medication Administration Record (MAR) in the MR revealed that [He/She] was prescribed [redacted] two times a day for [His/Her] [redacted], with a start date on [redacted].

At 10:15 a.m., the surveyor reviewed the medication bingo card, which is how the medication was dispensed from the pharmacy, of Resident #2's which revealed that there was no description of the [redacted] or markings on the label attached to the bingo card.

At 10:17 a.m., the surveyor reviewed the narcotic sign out sheet for Resident #2 which revealed that 60 pills of the [redacted] was received on [redacted] Each bingo card contains 30 [redacted] The surveyor observed that the first [redacted] from the second card of 30 [redacted] was administered from [redacted] at 7:52 p.m. The remaining [redacted] from the same bingo card were administered to Resident #2 from [redacted] at 9:00 a.m. through [redacted] at 9 a.m. by facility Certified Medication Aides (CMA) and Licensed Practical Nurses (LPN) for a total of 28 doses.

At 11:49 a.m., the surveyor interviewed the Resident Care Director/Registered Nurse (RCD/RN) who stated that she did not conduct any retraining of the facility staff that administer

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A 935	Continued From page 7 medications regarding the safe and accurate medication administration after the medication error that was reported on [NJ Exec Order 26]. The RCD/RN also stated that she was not aware of any changes that the pharmacy made to ensure proper packaging of correct resident medications. At 3:21 p.m., the surveyor interviewed a facility CMA who stated that she was in the process of administering the evening dose of Resident #2's evening dose of [NJ Exec Order 26.4b1] and noticed the [NJ Exe] [redacted] appeared different from previous doses of the same medication she previously administered to Resident #2.	A 935		
A 937	8:36-11.5(a) Pharmaceutical Services (a) The administration of medications is within the scope of practice and remains the responsibility of the registered professional nurse. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00188527, NJ00188537 Based on observation, interview and review of records, it was determined that the facility Registered Nurse (RN), failed to ensure the responsibility of accurate administration and documentation of medication to 1 of 3 facility residents reviewed, Resident #2. This deficient	A 937		

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A 937	Continued From page 8 practice was evidenced by the following: On [redacted] a Facility Reportable Event (FRE) was called into the New Jersey Department of Health (NJDOH) complaint hotline. The FRE indicated that the incorrect medication was packaged in the bingo card by the pharmacy for one of the facility residents, Resident #2. On 8/27/25 at 10:00 a.m. the surveyor reviewed the Medical Record (MR) of Resident #2 which revealed an admission date of [redacted] with diagnoses that included [redacted] Surveyor review of Resident #2's Medication Administration Record (MAR) in the MR revealed that [He/She] was prescribed [redacted] two times a day for [His/Her] [redacted], with a start date on [redacted]. At 10:15 a.m., the surveyor reviewed the medication bingo card, which is how the medication was dispensed from the pharmacy, of Resident #2's which revealed that there was no description of the [redacted] or markings on the label attached to the bingo card. At 10:17 a.m., the surveyor reviewed the narcotic sign out sheet for Resident #2 which revealed that 60 [redacted] of the [redacted] was received on [redacted]. Each bingo card contains 30 [redacted] The surveyor observed that the first [redacted] from the second card of 30 [redacted] was administered from [redacted] at 7:52 p.m. The remaining [redacted] from the same bingo card were administered to Resident #2 from [redacted] at 9:00 a.m. through [redacted] at 9 a.m. by facility Certified Medication Aides (CMA) and Licensed Practical Nurses (LPN) for a total	A 937		

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A 937	Continued From page 9 of 28 doses. At 11:49 a.m., the surveyor interviewed the Resident Care Director/Registered Nurse (RCD/RN) who stated that she did not conduct any retraining of the facility staff that administer medications regarding the safe and accurate medication administration after the medication error that was reported on [NJ Exec Order 26.4] The RCD/RN also stated that she was not aware of any changes that the pharmacy made to ensure proper packaging of correct resident medications. During the same interview the RCD/RN stated that she performs skill competency evaluations for all facility CMA's to evaluate their safe and accurate medication practice every 3 months. At 3:30 p.m., the surveyor reviewed a facility document titled "MEDICATION SKILL CAPABILITY EVALUATION CHECKLIST" which revealed that a facility CMA who administered Resident #2 the incorrect medication did not have an evaluation every [NJ Exec Order 26.4b1] to ensure safe and accurate medication practice. Surveyor review of a facility policy, dated 5-8-23, and titled, "Medication Administration/Assistance: Training & Skill Capability Evaluation" revealed that "Policy Statement: Authorized unlicensed team members who administer or assist with resident medications are monitored for compliance ...Action Steps: ...2. Skill capability evaluation is performed by the Resident Care Director...."	A 937		

