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	60A013	A. BUILDING: _____ B. WING _____	C 05/21/2026

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BRIGHTVIEW RANDOLPH, LLC	175 QUAKER CHURCH ROAD RANDOLPH, NJ 07869

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A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ00190736 CENSUS: 62 SAMPLE SIZE: 14 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 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 or medical needs and for needed nursing care intervention or medical care.	A 779		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/10/26

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A 779	Continued From page 1 This REQUIREMENT is not met as evidenced by: Complaint #: NJ00190736 Based on interview and record review, it was determined that the facility's Registered Nurse (RN) failed to complete an assessment after medications were not administered for 14 of 14 residents reviewed, Resident #s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14. The deficient practice was evidenced by the following: On [NJ Exec Order 26.4b1], the New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by healthcare facilities to report incidents to NJDOH. The report indicated a "Date of Event" of [NJ Exec Order 26.4b1] and a "Time of Event" of 11:00 p.m. revealed that 14 Assisted Living (AL) residents did not receive their medications as ordered. The report stated that the Health Service Director (HSD) and the AL Director were aware, and the Wellness Nurse (WN) on the 3:00-11:00 p.m. shift was delegated the medication pass by the HSD over the phone. On 5/16/2026, the 7:00 a.m.-3:00 p.m. shift arrived, and the Licensed Practice Nurse (LPN) noticed that the entire floor did not receive their medications on the prior shift. The HSD was notified but did not read the text until 3:00 p.m. On 5/18/26, the HSD notified the Executive Director (ED) of the missed medications, and the investigation was initiated. On 5/21/2026 at 2:19 p.m., the surveyor interviewed the Regional Director of Clinical Services (RDCS) regarding the RN assessment, she stated that an RN assessment should have been done the next day. She continued to say that any triggered event warranted an RN	A 779		

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A 779	Continued From page 2 assessment. At 2:26 p.m., the surveyor interviewed the HSD on the telephone about the missed medications incident on [redacted], she stated "she thinks a RN assessment should have been done but she stated she had divided herself [with] doing notifications ..." At 3:49 p.m., the surveyor interviewed the RDCS a second time, she confirmed that there was no RN assessment done after the incident and the HSD should have assessed, supported the team and delegated the tasks. Surveyor review of a facility policy titled, "Resident Assessment (NJ)" with a last revised date of 1/17/2025, revealed "...The RN will be notified if there are significant changes in a resident's condition and will assess the resident's need for referral to a physician, advanced practice nurse or physician assistant...as appropriate..." Reference: 8:36-11.4(b)-A935	A 779		
A 783	8:36-7.5(e) Provision of Health Care Services (e) Each resident shall have an annual physical examination by a physician, advanced practice nurse or physician assistant, which shall be documented in the resident's record. The physician, advanced practice nurse or physician assistant shall certify annually that the resident does not have needs which exceed the care that the facility or program is capable of providing.	A 783		

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A 783	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that certification by a physician was completed annually for 1 of 14 residents reviewed, Resident #3. This deficient practice was evidenced by the following: On 5/21/2026 at 3:10 p.m., the surveyor reviewed Resident #3's Medical Record (MR) which revealed a move in date of [redacted] with diagnoses of [redacted] and [redacted] The surveyor reviewed a document titled, "Physician/Nurse Practicioner Annual Assessment Form" dated [redacted] revealed that the "applicant" [resident] was suitable for an [redacted]." At 3:49 p.m., the surveyor interviewed the Regional Director of Clinical Services (RDCS), she stated that the physician certification and ([redacted] were done yearly. There was no documented evidence provided that an updated annual physician certification and [redacted] were completed for Resident #3. At the time of the survey, the surveyor was not provided with a policy for physician certifcation and [redacted]	A 783		
A 935	8:36-11.4(b) Administration of medications	A 935		