POC#3
Acceptable
12/3/25

SUNRISE
SENIOR LIVING

Sunrise Senior Living
Plan of Correction

Name of Facility: Brighton Gardens of Middletown
Address of Facility: 620 Highway 35 South Middletown, NJ 07748
License number: 55A001
Inspection date(s): 08/27/2025
Name and Title of Legal Entity Representative Signing the Plan of Correction: [redacted] Executive Director
Signature of Sunrise Representative:
Date of Submission: 12/3/25

A355 - 8:36-4.1(a)(1) – Resident Rights
Target Completion Date: 10/22/25

1. Resident #2 currently living in community. Medication noted in Resident #2's blister pack was identified as the incorrect medication with correct label matching the prescribed order on [redacted] The incorrect medication was not administered to Resident #2 on [redacted] The correct medication was confirmed, using a new 30-day supply medication card and administered to Resident #2 on [redacted] d ongoing as ordered. Resident #2 was assessed by the Registered Nurse (RN) on [redacted] with [redacted] or symptoms, injuries or complaints noted. Resident #2 was sent to the [redacted] for further evaluation at family request on [redacted] Resident #2 was [redacted] or symptoms, acute illness or complaints identified and returned to community the same day [redacted] with no new orders. Resident #2 has been receiving the correct medication beginning on [redacted] and ongoing as prescribed. Resident #2's primary care physician and [redacted] notified on [redacted]

2. All residents have the potential to be affected by a deficit of incorrect packaging. Following the incident on 8/12/25, the Registered Nurse completed an audit on 8/13/25 to identify any other resident receiving [redacted] to ensure correct medication was packaged. No other residents were identified with incorrect packaging during the audit.

3. Resident #2 continues to reside in the community. On 8/13/25, The Executive Director reported the incident to the New Jersey Department of Health (NJDOH), the office of the Ombudsman, and notified Resident #2's physicians and Power of Attorney (POA). The Executive Director or designee completed a retraining on the facilities policy for "Resident

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SENIOR LIVING

Rights" for care managers and medication care managers which began on 10/09/25 and was completed on 10/22/25. Education and training for "Resident's Rights" will be ongoing upon hire, annually and as needed. A Registered Nurse completed a weekly audit review of all new medications on 8/19/25 to ensure physicians' orders are followed. This practice was in place prior to event and will continue indefinitely.

4. This plan of correction to ensure compliance of "Resident Rights" will be discussed and evaluated quarterly for two quarters by the Executive Director or designee and Department Coordinators at the Quality Management (QAPI) meeting to verify it is still effective. The first QAPI meeting occurred on 10/28/25. At the following meeting in January 2026, it will be determined if the plan has been effective. If not effective, it will be amended, and a new Plan of Correction (POC) and training will be implemented.

5. Completion date 10/22/25

A925 - 8:36-11.2 Pharmaceutical Services
Target Completion Date: 11/30/25

1. Resident #2 is currently residing in the community. Resident #2 was assessed by the Registered Nurse on NJ Exec Order 26.4b1 following identification of wrong medication packaged by community vendor pharmacy. NJ Exec Order 26.4b1 signs or symptoms, injuries or complaints reported, and no new physician orders were received. The community vendor pharmacy was notified NJ Exec Order 26. by the Resident Care Director RN. A response letter of summary and conclusion and Plan of Action was received from the community vendor pharmacy on NJ Exec Order 26. with a completion date of NJ Exec Order 26.4b for the Plan of Action.

2. All residents have the potential to be affected by a deficit of incorrect packaging.

3. The community vendor pharmacy was notified of incorrect packaging on 8/13/25, and an internal pharmacy audit was completed by the vendor on 8/14/25 with no further incorrect medications identified. Vendor pharmacy leadership confirmed pharmacy technician retraining and re-education was completed by 8/22/25. The Resident Care Director of the community assigned a Medication Care Manager Medication Refresher Training Course to all Medication Care Managers and Licensed Practical Nurses in the community on 10/06/2025 and completed on 10/31/25. The 5-module course includes safe medication administration and the 6 rights of medication administration.

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4. This plan of correction to demonstrate compliance will be monitored with monthly medication pass observations on all certified medication aides. This will be completed by a Registered Nurse or designee monthly times two months starting in October 2025 which is completed and will conclude in November 2025. The next quarterly observation by a Registered Nurse as per NJ Guidelines will begin in January 2026 and continue for each quarter ongoing. The observations will be reviewed, discussed, and evaluated quarterly by the Executive Director or designee, and Department Coordinators at the Quality Management (QAPI) meeting to verify it is still effective and maintains compliance. The first of the two QAPI meetings was held October 28th, 2025. At the following meeting in January 2026, it will be determined if the plan has been effective and compliance verified. If not effective, it will be amended, and a new Plan of Correction and training will be implemented.