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A 935	Continued From page 4 (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 #: NJ00190736 Based on interview and record review, it was determined that the Registered Nurse (RN) failed to administer medications as prescribed by the physician as ordered for 14 of 14 residents reviewed, Resident #s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 ,13 and 14. The deficient practice was evidenced by the following: On [redacted], the New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by healthcare facilities to report incidents to NJDOH. The report indicated a "Date of Event" of [redacted] and a "Time of Event" of 11:00 p.m. revealed that 14 Assisted Living (AL) residents did not receive their medications as ordered. The report stated that the Health Service Director (HSD) and the AL Director were aware, and the Wellness Nurse (WN) on the 3:00-11:00 p.m. shift was delegated the medication pass by the HSD over the phone.	A 935		

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A 935	Continued From page 5 On 5/16/2026, the 7:00 a.m.-3:00 p.m. shift arrived, and the Licensed Practice Nurse (LPN) noticed that the entire floor did not receive their medications on the prior shift. The HSD was notified but did not read the text until 3:00 p.m. On 5/18/26, the HSD notified the Executive Director (ED) of the missed medications, and the investigation was initiated. On 5/21/2026, the surveyor reviewed the following: 1. A review of Resident #1's "electronic Medication Administration Record Summary (eMARS)" dated NJ Exec Order 26.4b1 revealed the following medications were not administered as ordered on NJ Exec Order 26.4b1 on the 3:00 p.m.- 11:00 p.m. shift: NJ Exec Order 26.4b1 2. A review of Resident #2's eMARS dated 5/1/26 to NJ Exec Order 26.4b1 revealed the following medications were not administered as ordered on NJ Exec Order 26.4b1 on the 3:00 p.m.- 11:00 p.m. shift: NJ Exec Order 26.4b1 3.A review of Resident #3's eMARS dated NJ Exec Order 2 to NJ Exec Order 26.4b1 revealed the following medications were not administered as ordered on NJ Exec Order 26.4b1 on the 3:00 p.m.- 11:00 p.m. shift:	A 935		

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A 935	Continued From page 6 NJ Exec Order 26.4b1 [redacted] 4. A review of Resident #4's eMARS dated NJ Exec Order 26 to NJ Exec Order 26.4b1 revealed the following medications were not administered as ordered on NJ Exec Order 26.4b1 on the 3:00 p.m.- 11:00 p.m. shift: NJ Exec Order 26.4b1 [redacted] 5. A review of Resident #5's eMARS dated NJ Exec Order 26 to NJ Exec Order 26.4b1 revealed the following medications were not administered as ordered on NJ Exec Order 26.4b1 on the 3:00 p.m.- 11:00 p.m. shift: NJ Exec Order 26.4b1 [redacted] 6. A review of Resident #6's eMARS dated NJ Exec Order 26 to NJ Exec Order 26.4b1 revealed the following medications were not administered as ordered on NJ Exec Order 26.4b1 on the 3:00 p.m.- 11:00 p.m. shift: NJ Exec Order 26.4b1 [redacted]	A 935		

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A 935	Continued From page 7 NJ Exec Order 26.4b1 [redacted] 7. A review of Resident #7's eMARS dated NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 revealed the following medications were not administered as ordered on NJ Exec Order 26.4b1 on the 3:00 p.m.- 11:00 p.m. shift: NJ Exec Order 26.4b1 [redacted] 8. A review of Resident #8's eMARS dated NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 revealed the following medications were not administered as ordered on NJ Exec Order 26.4b1 on the 3:00 p.m.- 11:00 p.m. shift: NJ Exec Order 26.4b1 [redacted] 9. A review of Resident #9's eMARS dated NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 revealed the following medications were not administered as ordered on NJ Exec Order 26.4b1 on the 3:00 p.m.- 11:00 p.m. shift: NJ Exec Order 26.4b1 [redacted] 10. A review of Resident #10's eMARS dated NJ Exec Order 26.4b1 revealed the following medications were not administered as ordered on	A 935		

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A 935	Continued From page 8 NJ Exec Order 26.4b1 on the 3:00 p.m.- 11:00 p.m. shift: NJ Exec Order 26.4b1 11. A review of Resident #11's eMARS dated NJ Exec Order 26.4b1 revealed the following medications were not administered as ordered on NJ Exec Order 26.4b1 on the 3:00 p.m.- 11:00 p.m. shift: NJ Exec Order 26.4b1 12. A review of Resident #12's eMARS dated NJ Exec Order 26.4b1 revealed the following medications were not administered as ordered on NJ Exec Order 26.4b1 on 3:00 p.m.- 11:00 p.m. shift: NJ Exec Order 26.4b1 13. A review of Resident #13's eMARS dated NJ Exec Order 26.4b1 revealed the following medications were not administered as ordered on NJ Exec Order 26.4b1 on the 3:00 p.m.- 11:00 p.m. shift: NJ Exec Order 26.4b1 14. A review of Resident #14's eMARS dated NJ Exec Order 26.4b1 revealed the following medications were not administered as ordered on NJ Exec Order 26.4b1 on the 3:00 p.m.- 11:00 p.m. shift: NJ Exec Order 26.4b1) At 10:08 a.m., the surveyor interviewed the Executive Director (ED), he stated that the Health Service Director (HSD) was negligent. The ED continued to say that he expected the HSD to	A 935		

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A 935	Continued From page 9	A 935		

come into the facility that night and do the medication pass. If the HSD was unable to come in, she was to alert him immediately to find another medication technician or nurse from another community. The ED further stated that all the HSD had to do was call him or the Regional Director of Clinical Services (RDCS), she knew the process. The ED stated that the HSD called him on [redacted] morning, [redacted] to report the missed medications incident, the investigation began, and the HSD was [redacted] then [redacted]

At 1:53 p.m., the surveyor had a telephone interview with the WN, she stated that on [redacted] night, [redacted] the HSD texted her to help pass the medications. She continued to say that she never passed medications alone on the 3rd and 4th floors, so at 11:00 p.m., she texted the HSD that she finished the 4th floor meds [medications] and then she asked should she give the 3rd floor or will the night shift do them the HSD informed her that the overnight shift will give the medications then she left. The WN continued to say that she understood that the HSD would notify the overnight shift of the missed medications and she did not know how many medications were left to administer.

At 2:26 p.m., the surveyor had a telephone interview with the HSD, she stated that she received a call on [redacted] afternoon [redacted] from the daytime nurse (Licensed Practice Nurse/LPN)), that the residents on the 3rd floor did not receive their p.m. [night] medications. When the surveyor asked her what happened on [redacted], the HSD stated that [the] evening was short a med tech [medication technician] so she texted the WN to do the medication pass, at 11:00 p.m., the WN texted her back to say that

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A 935	Continued From page 10	A 935		

she was [NJ Exec Order 26.4b1] and she finished the 4th floor medications, but not the 3rd floor, only 2 people [residents] got medications. The HSD told her to go home, and the overnight med tech (OMT) could do it and that was the end of the conversation until [NJ Exec Order 26.4b1] morning when the LPN notified her.

In the same interview, the HSD stated that she should have called the Regional (RDCS) to cover for her, it was an "oversight on her part". The HSD continued to say that when she received notification at 3:00 p.m. from the day LPN on [NJ Exec Order 26.4b1] she told the LPN not to do anything until she investigated who didn't get medications before she called anyone else. The HSD further stated that on [NJ Exec Order 26.4b1] she should have called the ED right away.

At 3:01 p.m., the surveyor had a second telephone interview with the WN about the shift change report, she stated that change of shift usually happened, but there was no report because she did not see the OMT again, so that was when she texted the HSD that she did not finish and she thought the HSD told the OMT about the missed medications.