5. Completion date 11/30/25

A935 - 8:36-11.4 (b) Pharmaceutical Services
Target Completion Date: 11/19/25

1. Resident #2 is currently residing in the community. All prescriptions were carried out as per physician orders. Incorrect medication was identified in the packaging on [redacted] or Resident #2, not administered and immediately removed from use on [redacted]. The community vendor pharmacy was notified on [redacted] and the correct medication was confirmed using a new 30-day supply medication card and administered to Resident #2 beginning on [redacted] and ongoing.

2. All residents have the potential to be affected by incorrect packaging.

3. The Registered Nurse completed a weekly delegation review of all medications on 8/19/25 and weekly thereafter for three months ending 11/19/25. A weekly medication cart audit will be completed by the Licensed Practical Nurse or designee to ensure all medications prescribed are in the community as per physician orders completed on 8/18/25 and continuing weekly for 3 months ending November 18th, 2025. The Registered Nurse or designee completed a monthly cart audit on 10/22/25 to ensure all medications are in the community as prescribed by the physician. Registered Nurse Cart audits will continue monthly next audit to be completed in November 2025.

4. Audits will be discussed and evaluated quarterly for two quarters by the Executive Director of designee and Department Coordinators at the Quality Management (QAPI) meeting to

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verify compliance and effectiveness. The first QAPI meeting was held October 28th, 2025. At the following meeting in January 2026, it will be determined if the Plan of Correction has been effective and compliance verified. If not effective, it will be amended, and a new Plan of Correction and training will be implemented.

5. Completion date November 19th, 2025.

A935- 8:36-11.5 (a) Pharmaceutical Services
Target Completion Date: 12/31/25

1. Resident #2 is alive and residing in the community. The most recent Medication Pass Observation for the Medication Care Manager who identified the wrong medication for Resident #2 was completed prior to the incident on [redacted] This Medication Care Manager had two successful Medication Pass Observations prior to the event completed [redacted] and [redacted] Additional Medication Pass Observations have been completed on this medication care manager on [redacted] to ensure four observations have been completed for this year.

2. All residents have the potential to be affected by the deficiency. An audit was completed by the Resident Care Director Registered Nurse on 8/28/25 to identify any Medication Care Manager not compliant with their every three-month Medication Observation Pass evaluation. All currently due observations were scheduled for completion on 8/28/25 and have been completed as of 10/27/25.

3. The Regional Director of Resident Care reviewed and re-educated the Resident Care Director and Executive Director on the facilities Medication Administration/Assistance: Training and Skill Capability Evaluation Policy on 10/08/25. The policy includes the requirement of a quarterly medication pass observation to be completed for all licensed Medication Care Managers by a Registered Nurse. Since re-education, all medication care managers have quarterly medication pass observations that began 10/10/25 and all medication care managers will have 4 observations for 2025 completed by 12/31/25.

4. To ensure compliance the Executive Director or Designee will complete a monthly audit for compliance with Quarterly Medication Pass Observations that began on 10/13/25 and will be completed on the 13th of the month for 3 months ending on 12/13/25. The monthly audits will be reviewed at the Quality Management (QAPI) meeting for two quarters to identify continued compliance. The first of the two QAPI meetings was held 10/28/25. At

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the following meeting in January 2026, it will be determined if the plan has been effective and compliance verified. If not effective, it will be amended, and a new Plan of Correction (POC) and training will be implemented. If any Medication Care Manager is identified out of compliance, the Medication Care Manager will be removed from passing medication until the observation is completed.

5. Targeted completion date 12/31/25.

Brighton Gardens of Middletown
620 Highway 35 South Middletown NJ 07748
732-275-0790/Fax 732-275-0797
SunriseSeniorLiving.com

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
55A001 Y1	A. Building B. Wing Y2	12/3/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF MIDDLETOWN	620 STATE HIGHWAY 35 SOUTH MIDDLETOWN, NJ 07748

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0355	Correction	ID Prefix A0925	Correction	ID Prefix A0935	Correction
Reg. # 8:36-4.1(a)(1)	Completed	Reg. # 8:36-11.2	Completed	Reg. # 8:36-11.4(b)	Completed
LSC	10/22/2025	LSC	11/30/2025	LSC	11/19/2025
ID Prefix A0937	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-11.5(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/31/2025	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	
8/27/2025	☐ 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
55A001 Y1	A. Building B. Wing Y2	12/3/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF MIDDLETOWN	620 STATE HIGHWAY 35 SOUTH MIDDLETOWN, NJ 07748

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LSC	12/31/2025	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	
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