On 5/22/2026 at 2:03 p.m., the surveyor had a telephone interview with the OMT, she stated that on 5/16/2026 at 4:00 a.m., Resident #4 informed her that the resident did not receive his/her 3:00 p.m. -11:00 p.m. medications on [NJ Exec Order 26.4b1]. The OMT continued to say that there was no report given about any missed medications from the WN and at 7:00 a.m., she texted the HSD and the ALD about the missed medications. The HSD texted her back to say that the WN was to tell her to pass the medications.

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A 935	Continued From page 11 At the time of survey, 7:00 a.m.-3:00 p.m., LPN who worked on [NJ Exec Order 26.4b1] was not available for interview. Surveyor review of a facility policy titled, "Medication Errors (BV)" with an effective date of 1/3/2025, revealed "Policy: To ensure that each resident receives his/her medications without incident or error, according to physician orders. If ... a medication error or incident occurs, the incident is fully investigated in efforts to prevent further incident... Procedure: ... 2. A Medication Incident Report is initiated immediately by the associate who discovers the error or incident. 3. A Medication Incident Report must be completed when: ...c. A resident does not receive medication as ordered..." Surveyor review of a facility policy titled, "Medication Management (BV)" with a last revised date of 2/9/2024, revealed "Policy: Residents medications are managed and/or administered safely and in accordance with regulations set forthe by the licensing agency...Procedure: ...11. Medication not taken in accordance with the prescriber's orders shall be documented. 12. Medication errors will be reported immediately per the Medication Error Policy..."	A 935		
A1051	8:36-15.2 Record Availability The records required by this subchapter shall be maintained for all residents and shall be kept available on the premises for review at any time by representatives of the Department.	A1051		

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A1051	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on interview, and record review it was determined that the facility failed to ensure requested residents' Electronic Medical Records (EMRs) were available for review to the New Jersey Department of Health representative upon entry into the facility for 14 of 14 residents reviewed, Resident #s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 ,13 and 14. This deficient practice was evidenced by the following: On 5/21/26 at 9:27 a.m., during the entrance conference with the Alternate Administrator/Business Office Manager, the surveyor requested full access to the facility's EMR. The AA/BOM stated that the facility utilized an electronic system, and she would get the surveyor full access to the EMRs. At 9:46 a.m., the surveyor followed up with the AA/BON about the login, she was finding the surveyor a generic laptop and was working on the login. At 9:59 a.m., the surveyor tried the login provided, but the login did not work. At 10:53 a.m., the surveyor requested the login from the Executive Director (ED), he stated he was still working on the login. At 10:57 a.m., the ED provided a username and password, but they were invalid, and the ED called the IT (information technology) department. At 11:00 a.m., the login did not work, so the ED was to get a facility laptop for the surveyor.	A1051		

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A1051	Continued From page 13 At 12:22 p.m., the login still did not work, and the surveyor informed the ED that he can be cited for not providing full access to the EMRs and he stated that he was aware. At 12:37 p.m., the ED provided login access, but then the screen went blank. At 1:40 p.m., the login had to be reset again, and the ED stated that he was working with the corporate office on the login and that he would give the surveyor his laptop. At 1:45 p.m., the surveyor needed the laptop login access again from the ED. At the time of the survey, the surveyor was not granted full access to the EMRs, the facility provided paper copies of the requested documents. The surveyor was unable to access the EMRs of residents for review, which impeded the investigation and survey process of the Department.	A1051		
A1073	8:36-15.6(b) Resident Records (b) All assessments and treatments by health care and service providers shall be entered according to the standards of professional practice. Documentation and/or notes from all health care and service providers shall be entered according to the standards of professional practice.	A1073		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	60A013	A. BUILDING: _____ B. WING _____	C 05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTVIEW RANDOLPH, LLC	175 QUAKER CHURCH ROAD RANDOLPH, NJ 07869

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A1073	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on interview, and record review, it was determined that the facility failed to provide documentation that physician notifications were documented for 5 of 14 residents reviewed, Resident #'s 4, 8, 12, 13, and 14. This deficient practice was evidenced by the following: On 5/19/2026, the New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by healthcare facilities to report incidents to NJDOH. The report indicated a "Date of Event" of [redacted] and a "Time of Event" of 11:00 p.m. revealed that 14 Assisted Living (AL) residents did not receive their medications as ordered. The report stated that the Health Service Director (HSD) and the AL Director were aware, and the Wellness Nurse (WN) on the 3:00-11:00 p.m. shift was delegated the medication pass by the HSD over the phone. On 5/16/2026, the 7:00 a.m.-3:00 p.m. shift arrived, and the Licensed Practice Nurse (LPN) noticed that the entire floor did not receive their medications on the prior shift. The HSD was notified but did not read the text until 3:00 p.m. On 5/18/26, the HSD notified the Executive Director (ED) of the missed medications, and the investigation was initiated. At 10:08 a.m., the surveyor interviewed the ED, he stated that the incident report should have been done immediately, so he and the Regional Director of Clinical Services (RDCS) could enter the notifications into the electronic medical	A1073		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A1073	Continued From page 15 records system. He continued to say that the HSD started the physician notifications but did not complete them. At 2:26 p.m., the surveyor had a telephone interview with the HSD, she stated that she notified the physician, the Medical Director, regarding the missed medications for all the 14 residents and she began the documentation. On 5/21/2026 at 2:55 p.m., the surveyor reviewed the "Change of Shift Report" dated between NJ Exec Order 26.4b1 revealed no documentation that the physician was notified for Resident #s 4, 8, 12, 13 and 14. At 5:30 p.m., the surveyor interviewed the ED and the RDCS, the RDCS stated that the physician notifications were noted in the change of shift reports. The ED stated that the HSD did not complete the physician notifications documentation before her NJ Exec Order 26.4b1 then NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1. Surveyor review of a facility policy titled, "Medication Errors (BV)" with an effective date of 1/3/2025, revealed "Policy: To ensure that each resident receives his/her medications without incident or error, according to physician orders. If ... a medication error or incident occurs, the incident is fully investigated in efforts to prevent further incident... Procedure: ... 2. A Medication Incident Report is initiated immediately by the associate who discovers the error or incident. 3. A Medication Incident Report must be completed when: ...c. A resident does not receive medication as ordered... 4. The Executive Director is notified of the medication incident through the electronic incident system and at times verbally by the Health Services Director. 5. The Health Service	A1073		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A1073	Continued From page 16 Director or designee notifies the resident's physician of a medication incident. A. The physician's instructions or orders are recorded on the Incident Report ..." Reference: 8:36-11.4(b)-A935	A1073		

POC #3
Reviewed
7/10/26
Accepted

BRIGHTVIEW
SENIOR LIVING
RANDOLPH

Plan of Correction for Complaint Visit 5/21/2026

A779 8:36-7.5(c) Provision of Health Care Services

1. It was determined that the internal Medication Errors policy communication guidelines were not followed by the Health Services Director when she was notified by the Wellness Nurse on Duty on NJ Ex Order 26.4(b)(1) that the third-floor residents did not receive their medications. When the Executive Director was notified on 5/18/26, an investigation was immediately initiated in accordance with the Medication Errors policy and procedure. Physician notification was initiated on 5/18/26 by the Health Services Director, and family notifications were completed by the Regional Director of Clinical Services and Executive Director on 5/18/26. RN assessments were initiated on 5/18/26. Training was also provided to Wellness Nurses and Certified Medication Technicians on Medication Management and Medication Errors on 5/18/26. During the investigation, the Executive Director determined that the Health Services Director had been made aware of the medication error on NJ Exec Order 26.4b1 and had not followed the required communication guidelines or procedures. The Health Services Director was suspended pending the outcome of the investigation and was NJ Exec Order 26.4b1 Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13 and #14 who were affected by the deficient practice still reside in the community.
2. This was not an individual resident-specific incident. All residents had the potential to be affected by the deficient practice.
3. The Health Services Director was NJ Exec Order 26.4b1. As of 5/20/26 the recruitment process began to fill the role of Health Services Director. The Acting Health Services Director/Delegating RN started on 5/26/26 and is doing all RN assessments required. Orientation and ongoing training for the incoming Health Services Director position will include review of the Medication Errors policy, required communication guidelines, and training from the Acting Health Services

Director/Delegating RN on the medication administration auditing tool developed to ensure ongoing compliance.

4. The Acting Health Services Director/Delegating RN will oversee and verify medication administration on every floor and every shift for compliance daily for two weeks beginning 5/19/26. If compliance is maintained, audits will then be completed monthly for 3 months. If compliance continues to be maintained, audits will be completed quarterly for three quarters. Findings will be reviewed through QAPI, and any identified concerns will be corrected immediately through follow-up education and/or corrective action.
5. Date of completion: 6/27/26

A783 8:36-7.5(e) Provision of Health Care Services

1. Resident #3 received an annual assessment from their physician on NJ Exec Order 26.4b1 Initially Resident #3 had been seen by the physician on a NJ Exec Order 26.4b1 however, the required annual assessment was not present/current in the resident's record. Once this was identified, the annual assessment was scheduled and completed and family notified.
2. A full audit was completed by the Acting Health Services Director/Delegating RN on 6/24/26 to ensure no other residents were impacted by the deficient practice. This was not an individual resident-specific incident. All residents had the potential to be affected by the deficient practice.
3. The Health Services Director was NJ Exec Order 26.4b1 As of 5/20/26 the recruitment process has begun to fill the role of Health Services Director. The Acting Health Services Director/Delegating RN started on 5/26/26. Orientation and ongoing training for the Health Services Director position will include review of the annual physician assessment requirements. The Acting Health Services Director/Delegating RN will review residents' annual physical/assessment status quarterly during interdisciplinary meetings to ensure timely completion.
4. The Acting Health Services Director/Delegating RN will report quarterly audit findings, first of which was completed on 6/24/26, and compliance status for Assisted Living residents during the QAPI meeting and will extend for 1 year after the Health Services Director role is filled. Any identified concerns will be corrected immediately.
5. Date of completion: 6/27/26

A935 8:36-11.4(b) Administration of medications

1. Families of Residents #1 through #14 were notified on 5/18/26 by the Executive Director and Regional Director of Clinical Services of medication error. Residents #1 through #14 were assessed by an RN beginning on [redacted] When the Health Services Director was [redacted], this task was delegated to the Regional Director of Clinical Services and completed on 5/24/26. Residents #1 through #14 were assessed by the physician on [redacted] and [redacted] were noted related to the missed medications. Training was provided for the Wellness Nurses and Certified Medication Technicians on medication management and medication errors on 5/18/26. Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13 and #14 who were affected by the deficient practice still reside in the community.
2. This was not an individual resident-specific incident. All residents had the potential to be affected by the deficient practice.
3. The Health Services Director was [redacted] As of 5/20/26 the recruitment process began to fill the role of Health Services Director. Orientation and ongoing training for the Health Services Director position will include review of the Medication Errors policy, required follow-up procedures, and training from the Acting Health Services Director/Delegating RN on the medication administration auditing tool to ensure compliance. Training was provided to Wellness Nurses and Certified Medication Technicians by Business Office Director and Health Services Director on Medication Management and Medication Errors policy on 5/18/26. Training was provided by Acting Health Services Director/Delegating RN on Incident Reports and Medication Administration on 6/18/26. Training was provided by Acting Health Services Director/Delegating RN & Clinical Informatics Specialist for the Wellness Nurses on our EHR/EMAR system and Incident Reports on 6/18/26.
4. The Acting Health Services Director/Delegating RN will oversee and verify medication administration on every floor and every shift for compliance daily for two weeks beginning 5/19/26. If compliance is maintained, audits will then be completed monthly for 3 months. If compliance continues to be maintained, audits will be completed quarterly for three quarters. Findings will be reviewed through QAPI, and any identified concerns will be corrected immediately through follow-up education and/or corrective action.
5. Date of completion: 6/27/26

A1051 8:36-15.2 Record Availability

1. Access to the EMAR system was delayed due to IT infrastructure safeguards, security protocols, and two-factor authentication designed to protect resident records. Corporate IT was engaged during the survey to assist with access.

Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13 and #14 who were affected by the deficient practice still reside in the community.

2. This was not an individual resident-specific incident. All residents had the potential to be affected by the deficient practice.
3. The Executive Director spoke with IT on 5/22/26 to ensure the access pathways are shared, accessible upon request, and monitored by [NJ Exec Order 26.4b1] IT. This information is now available through the [NJ Exec Order 26] portal for leadership access as needed.
4. A semi-annual review of login credentials and record accessibility will be completed by the Executive Director or Designee. This review began on 5/25/26, and findings will be reviewed through QAPI to ensure ongoing compliance and timely access to resident records for 1 year.
5. Date of completion: 6/27/26

A1073 8:36-15.6(b) Resident Records

1. On [NJ Exec Order 26.4b1], during the investigation and physician notification process, the Health Services Director was [NJ Exec Order 26.4b1] due to the Executive Director's findings of non-compliance with policy. All 14 residents' physicians had been notified; however, prior to [NJ Exec Order 26.4b1] the Health Services Director had only entered 9 of the 14 required incident reports. On 5/20/26, the Regional Director of Clinical Services came to the community to provide RN coverage, verify physician notifications had been completed, and complete the remaining incident reports. Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13 and #14 who were affected by the deficient practice still reside in the community.
2. This was not an individual resident-specific incident. All residents had the potential to be affected by the deficient practice. The Acting Health Services Director/Delegating RN completed a three-month lookback audit on 5/26/26 to review resident incident reports and ensure physician notifications had been completed and documented appropriately.
3. The Acting Health Services Director/Delegating RN will review all incident reports to ensure physician notification and required documentation have been completed. The Acting Health Services Director/Delegating RN provided incident reporting training to Health & Wellness associates on 6/18/26.
4. The Health Services Director or designee will report incident report audit findings during the monthly QAPI meeting. This review began on 6/17/26 and will continue monthly for one year after the Health Services Director role is filled. Any identified concerns will be corrected immediately through re-education and/or corrective action.
5. Date of completion: 6/27/26

NJ Exec Order 26.4b1

Executive Director

7/10/26

Date

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
60A013 Y1	A. Building B. Wing Y2	7/10/2026 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTVIEW RANDOLPH, LLC	175 QUAKER CHURCH ROAD RANDOLPH, NJ 07869

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 A0779	Correction	ID Prefix A0783	Correction	ID Prefix A0935	Correction
Reg. # 8:36-7.5(c)	Completed	Reg. # 8:36-7.5(e)	Completed	Reg. # 8:36-11.4(b)	Completed
LSC	06/27/2026	LSC	06/27/2026	LSC	06/27/2026
ID Prefix A1051	Correction	ID Prefix A1073	Correction	ID Prefix	Correction
Reg. # 8:36-15.2	Completed	Reg. # 8:36-15.6(b)	Completed	Reg. #	Completed
LSC	06/27/2026	LSC	06/27/2026	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	
5/21/2026	☐ 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
60A013 Y1	A. Building B. Wing Y2	7/10/2026 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTVIEW RANDOLPH, LLC	175 QUAKER CHURCH ROAD RANDOLPH, NJ 07869

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Reg. # 8:36-15.2	Completed	Reg. # 8:36-15.6(b)	Completed	Reg. #	Completed
LSC	06/27/2026	LSC	06/27/2026	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	
5/21/2026	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO